help the NRC resolve current challenges and prepare for anticipated future regulatory issues. The responding submittal should describe the proposed research and the potential use of the research results in current or future regulatory activities. We also solicit your comments on the factors that should be considered when anticipatory research topics are prioritized. Responses to this request will be evaluated for possible inclusion in the FY 2006 and FY 2007 budgets.

To permit these new topics to be considered in developing future plans, your recommendations should be submitted no later than November 28, 2003, to: Michael Lesar, Chief, Rules and Directives Branch, Mail Stop T–6D59, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001. Comments may also be submitted by e-mail to *NRCREP@NRC.GOV.*

(5 U.S.C. 552(a))

Dated at Rockville, MD, this 27th Day of October 2003.

For the Nuclear Regulatory Commission.

Alan E. Levin,

Senior Technical Advisor to the Director, Office of Nuclear Regulatory Research.

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BILLING CODE 7590–01–P

OFFICE OF MANAGEMENT AND BUDGET

Cost of Hospital and Medical Care Treatment Furnished by the United States; Certain Rates Regarding Recovery From Tortiously Liable Third Persons

By virtue of the authority vested in the President by Section 2(a) of Pub. L. 87–693 (76 Stat. 593; 42 U.S.C. 2652), and delegated to the Director of the Office of Management and Budget by Executive Order No. 11541 of July 1, 1970 (35 **Federal Register** 10737), the two sets of rates outlined below are hereby established. These rates are for use in connection with the recovery, from tortiously liable third persons, of the cost of hospital and medical care and treatment furnished by the United States (Part 43, Chapter I, Title 28, Code of Federal Regulations) through three separate Federal agencies. The rates have been established in accordance with the requirements of OMB Circular A–25, requiring reimbursement of the full cost of all services provided and will remain in effect until further notice. The rates for the Department of Veterans Affairs and the Indian Health Service in the Department of Health and Human Services that were published in the **Federal Register** on October 31, 2000 and December 26, 2001, respectively, remain in effect until further notice. In addition, the inpatient rates for the Department of Defense published in on December 9, 2002 remain in effect until further notice. The rates are as follows:

1. Department of Defense

The Fiscal Year (FY) and Calendar Year (CY) 2003 Department of Defense (DoD) reimbursement rates for inpatient, outpatient, and other services are provided in accordance with Title 10, United States Code, section 1095. Due to size, the sections containing the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) Maximum Allowable Charges (CMAC, section II), Dental (section III. F), Pharmacy (section III. D), and Durable Medical Equipment/Durable Medical Supplies (DME/DMS) (section III. K) are not included in this package. Those rates are available from the TRICARE Management Activity (TMA) Uniform Business Office (UBO) Web site: *http://www.tricare.osd.mil/ebc/rm_home/ubo_documents_rates_tables.cfm.*

The outpatient rates in this package will have an effective date of May 1, 2003. The inpatient medical rates in this package, republished in this package, are from the December 9, 2002 package and are referenced above on the UBO Web site; these became effective October 1, 2002.

A government billing calculation factor (percentage discount) for billing outpatient International Military Education and Training (IMET) (58.57% of full rate), and Interagency and Other Federal Agency Sponsored Patients (IAR) rate (93.14% of full rate), will be applied to the line item charges calculated for outpatient medical and ancillary services using CMAC or anesthesia charges.

