parties are invited to attend and participate in the workshop and are requested to register in advance.

DATES: The public workshop will be held on Monday, March 30, 1998, 10:30 a.m.–5:00 p.m., Mountain Standard Time.

ADDRESSES: The workshop will be held in the Building 85 Auditorium at the Denver Federal Center, Denver, Colorado. You also may mail comments to Hugh Hilliard, as listed in the **FOR FURTHER INFORMATION CONTACT** section of this notice.

FOR FURTHER INFORMATION CONTACT: Mr. Hugh Hilliard, Chief, Appeals Division (MS 4230), or Ms. Charlotte Bennett, Appeals Division, (MS 4230), Minerals Management Service, 1849 C Street, NW, Washington, D.C., 20240, telephone number (202) 208–2622, fax number (202) 219–5565, e:mail: Hugh.Hilliard@mms.gov or Charlotte.Bennett@mms.gov.

SUPPLEMENTARY INFORMATION: In response to the notice of proposed rule to amend regulations governing the administrative appeals process, published in the **Federal Register** on October 28, 1996 (61 FR 55607), MMS received as a comment a comprehensive report from the Royalty Policy Committee (RPC), which adopted a recommendation from its Appeals and Alternative Dispute Resolution Subcommittee. The RPC, which is composed of representatives from states, Indian tribes and allottees, the mineral industries, other Federal agencies, and the public, advises the Secretary of the Interior under a charter authorized by the Federal Advisory Committee Act. On March 27, 1997, the RPC sent its report to the Secretary and requested adoption of its proposal in lieu of the October 28, 1996, proposed rule.

The Secretary sent a response to the RPC on September 22, 1997, stating that the Department planned to prepare revised proposed regulations to implement the RPC proposal, with several changes. The Secretary also stated that the public would have the opportunity to comment on these proposed regulations, which could change before they become final. MMS held its first public workshop on this matter on January 27, 1998 (see **Federal Register** notice at 62 FR 68244, December 31, 1997, for additional background provided before the first meeting).

The revised notice of proposed rule will affect not only appeals involving actions taken by officials of the MMS's Royalty Management Program, but also will affect appeals involving actions taken by the Offshore Minerals Management Program of MMS under the regulations at 30 CFR Part 250. In addition, the rule will affect activities of the Office of Hearings and Appeals, Interior Board of Land Appeals, as set out at 43 CFR Part 4 (though these effects are expected to be limited to appeals generated by actions of the Minerals Management Service).

We invite participation at the workshop by representatives of states, Indian tribes and allottees, the minerals industries, and the general public. We plan to present our initial views as to what will be in the revised proposed rule and to engage in open discussion with participants about any suggestions for improvement.

In order to help us plan for a successful workshop, we would appreciate your pre-registration by March 16. If you plan to attend, please contact Ms. Charlotte Bennett, using the methods provided in the **FOR FURTHER INFORMATION CONTACT** section of this notice, and provide your name, address, and telephone and fax numbers. This will help us to ensure sufficient space for all and to provide you with any relevant information available in advance of the meeting. In particular, we intend to distribute in advance a draft version of the revised notice of proposed rule.

Dated: March 3, 1998.

Walter D. Cruickshank,

Associate Director for Policy and Management Improvement.

[FR Doc. 98–6062 Filed 3–9–98; 8:45 am]

BILLING CODE 4310–MR–P

DEPARTMENT OF DEFENSE

Office of the Secretary

32 CFR Part 220

[RIN 0790–AG51]

Collection From Third Party Payers of Reasonable Costs of Healthcare Services

AGENCY: Office of the Assistant Secretary of Defense (Health Affairs), DoD.

ACTION: Proposed rule.

SUMMARY: This proposed rule implements several recent statutory changes and makes other revisions to the Third Party Collection Program. The primary matter include implementation of new statutory authority to include workers' compensation programs under the Third Party Collection Program; the addition of special rules for collections from preferred provider organizations; and other program revisions.

DATES: Comments are requested by May 11, 1998.

ADDRESSES: Forward comments to: Third Party Collection Program, Office of the Assistant Secretary of Defense (Health Affairs), Health Services Operations and Readiness, 1200 Defense Pentagon, Washington, DC 20301–1200.

FOR FURTHER INFORMATION CONTACT: LTC Michael Montgomery, 703–681–8910.

SUPPLEMENTARY INFORMATION: This proposes rule implements several recent statutory changes and makes other revisions to the Third Party Collection Program under 10 U.S.C. 1095, as discussed below.

1. Preferred Provider Organizations

Section 713(b)(1) of the National Defense Authorization Act for Fiscal Year 1994, Pub. L. 103–160, amended the Third Party Collection Program's definition of ''insurance, medical service, or health plan'' to clarify that any ''preferred provider organization'' (PPO) is included in the definition. This amendment codified DoD's previous interpretation. Experience in applying the statutory authority to the context of preferred provider organizations has indicated a need to establish some special rules for plans with PPO provisions or options so that all parties will have a clear understanding of their obligations and rights under the statute. We propose to do this by amending § 220.12.