Inpatient, Outpatient, and Other Rates and Charges

I. Inpatient Rates

A. All Inpatient Services

(Based on Diagnosis Related Groups (DRG) [1] [2])

1. Average FY 2003 Direct Care Inpatient Reimbursement Rates

Adjusted standard amount (ASA)	International military education & training (IMET)	Interagency and other federal agency sponsored patients	Other (full/third party)
Large Urban	$3,521.00	$6,434.00	$6,748.00
Other Urban/Rural	4,316.00	7,191.00	7,575.00
Overseas	4,443.00	9,879.00	10,344.00

2. Overview

The FY 2003 inpatient rates are based on the cost per DRG, which is the inpatient full reimbursement rate per hospital discharge weighted to reflect the intensity of the principal diagnosis, secondary diagnoses, procedures, patient age, etc. involved. The average cost per Relative Weighted Product (RWP) for large urban, other urban/rural, and overseas facilities will be published annually as an inpatient adjusted standardized amount (ASA) (see paragraph I.A.1., above). The ASA will be applied to the RWP for each inpatient case, determined from the DRG weights, outlier thresholds, and payment rules published annually for hospital reimbursement rates under CHAMPUS pursuant to 32 CFR 199.14(a)(1), including adjustments for length of stay (LOS) outliers. Each military treatment facility (MTF) providing inpatient care has a separate ASA rate. The MTF-specific ASA rate is the published ASA rate adjusted for area wage differences and indirect medical education (IME) for the discharging hospital (see Attachment 1). The MTF-specific ASA rate submitted on the claim is the rate that payers will use for reimbursement purposes. An example of

how to apply a specific military treatment facility's ASA rate to a DRG standardized weight to arrive at the costs to be recovered is contained in paragraph I.A.3., below.

3. Example of Adjusted Standardized Amounts for Inpatient Stays

Figure 1 shows examples for a non-teaching hospital (Reynolds Army Community Hospital) in an Other Urban/Rural area.

a. The cost to be recovered is the MTF's cost for medical services provided. Billings will be at the third party rate.

b. DRG 020: Nervous System Infection Except Viral Meningitis. The RWP for an inlier case is the CHAMPUS weight of 2.1159. (DRG statistics shown are from FY 2002.)

c. The FY 2003 MTF-applied ASA rate is $7,152.00 (Reynolds Army Community Hospital's third party rate as shown in Attachment 1).

d. The MTF cost to be recovered is the RWP factor (2.1159) in subparagraph 3.b., above, multiplied by the amount ($7,152.00) in subparagraph 3.c., above.

e. Cost to be recovered is $15,134.00.

FIGURE 1.—THIRD PARTY BILLING EXAMPLES

DRG No.	DRG description	DRG weight	Arithmetic mean LOS	Geometric mean LOS	Short stay threshold	Long stay threshold
020	Nervous System Infection Except Viral Meningitis	2.1159	7.6	5.5	1	29

Hospital	Location	Area wage rate index	IME adjustment	Group ASA	MTF-applied ASA
Reynolds Army Community Hospital	Other Urban/Rural	.8251	1.0	$7,575.00	$7,152.00

Patient	Length of stay	Days above threshold	Relative weighted product			TPC amount***
			Inlier*	Outlier**	Total	
#1	7 days	0	2.1159	000	2.1159	$15,134.00
#2	21 days	0	2.1159	000	2.1159	15,134.00
#3	35 days	6	2.1159	.7617	2.8776	20,581.00

* DRG Weight.
** Outlier calculation = 33 percent of per diem weight × number of outlier days.
=.33 (DRG Weight/Geometric Mean LOS) × (Patient LOS − Long Stay Threshold).
=.33 (2.1159/5.5) × (35–29).
=.33 (.38471) × 6 (extend to five decimal places).
=.12695 × 6 (extend to five decimal places).
=.7617 (extend to four decimal places).
*** MTF-Applied ASA x Total RWP.

II. Outpatient Rates[2 3 4]

A. *CMAC Rates.* The CHAMPUS Maximum Allowable Charge (CMAC) rates, established under 32 CFR 199.14(h), are used for determining the appropriate charge for services in an itemized format, based on Healthcare Common Procedure Coding System (HCPCS) methodology. The CMAC rates are available on the TMA UBO Web site at *http://www.tricare.osd.mil/ebc/rm_home/ubo_documents_rates_tables.cfm.* The CMAC rate tables contain the rates for radiology, laboratory, clinic procedures/services, and Evaluation and Management (E/M) Current Procedural Terminology (CPT) codes.