It is our interpretation of 10 U.S.C. 1095 that a plan with a PPO provision or option generally has an obligation to pay the United States the reasonable costs of health care services provided through any facility of the Uniformed Services to a Uniformed Services beneficiary who is also a beneficiary under the plan. No provision of any PPO plan having the effect of excluding from coverage or limiting payment for certain care if that care is provided through a facility of the Uniformed Services shall operate to prevent collection under this part.

10 U.S.C. 1095 strikes a careful balance. On the one hand, it disallows third party payer rules that would have the effect of excluding from coverage or limiting payment because the care was provided in a DoD facility. The law renders inoperative numerous administrative procedures and payments rules of third party payers that would defeat the purpose of 10 U.S.C. 1095 or result in a windfall for a third party payer who has collected premiums but then avoided payments. On the other hand, the statute does not require third party payers to maker

fundamental changes in their own rules in order to accommodate Government providers. This proposed rule seeks to reflect that balance in our special rules for PPOs.

Consistent with the statutory mandate that the operation of the Third Party Collection Program is not dependent upon a participation agreement or similar contractual relationship between military treatment facilities and third party payers, this proposed rule states that the lack of a PPO agreement or the absence of privity of contract is not a permissible ground for refusing or reducing payment. Based on this and the careful statutory balance, we believe that under the law, the lack of a contractual relationship between the PPO and the facility of the Uniformed Services may not be a basis for the plan to treat the DoD facility as a non-PPO provider for purposes of the PPO's payment amount, if the facility of the Uniformed Services accommodates the PPO's fundamental price and utilization review standards.

Under this proposed rule, a DoD facility accommodates a PPO's fundamental price standards by accepting, in lieu of the normal Third Party Collection Program rates established under § 220.8, the PPO's prevailing rates of payment paid to preferred providers in the same geographic area for the same or similar aggregate groups of services, if such rates are, in the aggregate, less than the DoD rates. A DoD facility accommodates a PPO's fundamental utilization review standards by complying with the reasonable pretreatment, concurrent, or retrospective review procedures that are required of all preferred providers under the PPO plan and by accepting denials of requested payment that are consistent with prevailing standards in the geographic area of medical necessity and proper level of care for the services involved.

By accommodating a PPO's fundamental price and utilization review standards, DoD does not seek to compel the third party payer to make fundamental changes in the PPO program in order to conform to the DoD facility's operations. But other rules and procedures of the PPO that would have the effect of denying or limiting payment are not allowed. This proposed rule includes several examples of such impermissible PPO requirements. Among these is any PPO requirement that would purport to require a facility of the Uniformed Services, in order to effectuate the legislative purpose of 10 U.S.C. 1095, to act in a manner inconsistent with the basic nature of facilities of the Uniformed Services.

2. Workers' Compensation Programs

Section 735(b)(1) of the National Defense Authorization Act for Fiscal Year 1997, Pub. L.104–201, expanded the definition of ''third party payer'' to include any ''workers' compensation program or plan.'' The proposed rule adds § 220.13 and a definition of the statutory term to implement this amendment.

While specific statutory schemes vary from State to State, workers' compensation plans generally provide compensation to employees or their dependents for loss resulting from the injury, disablement, or death of a worker due to an employment related accident, casualty, or disease. The common characteristic of workers' compensation programs is the provision of compensation based upon a fixed statutory scheme without regard to fault. Payment for the costs and provision of medical care are also common elements of workers' compensation programs, whether the program operates on the basis of insurance, a State fund, or other mechanism.

Proposed § 220.13 states that a workers' compensation program generally has an obligation to pay the United States the reasonable costs of health care services provided in or through any facility of the Uniformed Services to a Uniformed Services beneficiary who is also a beneficiary of the workers' compensation program and whose condition is due to an employment related accident, casualty, or disease, We have added several special rules concerning lump-sum payments and compromise settlements. These special rules are modeled after Medicare Secondary Payer rules applicable to workers' compensation programs, which appear at 42 CFR 411.46–47. We have not determined whether additional special rules for applying 10 U.S.C. 1095 in the context of workers' compensation programs are necessary. Therefore, we solicit public comments from all interested parties on whether we need to clarify further the applicability of 10 U.S.C. 1095 to workers' compensation plan and, if so, specific suggestions as to such special rules.

3. Other Program Revisions and Clarifications

This proposed rule makes several other program revisions and clarifications, including:

- Proposed amendment to § 220.2(a) to conform with statutory language making 10 U.S.C. 1095 applicable to services provided in or ''through'' a facility of the Uniformed Services.
- Proposed amendment to § 220.2(d) to clarify the obligation of the third party payer to pay under the Third Party Collection Program is not only not dependent upon an assignment of benefits, it is also not dependent upon any other submission by the beneficiary to the third party payer, including any claim or appeal.
- Proposed addition of § 220.2(e) to codify in the regulation our interpretation of the preemptive effect of 10 U.S.C. 1095 in relation to any conflicting State laws or regulations.
- Proposed addition of § 220.3(c)(5) to record our interpretation of the applicability of 10 U.S.C. 1095 in connection with Medicare carve-out and Medicare secondary payer provisions of third party payer plans (other than Medicare supplemental plans). This is another application of the general rule that third party payers may not treat claims from facilities of the Uniformed Services less favorably than they lawfully treat claims from other provider (in this context, other providers to whom primary payment would not be made by Medicare or a Medicare HMO).
- Proposed amendment to § 220.4 to clarify the permissibility of certain third party payer rules, including utilization review practices, and HMO plan restrictions.
- Proposed addition of § 220.4(d) to record our requirement for payers to provide us plan information necessary to establish the permissibility of terms and conditions of third party payers' plans.
- Proposed amendment to § 220.7 to clarify the United States' remedies concerning collections from third party payers.
- Proposed amendment to § 220.8 to change and clarify DoD's actions in categorizing standardized amounts for the DRG-based payment method for inpatient care, in subdividing outpatient billings, and in replacing the ''same day surgery'' category of care with an expanded ''ambulatory procedure visit'' category.
- Proposed amendment to § 220.8(h), a special rule for certain ancillary services ordered by outside providers and provided by a facility of the Uniformed Services, to lower the high cost ancillary threshold value from $25 to $0. For this reason, effective March 1, 1998, ''high cost ancillary services'' will be referred to as ''ancillary services ordered by an outside provider and provided by a facility of the Uniformed Services.''
- Proposed amendment to § 220.8(j), concerning the former Public Health Service hospitals, to conform to the

changes to that program directed by Congress in sections 721 to 727 of the National Defense Authorization Act for Fiscal Year 1997.

- Proposed amendment to § 220.9(c) which elaborates on the obligations of beneficiaries to cooperate with facilities of the Uniformed Services in implementing these regulations.
- Proposed additions and amendments to § 220.14 to add and change, as necessary, the definitions of terms used in this part.

4. Other Issues

Under § 220.10(c), we provide preliminary notice of our intention to begin, effective January 1, 1998, to collect from Medicare supplemental plans reasonable costs for inpatient and outpatient copayments, other than the inpatient hospital deductible amount, and other services covered by Medicare supplemental plans. Although this authority is currently established in § 220.10(c), we had previously decided to defer implementation.

Executive Order 12866, "Regulatory Planning and Review"

It has been determined that this rule is not a significant rule as defined under section 3(f)(1) through 3(f)(4) of Executive Order 12866.

Public Law 96–354, "Regulatory Flexibility Act" (5 U.S.C. 601)

It has been determined that this rule will not have a significant economic impact on a substantial number of small entities because it affects only DoD employees and certain former DoD employees.

Public Law 96–511, "Paperwork Reduction Act" (44 U.S.C. Charter 35)

It has been certified that this rule does not impose any reporting or recordkeeping requirements under the Paperwork Reduction Act of 1995.

Public comments are invited on all provisions. All comments will be considered. Significant comments will be addressed in the final rule.

List of Subjects in 32 CFR Part 220

Claims, Health care, Health insurance.

For the reasons stated in the preamble, 32 CFR part 220 is proposed to be amended as follows:

PART 220—COLLECTION FROM THIRD PARTY PAYERS OF REASONABLE COSTS OF HEALTH CARE SERVICES

1. The authority citation for 32 CFR part 220 continues to read as follows:

Authority: 5 U.S.C. 301, 10 U.S.C. 1095.

2. Section 220.2 is proposed to be amended by revising paragraphs (a) and (d) and by adding a new paragraph (e) to read as follows:

§ 220.2 Statutory obligation of third party payer to pay.

(a) *Basic rule.* Pursuant to 10 U.S.C. 1095(a)(1), a third party payer has an obligation to pay the United States the reasonable costs of health care services provided in or through any facility of the Uniformed Services to a Uniformed Services beneficiary who is also a beneficiary under the third party payer's plan. The obligation to pay is to the extent that the beneficiary would be eligible to receive reimbursement of indemnification from the third party payer if the beneficiary were to incur the costs on the beneficiary's own behalf.

* * * * *

(d) *Assignment of benefits or other submission by beneficiary not necessary.* The obligation of the third party payer to pay is not dependent upon the beneficiary executing an assignment of benefits to the United States. Nor is the obligation to pay dependent upon any other submission by the beneficiary to the third party payer, including any claim or appeal. In any case in which a facility of the Uniformed Services makes a claim, appeal, representation, or other filing under the authority of this part, any procedural requirement in any third party payer plan for the beneficiary of such plan to make the claim, appeal, representation, or other filing must be deemed to be satisfied. A copy of the completed and signed DoD insurance declaration form will be provided to payers upon request, in lieu of a claimant's statement or coordination of benefits form.

(e) *Preemption of conflicting State laws.* Any provision of a law or regulation of a State or political subdivision thereof that purports to establish any requirement on a third party payer that would have the effect of excluding from coverage or limiting payment, for any health care services for which payment by the third party payer under 10 U.S.C. 1095 or this part is required, is preempted by 10 U.S.C. 1095 and shall have no force or effect in connection with the third party payer's obligations under 10 U.S.C. 1095 or this part.