CMAC is organized by 90 distinct ''localities,'' which account for differences in geographic regions based on demographics, cost of living, and population. Each MTF Defense Military Information System identification (DMIS ID) will map to a locality code to obtain the correct rates. For the complete DMIS ID locality table please refer to the DMIS ID Web site at *http://www.dmisid.com/cgi-dmis/default.*

In each locality, there are three subtables of rates: CMAC, Component, and Non-CMAC. The CMAC rate table determines the payment for individual professional services and procedures identified CPT and HCPCS codes. The Component rate table is based on component rates comprising professional, technical and global rates. The Non-CMAC rate table captures pricing for procedure codes at the local or state level. Each state/locality does not have the same set of prevailing rates. When rates are pulled from the Non-CMAC table, the prevailing local fee is used in all cases.

Within the CMAC tables, the rates are based not only on HCPCS but on a ''Provider Class'' based on medical specialty of the provider. Each provider is mapped to a provider class to calculate the correct rate.

B. *Per Clinic Visit.* With implementation of OIB, an all-inclusive rate per clinic visit will no longer be charged. Instead, charges will be based on services provided and will be itemized.

C. *Ambulatory Procedure Visit (APV)—Per Visit*[5]. APV charges are based on the CPT codes of the procedures performed. An itemized bill will be produced for the charges associated with the APV including ancillaries and anesthesia as applicable.

III. Other Rates and Charges

A. *Immunization* The charge for immunizations, allergen extracts, allergic condition tests, and the administration of certain medications when these services are provided in a separate immunization or shot clinic, are based on CMAC rates in cases in which such rates are available. In cases in which such rates are not available, rates will be based on the average full cost of these services, exclusive of any costs considered for purposes of any outpatient visit. A separate charge shall be made for each immunization, injection or medication administered. If there is no CMAC rate available for an immunization or injection then the flat rate of $34.00 will be billed.

B. *Subsistence Rate*[6]. The standard and discount rates for subsistence are available from the DoD Comptrollers Web site, Tab G: *http://www.dod.mil/comptroller/ratesindex2003.html.*

C. *Family Member Rate* $12.72 (with exception of spouses and other

dependents of enlisted personnel in pay grades E–1 through E–4, who are charged the discount meal rate—See Comptrollers Web site, Tab G: *http://www.dod.mil/comptroller/ratesindex2003.html.*

D. *Pharmacy*[7]. All medications, both internal and external, are billable. The rates for pharmacy are based on the average full cost of these drugs. These rates will be updated quarterly. These rates in this table are based on National Drug Code (NDC) codes. This rate table may be found on the TMA UBO Web site at *http://www.tricare.osd.mil/ebc/rm_home/ubo_documents_rates_tables.cfm.*

E. *Ancillary Services. Per Procedure*[8]. All Laboratory and Radiology procedures will be billed per CMAC Rates, including those associated with a clinic visit.

F. *Dental Rate—Per Procedure*[9].

CDT/CPT	Clinical service	International military education and training (IMET)	Interagency and other Federal agency sponsored patients	Other (full/third party)
	Dental Services ADA code weight multiplier	$26.00	$60.00	$63.00

G. *Ambulance Rate—Per Hour*[10].

CDT/CPT	Clinical service	International military education and training (IMET)	Interagency and other Federal agency sponsored patients	Other (full/third party)
A0999	Ambulance	$102.00	$140.00	$147.00

H. *AirEvac Rate—Per Trip (24-hour period)*[11].

Clinical Service	International military education & training (IMET)	Interagency & other Federal agency sponsored patients	Other (full/third party)
AirEvac Services—Ambulatory	$361.00	$494.00	$518.00
AirEvac Services—Litter	1,047.00	1,435.00	1,503.00

I. *Observation Rate—Per Hour*[12]. Under OIB, observation services will be billed according to applicable CPT codes.

J. *Anesthesia* The flat rate for anesthesia services is based on an average DoD cost of service in all MTFs. The range of HCPCS codes for anesthesia is 00100–01999. The flat rate for anesthesia will be $174.00.