3. Section 220.3 is proposed to be amended by adding a new paragraph (c)(5) to read as follows:

§ 220.3 Exclusions impermissible.

* * * * *

(c) * * *

(5) *Medicare carve-out and Medicare secondary payer provisions.* A provision in a third party payer plan, other than a Medicare supplemental plan under § 220.10, that seeks to make Medicare the primary payer and the plan the secondary payer or that would operate to carve out of the plan's coverage an amount equivalent to the Medicare payment the would be made if the services were provided by a provider to whom payment would be made under Part A or Part B of Medicare is not a permissible ground for refusing or reducing payment as the primary payer to the facility of the Uniformed Services by the third party payer unless the provision:

(i) Expressly disallows payment as the primary payer to all providers to whom payment would not be made under Medicare (including payment under Part A, Part B, or a Medicare HMO); and

(ii) Is otherwise in accordance with applicable law.

4. Section 220.4 is proposed to be amended by revising paragraphs (b)(2), (c)(2), and (c)(3) and by adding a new paragraph (d) to read as follows:

§ 220.4 Reasonable terms and conditions of health plan permissible.

* * * * *

(b) * * *

* * * * *

(2) Except as provided by 10 U.S.C. 1095, this part, or other applicable law, third party payers are not required to treat claims arising from services provided in or through facilities of the Uniformed Services more favorably than they treat claims arising from services provided in other facilities or by other health care providers.

(c) * * *

(2) *Generally applicable utilization review provisions.* (1) Reasonable and generally applicable provisions of a third party payer's plan requiring pre-admission screening, second surgical opinions, retrospective review or other similar utilization review activities may be permissible grounds to refuse or reduce third party payment if such refusal or reduction is required by the third party payer's plan.

(ii) Such provisions are not permissible if they are applied in a manner that would result in claims arising from services provided by or through facilities of the Uniformed Services being treated less favorably than claims arising from services provided by other hospitals or providers.

(iii) Such provisions are not permissible if they would not affect a third party payer's obligation under this part. For example, concurrent review of an inpatient hospitalization would

generally not affect the third party payer's obligation because of the DRG-based, per-admission basis for calculating reasonable costs under § 220.8(a) (except in long stay outlier cases, noted in § 220.8(a)(4)).

(3) *Restrictions in HMO plans.* Generally applicable exclusions in Health Maintenance Organization (HMO) plans of non-emergency or non-urgent services provided outside the HMO (or similar exclusions) are permissible. However, HMOs may not exclude claims or refuse to certify emergent and urgent services provided within the HMO's service area or otherwise covered non-emergency services provided out of the HMO's service area. In addition, opt-out or point-of-service options available under an HMO plan may not exclude services otherwise payable under 10 U.S.C. 1095 or this part.

(d) *Procedures for establishing reasonable terms and conditions.* In order to establish that a term or condition of a third party payer's plan is permissible, the third party payer must provide appropriate documentation to the facility of the Uniformed Services. This includes, when applicable, copies of explanation of benefits (EOBs), remittance advice, or payment to provider forms. It also includes copies of policies, employee certificates, booklets, or handbooks, or other documentation detailing the plan's health care benefits, exclusions, limitations, deductibles, co-insurance, and other pertinent policy or plan coverage and benefit information.

5. Section 220.7 is proposed to be amended by revising the section heading and paragraph (c) and by adding a new paragraph (d) to read as follows:

§ 220.7 Remedies and procedures.

* * * * *

(c) The authorities provided by 31 U.S.C. 3701, *et seq.*, 28 CFR part 11, and 4 CFR parts 101–104 regarding collection of indebtedness due the United States shall be available to effect collections pursuant to 10 U.S.C. 1095 and this part.

(d) A third party payer may not, without the consent of a U.S. Government official authorized to take action under 10 U.S.C. 1095 and this part, offset or reduce any payment due under 10 U.S.C. 1095 or this part on the grounds that the payer considers itself due a refund from a facility of the Uniformed Services. A request for refund must be submitted and adjudicated separately from any other claims submitted to the third party payer under 10 U.S.C. 1095 or this part.

6. Section 220.8 is proposed to be amended by revising paragraphs (a)(2), (a)(6), (e)(1), (f), and (h); by redesignating paragraph (j) as paragraph (j)(1); and by adding a new paragraph (j)(2), to read as follows:

§ 220.8 Reasonable costs.

(a) * * *

(2) *Standardized amount.* The standardized amount shall be determined by dividing the total costs of all inpatient care in all military treatment facilities by the total number of discharges. This will produce a single national standardized amount. The Department of Defense is authorized, but not required by this part, to calculate three standardized amounts, one for large urban, other urban/rural, and overseas areas, utilizing the same distinctions in identifying the first two areas as is used for CHAMPUS under 32 CFR 199.14(a)(1). Using this applicable standardized amount, the Department of Defense may make adjustments for area wage rates and indirect medical education costs (as identified in paragraph (a)(4) of this section), producing for each inpatient facility of the Uniformed Services a facility-specific ''adjusted standardized amount'' (ASA).

* * * * *

(6) *Outpatient billings.* Outpatient billings (including those for ambulatory procedure visits) may, but are not required by this part, to be subdivided into two categories:

(i) Professional charges (which refers to professional services provided by physicians and certain other providers); and

(ii) Outpatient services (which refers to overhead and ancillary, diagnostic and treatment services, other than professional services provided in connection with the outpatient visit).

* * * * *

(e) *Per visit rates.* (1) As authorized by 10 U.S.C. 1095(f)(2), the computation of reasonable costs for purposes of collections for most outpatient services shall be based on a per visit rate for a clinical specialty or subspecialty. The per visit charge shall be equal to the outpatient full reimbursement rate for that clinical specialty or subspecialty and includes all routine ancillary services. A separate charge will be calculated for cases that are considered ambulatory procedure visits. These rates shall be updated and published annually. As with inpatient billing categories, clinical groups representing selected board certified specialties/subspecialties widely accepted by graduate medical accrediting organizations such as the Accreditation Council for Graduate Medical Education (ACGME) or the American Board of Medical Specialties will be used for ambulatory billing categories. Related clinical groups may be combined for purposes of billing categories.

* * * * *

(f) *Ambulatory procedure visit rates.* A separate charge will be calculated for ambulatory procedure visits (APVs). APVs are same day surgery visits and other outpatient visits provided by designated, special treatment units in facilities of the Uniformed Services. APV rates shall be based on the total cost of immediate (day of procedure) pre-procedure; procedure; and immediate post-procedure care performed in the ambulatory procedure unit setting for care requiring less than 24 hours in the facility. An APV is not inpatient care. Initially, a single rate will be established for all types of ambulatory procedure visits. The Department of Defense is authorized, but not required by this part, to establish multiple ambulatory procedure visit reimbursement categories based on the clinic or subspecialty performing the ambulatory procedure. The average cost of APVs will be published annually.

* * * * *

(h) *Special rule for ancillary services ordered by outside providers and provided by a facility of the Uniformed Services.* If a Uniformed Services facility provides certain ancillary services, prescription drugs or other procedures requested by a source other than a Uniformed Services facility and are not incident to any outpatient visit or inpatient services, the reasonable cost will not be based on the usual Diagnostic Related Group (DRG) or per visit rate. Rather, a separate standard rate shall be established based on the cost of the particular services, drugs, or procedures provided. Effective March 1, 1998, this special rule applies to all services, drugs or procedures ordered by an outside provider and provided by a facility of the Uniformed Services. For such ancillary services provided prior to March 1, 1998, this special rule applies only to services, drugs or procedures having a cost of at least $25. The reasonable cost for the services, drugs or procedures to which this special rule applies shall be calculated and made available to the public annually.

* * * * *

(j) * * *

(2) The special rule set forth in paragraph (j)(1) of this section expires September 30, 1997. Effective October 1, 1997, collections for health care services

provided by these facilities are no longer covered by this part, but are covered by 32 CFR 199.8 (CHAMPUS Double Coverage).

* * * * *

7. Section 220.9 is proposed to be amended by revising paragraph (c) to read as follows:

§ 220.9. Rights and obligations of beneficiaries.

* * * * *

(c) *Obligation to disclose information and cooperate with collection efforts.* (1) Uniformed Services beneficiaries are required to provide correct information to the facility of the Uniformed Services regarding whether the beneficiary is covered by a third party payer's plan. Such beneficiaries are also required to provide correct information regarding whether particular health care services might be covered by a third party payer's plan, including services arising from an accident or workplace injury or illness. In the event a third party payer's plan might be applicable, a beneficiary has an obligation to provide such information as may be necessary to carry out 10 U.S.C. 1095 and this part, including identification of policy numbers, claim numbers, involved parties and their representatives, and other relevant information.

(2) Uniformed Services beneficiaries are required to take other reasonable steps to cooperate with the efforts of the facility of the Uniformed Services to make collections under 10 U.S.C. 1095 and this part, such as submitting to the third party payer (or other entity involved in adjudicating a claim) any requests or documentation that might be required by the third party payer (or other entity), if consistent with this part, to facilitate payment under this part.

(3) Intentionally providing false information or willfully failing to satisfy beneficiary's obligations are grounds for disqualification for health care services from facilities of the Uniformed Services.

8. Part 220 is further proposed to be amended by redesignating § 220.12 as § 220.14 and by adding new §§ 220.12 and 220.13 to read as follows:

§ 220.12 Special rules for preferred provider organizations.

(a) *Statutory requirement.* (1) Pursuant to the general duty of third party payers to pay under 10 U.S.C. 1095(a)(1) and the definitions of 10 U.S.C. 1095(h), a plan with a preferred provider organization (PPO) provision or option generally has an obligation to pay the United States the reasonable costs of health care services provided through any facility of the Uniformed Services to a Uniformed Services beneficiary who is also a beneficiary under the plan.

(2) This section provides specific rules for applying 10 U.S.C. 1095 and this part in the context of plans with a PPO provision or option.