K. *Durable Medical Equipment/Durable Medical Supplies (DME/DMS)* Durable Medical Equipment (DME) and Durable Medical Supplies (DMS) are based on the Medicare Fee Schedule floor rate. The HCPCS codes contained in this table are for A4212–A7509, E0100–E2101, K0001–K0551, L0100–L8670, and V2020–V2780. This rate table may be found on the TMA UBO Web Site at *http://www.tricare.osd.mil/ebc/rm_home/ubo_documents_rates_tables.cfm.*

IV. Elective Cosmetic Surgery Procedures and Rates 13/

Cosmetic surgery procedure	Current procedural terminology (CPT)[e]	FY 2003 charge	Amount of charge
Abdominoplasty	15831	Inpatient Charge per DRG or CPT	(a b c)
Blepharoplasty	15820, 15821, 15822, 15823	Inpatient Charge per DRG or CPT	(a b c)
Botox Injection for rhytids	J0585	Inpatient Charge per DRG or CPT	(a b c)
Brachioplasty	15836	Inpatient Charge per DRG or CPT	(a b c)
Brow Lift	15824, 15839	Inpatient Charge per DRG or CPT	(a b c)
Buttock Lift	15835	Inpatient Charge per DRG or CPT	(a b c)
Canthopexy	21282, 67950	Inpatient Charge per DRG or CPT	(a b c)
Cervicoplasty	15819	Inpatient Charge per DRG or CPT	(a b c)
Chemical Peel	15788, 15789, 15792, 15793	Inpatient Charge per DRG or CPT	(a b c)
Collagen Injection, subcutaneous	11950, 11951, 11952, 11954	Inpatient Charge per DRG or CPT	(a b c)
Dermabrasion	15780, 15781, 15782, 15783	Inpatient Charge per DRG or CPT	(a b c)
Arm/Thigh Dermolipectomy	15836, 15832	Inpatient Charge per DRG or CPT	(a b c)

Cosmetic surgery procedure	Current procedural terminology (CPT)[e]	FY 2003 charge	Amount of charge
Excision/destruction of minor benign skin lesions.	11400, 11401, 11402, 11403, 11404, 11406, 11420, 11421, 11422, 11423, 11424, 11426, 11440, 11441, 11442, 11443, 11444, 11446, 17000, 17003, 17004, 17106, 17107, 17108, 17110, 17111, 17250.	Inpatient Charge per DRG or CPT	(a b c)
Facial Rhytidectomy	15824, 15825, 15826, 15828, 15829	Inpatient Charge per DRG or CPT	(a b c)
Genioplasty	21120, 21121	Inpatient Charge per DRG or CPT	(a b c)
Hair Restoration	15775, 15776	Inpatient Charge per DRG or CPT	(a b c)
Hip Lift	15834	Inpatient Charge per DRG or CPT	(a b c)
Laser Resurfacing	17999	Inpatient Charge per DRG or CPT	(a)
Lipectomy Suction per region	15876, 15877, 15878, 15879	Inpatient Charge per DRG or CPT	(a b c f)
Malar Augmentation	21270	Inpatient Charge per DRG or CPT	(a b c)
Mammaplasty—augmentation	19318, 19324, 19325,	Inpatient Charge per DRG or CPT	(a b)
Mandibular or Maxillary Repositioning	21194	Inpatient Charge per DRG or CPT	(a b c)
Mastopexy	19316	Inpatient Charge per DRG or CPT	(a b c)
Mentoplasty (Augmentation/Reduction)	21208, 21209	Inpatient Charge per DRG or CPT	(a b c)
Otoplasty	69300	Inpatient Charge per DRG or CPT	(a b c)
Refractive surgery (see the following two procedures):			
Radial Keratotomy	65771	CPT	(b c d)
Other Procedure (if applies to laser or other refractive surgery).	66999	CPT	(b c d)
Rhinoplasty	30400, 30410, 30430, 30435, 30450, 30460, 30462.	Inpatient Charge per DRG or CPT	(a b c)
Scar Revisions beyond CHAMPUS	13120, 13121, 13122, 13131, 13132, 13133, 13150, 13152, 13153.	Inpatient Charge per DRG or CPT	(a b c)
Sclerotherapy	36468, 36469, 36470, 36471, 15780, 15781, 15782, 15783, 15786.	Inpatient Charge per DRG or CPT	(a b c)
Tattoo Removal	15780, 15783, 17999	Inpatient Charge per DRG or CPT	(a b c)
Thigh Lift	15832	Inpatient Charge per DRG or CPT	(a b c)
Vein Stripping	37720, 37730, 37735	Inpatient Charge per DRG or CPT	(a b c)