(b) *PPO plan exclusions and limitations impermissible.* Under 10 U.S.C. 1095(b), no provision of any plan with a PPO provision or option having the effect of excluding from coverage or limiting payment for certain care if that care is provided through a facility of the Uniformed Services shall operate to prevent collection under this part.

(c) *PPO agreement not required.* The lack of a PPO agreement or the absence of privity of contract between a plan with a preferred provider organization provision or option and a facility of the Uniformed Services is not a permissible ground for refusing or reducing payment by the plan. The lack of a contractual relationship between the plan and the facility of the Uniformed Services may not be a basis for the plan to treat a facility of the Uniformed Services as a non-PPO provider for purposes of the plan's PPO payment amount, if the facility of the Uniformed Services accommodates the plan's fundamental price and utilization review standards for its PPO provision or option, as provided in this section.

(d) *Accommodation of PPO's fundamental price and utilization review standards.* A plan's duty to pay under this section is premised on the accommodation by the facility of the Uniformed Services of the plan's fundamental price and utilization review standards for its PPO provision or option, as provided in this paragraph.

(1) A facility of the Uniformed Services accommodates a plan's fundamental PPO price standards by accepting, in lieu of the rates established under § 220.8, the plan's demonstrated PPO prevailing rates of payment paid to preferred providers in the same geographic area for the same or similar aggregate groups of services, if such rates are, in the aggregate, less than the rates established under § 220.8. The determination of the plan's PPO prevailing rates shall be based on a review of all rates, including the professional and technical components, contained in all valid contractual arrangements with facilities and providers in the PPO network for the year in which the services were rendered. The rates for any specific ancillary procedure must include both professional and technical components.

(2) A facility of the Uniformed Services accommodates a plan's fundamental PPO utilization review standards by complying with the reasonable pretreatment, concurrent, or retrospective review procedures that are required of all preferred providers under the plan and by accepting denials or reductions of requested payment that are consistent with prevailing standards in the geographic area for medical necessity and proper level of care for the services involved.

(e) *Examples of impermissible PPO requirements.* PPO requirements unnecessary for the achievement of the PPO's fundamental price and utilization review standards and would have the effect of excluding or limiting payment to a facility of the Uniformed Services are impermissible. Examples of such impermissible PPO requirements follow:

(1) A requirement that a PPO provider accept all beneficiaries of the PPO's plan. A facility of the Uniformed Services may provide health care services only to persons with eligibility established pursuant to 10 U.S.C.

(2) A requirement that a PPO provider meet particular credentialing, licensing, certification, or other provider selection requirements intended to promote good quality of care. Facilities of the Uniformed Services comply with federal quality standards and a comprehensive system of provider credentialing and quality assurance.

(3) A requirement that PPO providers restrict patient referrals to particular providers in the PPO network or order ancillary services only from particular providers. Facilities of the Uniformed Services carry out patient referrals and the ordering of ancillary services in accordance with applicable Department of Defense rules and procedures.

(4) Any other PPO requirement that would purport to require a facility of the Uniformed Services, in order to effectuate the legislative purpose of 10 U.S.C. 1095, to act in a manner inconsistent with the basic nature of facilities of the Uniformed Services.

§ 220.13 Special rules for workers' compensation programs.

(a) *Basic rule.* Pursuant to the general duty of third party payers under 10 U.S.C. 1095(a)(1) and the definitions of 10 U.S.C. 1095(h), a workers' compensation program or plan generally has an obligation to pay the United States the reasonable costs of health care services provided in or through any facility of the Uniformed Services to a Uniformed Services beneficiary who is also a beneficiary under a workers' compensation program due to an employment related injury, illness, or disease. Except to the extent modified or supplemented by this section, all provisions of this part are applicable to

any workers' compensation program or plan in the same manner as they are applicable to any other third party payer.

(b) *Special rules for lump-sum settlements.* In cases in which a lump-sum workers' compensation settlement is made, the special rules established in this paragraph (b) shall apply for purposes of compliance with this section.

(1) *Lump-sum commutation of future benefits.* If a lump-sum worker's compensation award stipulates that the amount paid is intended to compensate the individual for all future medical expenses required because of the work-related injury, illness, or disease, the Uniformed Service health care facility is entitled to reimbursement for injury, illness, or disease related, future health care services or items rendered or provided to the individual up to the amount of the lump-sum payment.

(2) *Lump-sum compromise settlement.* (i) A lump sum compromise settlement, unless otherwise stipulated by an official authorized to take action under 10 U.S.C. 1095 and this part, is deemed to be a workers' compensation payment for the purpose of reimbursement to the facility of the Uniformed Services for services and items provided, even if the settlement agreement stipulates that there is no liability under the workers' compensation law, program, or plan.

(ii) If a settlement appears to represent an attempt to shift to the facility of the Uniformed Services the responsibility of providing uncompensated services or items for the treatment of the work-related condition, the settlement will not be recognized and reimbursement to the unformed health care facility will be required. For example, if the parties to a settlement attempt to maximize the amount of disability benefits paid under workers' compensation by releasing the employer or workers' compensation carrier from liability for medical expenses for a particular condition even though the facts show that the condition is work-related, the facility of the Uniformed Services must be reimbursed.

(iii) Except as specified in paragraph (b)(2)(iv) of this section, if a lump-sum compromise settlement forecloses the possibility of future payment or workers' compensation benefits, medical expenses incurred by a facility of the Uniformed Services after the date of the settlement are not reimbursable under this section.

(iv) As an exception to the rule of paragraph (b)(2)(iii) of this section, if the settlement agreement allocates certain amounts for specific future medical services, the facility of the Uniformed Services is entitled to reimbursement for those specific services and items provided resulting from the work-related injury, illness, or disease up to the amount of the lump-sum settlement allocated to future expenses.

(3) *Apportionment of a lump-sum compromise settlement of a workers' compensation claim.* If a compromise settlement allocates a portion of the payment for medical expenses and also gives reasonable recognition to the income replacement element, that apportionment may be accepted as a basis for determining the payment obligation of a workers' compensation program or plan under this section to a facility of the Uniformed Services. If the settlement does not give reasonable recognition to both elements of a workers' compensation award or does not apportion the sum granted, the portion to be considered as payment for medical expenses is computed as follows: Determine the ratio of the amount awarded (less the reasonable and necessary costs incurred in procuring the settlement) to the total amount that would have been payable under workers' compensation if the claim had not been compromised; multiply that ratio by the total medical expenses incurred as a result of the injury or disease up to the date of settlement. The product is the amount of workers' compensation settlement to be considered as payment or reimbursement for medical expenses.

(c) *Other special rules.* [Reserved]

8. Newly designated § 220.14 is amended by removing paragraph designations (a) through (l), by revising the definitions of ''insurance, medical service or health plan,'' ''Medicare supplemental insurance plan,'' ''third party payer,'' and ''third party payer plan,'' and by adding and placing in alphabetical order new definitions of ''ambulatory procedure visit,'' ''Assistant Secretary of Defense (Health Affairs),'' ''covered beneficiaries,'' ''preferred provider organization,'' and ''workers' compensation program or plan,'' to read as follows:

§ 220.14 Definitions.

Ambulatory procedure visit. An ambulatory procedure visit is a type of outpatient visit in which immediate (day of procedure) pre-procedure and immediate post-procedure care require an unusual degree of intensity and are provided in an ambulatory procedure unit (APU) of the facility of the Uniformed Services. Care is required in the facility for less than 24 hours. An APU is specially designated and is accounted for separately from any outpatient clinic.

Assistant Secretary of Defense (Health Affairs). This term includes any authorized designee of the Assistant Secretary of Defense (Health Affairs).

Automobile liability insurance. * * *

CHAMPUS supplemental plan. * * *

Covered beneficiaries. Covered beneficiaries are all health care beneficiaries under chapter 55 of title 10, United States Code, except members of the Uniformed Services on active duty.

Facility of the Uniformed Services. * * *

Healthcare services. * * *

Inpatient hospital care. * * *

Insurance, medical service or health plan. Any plan (including any plan, policy program, contract, or liability arrangement) that provides compensation, coverage, or indemnification for expenses incurred by a beneficiary for health or medical services, items, products, and supplies. It includes but is not limited to:

(1) Any plan offered by an insurer, reinsurer, employer, corporation, organization, trust, organized health care group or other entity.

(2) Any plan for which the beneficiary pays a premium to an issuing agent as well as any plan to which the beneficiary is entitled as a result of employment or membership in or association with an organization or group.

(3) Any Employee Retirement Income and Security Act (ERISA) plan.

(4) Any Multiple Employer Trust (MET).

(5) Any Multiple Employer Welfare Arrangement (MEWA).

(6) Any Health Maintenance Organization (HMO) plan, including any such plan with a point-of-service provision or option.

(7) Any individual practice association (IPA) plan.

(8) Any exclusive provider organization (EPO) plan.

(9) Any physician hospital organization (PHO) plan.

(10) Any integrated delivery system (IDS) plan.

(11) Any management service organization (MSO) plan.

(12) Any group or individual medical services account.

(13) Any preferred provider organization (PPO) plan or any PPO provision or option of any third party payer plan.

(14) Any Medicare supplemental insurance plan.

(15) Any automobile liability insurance plan.

(16) Any no fault insurance plan, including any personal injury protection plan or medical payments benefit plan

for personal injuries arising from the operation of a motor vehicle.

Medicare eligible provider. * * *

Medicare supplemental insurance plan. A Medicare supplemental insurance plan is an insurance, medical service or health plan primarily for the purpose of supplementing an eligible person's benefit under Medicare. The term has the same meaning as ''Medicare supplemental policy'' in section 1882(g)(1) of the Social Security Act (42 U.S.C. 1395ss) and 42 CFR part 403, subpart B.

No-fault insurance. * * *

Preferred provider organization. A preferred provider organization (PPO) is any arrangement in a third payer plan under which coverage is limited to services provided by a select group of providers who are members of the PPO or incentives (for example, reduced copayments) are provided for beneficiaries under the plan to receive health care services from the members of the PPO rather than from other providers who, although authorized to be paid, are not included in the PPO. However, a PPO does not include any organization that is recognized as a health maintenance organization.