Notes on Cosmetic Surgery Charges:

[a] Charges for Inpatient surgical care services are based on the cost per DRG.

[b] Charges for outpatient surgical care services are based on the cost per CPT code.

[c] All required DoD guidelines and instructions for APVs must be followed. An ambulatory procedure visit is defined in DoD Instruction 6025.8, ''Ambulatory Procedure Visit (APV),'' dated September 23, 1996, as immediate (day of procedure) pre-procedure and immediate post-procedure care requiring an unusual degree of intensity and provided in an ambulatory procedure unit (APU). An APU is a location or organization within an MTF (or freestanding outpatient clinic) that is specially equipped, staffed, and designated for the purpose of providing the intensive level of care associated with APVs. Care is required in the facility for less than 24 hours. All expenses and workload are assigned to the MTF-established APU associated with the referring clinic.

[d] Refer to Office of the Assistant Secretary of Defense (Health Affairs) policy on Vision Correction Via Laser Surgery For Non-Active Duty Beneficiaries, April 7, 2000, for further guidance on billing for these services. The policy can be downloaded from: *http://www.ha.osd.mil/policies/2000/00_003.pdf.*

[e] The attending physician is to document and record the appropriate DRG/CPT code to indicate the procedure followed during cosmetic surgery. It is up to the physician to decide whether or not the services are considered medically necessary or elective.

[f] Each regional lipectomy shall carry a separate charge. Regions include head and neck, abdomen, flanks, and hips.

Notes on Reimbursable Rates

[1] The cost per Diagnosis Related Group (DRG) is based on the inpatient full reimbursement rate per hospital discharge, weighted to reflect the intensity of the principal and secondary diagnoses, surgical procedures, and patient demographics involved. The ASA per RWP for use in the direct care system is comparable to procedures used by the Centers for Medicare and Medicaid Services (CMS) and CHAMPUS. These expenses include all direct care expenses associated with direct patient care. The average cost per RWP for large urban, other urban/rural, and overseas will be published annually as an adjusted standardized amount (ASA) and will include the cost of inpatient professional services. The DRG rates will apply to reimbursement from all sources, not just third party payers.

MTFs without inpatient services, whose providers are performing inpatient care in a civilian facility for a DoD beneficiary, can bill payers the percentage of the charge that represents professional services as provided above. The ASA rate used in these cases, based on the absence of an ASA rate for the facility, will be based on the average ASA rate for the type of metropolitan statistical area the MTF resides, large urban, other urban/rural, or overseas (see paragraph I.A.1.). The UBO must receive documentation of care provided in order to produce a bill.

[2] Percentages can be applied when preparing bills for inpatient services. Pursuant to the provisions of 10 U.S.C. 1095, the inpatient Diagnosis Related Groups percentages are 96 % hospital and 4% professional charges. When preparing bills for outpatient services, professional fees are based on the E/M charges, the hospital fees are based on the charges for ancillary services, pharmacy and supplies.

[3] The Medical Expense and Performance Reporting System (MEPRS) code is a three digit code which defines the summary account and the subaccount within a functional category in the DoD medical system. MEPRS codes are used to ensure that consistent expense and operating performance data is reported in the DoD military medical system. An example of the MEPRS hierarchical arrangement follows:

	MEPRS Code
Outpatient Care (Functional Category).	B
Medical Care (Summary Account).	BA
Internal Medicine (Subaccount) ..	BAA

[4] The following chart of MEPRS work centers are DoD approved for outpatient itemized billing. Claims can be generated for encounters, ancillaries, pharmacy, DME/DMS, etc. from these workcenters.

MEPRS code	Clinical service
BAA	Internal Medicine.

MEPRS code	Clinical service
BAB	Allergy.
BAC	Cardiology.
BAE	Diabetic.
BAF	Endocrinology (Metabolism).
BAG	Gastroenterology.
BAH	Hematology.
BAI	Hypertension.
BAJ	Nephrology.
BAK	Neurology.
BAL	Outpatient Nutrition.
BAM	Oncology.
BAN	Pulmonary Disease.
BAO	Rheumatology.
BAP	Dermatology.
BAQ	Infectious Disease.
BAR	Physical Medicine.
BAS	Radiation Therapy.
BAT	Bone Marrow Transplant.
BAU	Genetic.
BAV	Hyperbaric.
BBA	General Surgery.
BBB	Cardiovascular and Thoracic Surgery.
BBC	Neurosurgery.
BBD	Ophthalmology.
BBE	Organ Transplant.
BBF	Otolaryngology.
BBG	Plastic Surgery.
BBH	Proctology.
BBI	Urology.
BBJ	Pediatric Surgery.
BBK	Peripheral Vascular Surgery.
BBL	Pain Management.
BBM	Vascular and Interventional Radiology.
BCA	Family Planning.
BCB	Gynecology.
BCC	Obstetrics.
BCD	Breast Cancer Clinic.
BDA	Pediatric.
BDB	Adolescent.
BDC	Well Baby.
BEA	Orthopedic.
BEB	Cast.
BEC	Hand Surgery.
BEE	Orthotic Laboratory.
BEF	Podiatry.
BEZ	Chiropractic.
BFA	Psychiatry.
BFB	Psychology.
BFC	Child Guidance.
BFD	Mental Health.
BFE	Social Work.
BFF	Substance Abuse.
BGA	Family Practice.
BHA	Primary Care.
BHC	Optometry.
BHD	Audiology.
BHE	Speech Pathology.
BHF	Community Health.
BHG	Occupational Health.
BHH	TRICARE Outpatient.
BHI	Immediate Care.
BIA	Emergency Medical.
BKA	Underseas Medicine.
BLA	Physical Therapy.
BLB	Occupational Therapy.

MEPRS code	Other billable services
DAA	Pharmacy.
DBA	Clinical Pathology.
DBB	Anatomical Pathology.
DBD	Cytogenetic Laboratory.
DBE	Molecular Genetic Laboratory.
DBF	Biochemical Genetic Laboratory.
DCA	Diagnostic Radiology.
FBI	Immunizations.
FBN	Hearing Conservation (MSA Billing Only).
FC	Pharmacy, Laboratory and Radiology (External Civilian Ancillary and Support to other Military and Federal), except in cases where there is a specific VA/DoD MOU.
FEA	Ambulance.

[5] Ambulatory procedure visit is defined in DoD Instruction 6025.8, ''Ambulatory Procedure Visit (APV),'' dated September 23, 1996, as immediate (day of procedure) pre-procedure and immediate post-procedure care requiring an unusual degree of intensity and provided in an ambulatory procedure unit (APU). An APU is a location or organization within an MTF (or freestanding outpatient clinic) that is specially equipped, staffed, and designated for the purpose of providing the intensive level of care associated with APVs. Care is required in the facility for less than 24 hours. All expenses and workload are assigned to the MTF-established APU associated with the referring clinic.