Third party payer. A third party payer is an entity that provides an insurance, medical service, or health plan by contract or agreement. It includes but is not limited to:

(1) State and local governments that provide such plans.

(2) Insurance underwriters or carriers.

(3) Private employers or employer groups offering self-insured or partially self-insured medical service or health plans.

(4) Automobile liability insurance underwriter or carrier.

(5) No fault insurance underwriter or carrier.

(6) Workers' compensation program or plan sponsor, underwriter, carrier, or self-insurer.

Third party payer plan. A third party payer plan is any plan or program provided by a third party payer, but not including an income or wage supplemental plan.

Uniformed Services beneficiary. * * *

Workers' compensation program or plan. A workers' compensation program or plan is any program or plan that provides compensation for loss, to employees or their dependents, resulting from the injury, disablement, or death of an employee due to an employment related accident, casualty or disease. The common characteristic of such a plan or program is the provision of compensation regardless of fault, in accordance with a delineated schedule based upon loss or impairment of the worker's wage earning capacity, as well as indemnification or compensation for medical expenses relating to the employment related injury or disease. A workers' compensation program or plan includes any such program or plan:

(1) Operated by or under the authority of any law of any State (or the District of Columbia, American Samoa, Guam, Puerto Rico, and the Virgin Islands).

(2) Operated through an insurance arrangement or on a self-insured basis by an employer.

(3) Operated under the authority of the Federal Employees Compensation Act or the Longshoremen's and Harbor Workers' Compensation Act.

Dated: March 4, 1998.

L.M.Bynum,

Alternate OSD Federal Register Liaison Officer Department of Defense.

[FR Doc. 98–6076 Filed 3–9–98; 8:45 am]

BILLING CODE 5000–04–M

DEPARTMENT OF TRANSPORTATION

Coast Guard

33 CFR Part 117

[CGD08–96–048]

Drawbridge Operating Regulation; Tchefuncta River, LA

AGENCY: Coast Guard, DOT.

ACTION: Notice; withdrawal of proposed rule.

SUMMARY: The Coast Guard is withdrawing a notice of proposed rulemaking (NPRM) to amend the regulation for the draw of the swing span bridge across the Tchefuncta River, mile 2.5, near Madisonville, St. Tammany Parish, Louisiana. The proposed rule did not meet the reasonable needs of navigation. The Coast Guard is withdrawing the notice of proposed rulemaking and terminating this rulemaking.

DATES: The proposed rule is withdrawn effective March 10, 1998.

ADDRESSES: Unless otherwise indicated, documents referred to in this notice are available for inspection or copying at the office of the Eighth Coast Guard District, Bridge Administration Branch, Hale Boggs Federal Building, room 1313, 501 Magazine Street, New Orleans, Louisiana 70130–3396 between 7 a.m. and 4 p.m., Monday through Friday, except Federal holidays. The telephone number is (504) 589–2965. Commander (ob) maintains the public docket for this rulemaking.

FOR FURTHER INFORMATION CONTACT: Mr. David Frank, Bridge Administration Branch, Commander (ob), Eighth Coast Guard District, 501 Magazine Street, New Orleans, Louisiana, 70130–3396, telephone number 504–589–2965.

SUPPLEMENTARY INFORMATION:

Regulatory History

On November 22, 1996, the Coast Guard published a notice of proposed rulemaking (NPRM) in the **Federal Register** (61 FR 59396). The NPRM proposed to require that the draw of the swing span bridge across the Tchefuncta River, mile 2.5, at Madisonville will open on demand; except that from 5 a.m. until 8 p.m. the draw would open only on the hour. Presently, the draw is required to open on signal; except that from 5 a.m. until 8 p.m. the draw opens on the hour and half-hour.

The Coast Guard received 22 letters in response to the NPRM. Seventeen of the letters were in opposition to the new proposed rule based on the fact that the majority of the waterway users are sailing vessels with single screw propulsion which cannot maneuver easily raising safety concerns. The bridge owner has not addressed the concerns of these objectors, offered an alternative proposal, or pursued the matter any further. No other parties submitted alternative proposals.

The Coast Guard agreed with the comments that the proposal was too burdensome and did not meet the reasonable needs of vessel traffic. The Louisiana Department of Transportation and Development has not offered an alternative proposal. The Coast Guard is, therefore, withdrawing the notice of proposed rulemaking and terminating further rulemaking on this proposal (CGD08–96–048).

Dated: February 23, 1998.

T.W. Josiah,

Rear Admiral, U.S. Coast Guard, Commander, Eighth Coast Guard District.

[FR Doc. 98–6009 Filed 3–9–98; 8:45 am]

BILLING CODE 4910–14–M

DEPARTMENT OF TRANSPORTATION

Coast Guard

33 CFR Part 117

[CGD08–94–033, CGD08–95–011]

Drawbridge Operating Regulation; Gulf Intracoastal Waterway, LA

AGENCY: Coast Guard, DOT.

ACTION: Notice; withdrawal of proposal rules.