[6] Subsistence is billed under the Medical Services Account (MSA) Program only. The MSA office shall collect subsistence charges from all persons, including inpatients and transient patients not entitled to food service at Government expense. Please refer to DoD 6010.15–M, Military Treatment Facility UBO Manual, April 1997, and the DoD 7000.14–R, ''Department of Defense Financial Management Regulation,'' Volume 12, Chapter 19 for guidance on the use of these rates.

[7] Third party payers (such as insurance companies) shall be billed for prescription services when beneficiaries who have medical insurance obtain medications from MTFs that are prescribed by providers both internal and external to the MTF (*e.g.*, physicians and dentists). Eligible beneficiaries (family members or retirees with medical insurance) are not liable personally for this cost and shall not be billed by the MTF. Medical Services Account (MSA) patients, who are not beneficiaries as defined in 10 U.S.C. 1074 and 1076, are charged at the ''Other'' rate if they are seen by an outside provider and only come to the MTF for prescription services. The standard cost of medications includes the DoD-wide average cost of the drug, calculated by lowest cost for the generic drugs with the same dosage and strength. The prescription charge is calculated by multiplying the number of units (*e.g.*, tablets or capsules) by the unit cost and adding $6.00 for the cost of dispensing the prescription. Dispensing costs include overhead, supplies, and labor, etc. to fill the prescription.

The list of drug reimbursement rates is too large to include in this document. Those rates are available from the TMA's UBO Web site, *http://www.tricare.osd.mil/ebc/rm_home/ubo_documents_rates_tables.cfm.*

[8] Charges for ancillary services requested by an internal (associated with a clinic visit) or an outside provider (*e.g.*, physicians and dentists) are relevant to the Third Party Collection Program. Third party payers (such as insurance companies) shall be billed for ancillary services when beneficiaries who have medical insurance obtain services from the MTF which are prescribed by providers external to the MTF.

Eligible beneficiaries (family members or retirees with medical insurance) are not personally liable for this cost and shall not be billed by the MTF. MSA patients, who are not beneficiaries as defined by 10 U.S.C. 1074 and 1076, are charged at the ''Other'' rate if they are not seen by an outside provider and only come to the MTF for ancillary services.

[9] Dental service rates are based on a dental rate multiplied by the DoD established weight for the American Dental Association (ADA) code performed. For example, for ADA code 00270, bite wing single film, the weight is 0.15. The weight of 0.15 is multiplied by the appropriate rate, IMET, IAR, or Full/Third Party rate to obtain the charge. If the Full/Third Party rate is used, then the charge for this ADA code will be $9.45 ($63 x .15 = $9.45).

The list of CY 2003 ADA codes and weights for dental services is too large to include in this document. This rate table may be found on the TMA's UBO Web site at *http://www.tricare.osd.mil/ebc/rm_home/ubo_documents_rates_tables.cfm.*

[10] Ambulance charges shall be based on hours of service in 15-minute increments. The rates listed in section III.G. are for 60 minutes or 1 hour of service. Providers shall calculate the charges based on the number of hours (and/or fractions of an hour) that the ambulance is logged out on a patient run. Fractions of an hour shall be rounded to the next 15-minute increment (*e.g.*, 31 minutes shall be charged as 45 minutes).

[11] Air in-flight medical care reimbursement charges are determined by the status of the patient (ambulatory or litter) and are per patient during a 24-hour period. The appropriate charges are billed only by the Air Force Global Patient Movement Requirement Center (GPMRC). These charges are only for the cost of providing medical care. Flight charges are billed by GPMRC separately.

[12] Observation Services are billed based on applicable CPTs. If the status of a patient changes to inpatient, the charges for observation services are added to the DRG assigned to the case and not separately billed. If a patient is released from observation status and is sent to an APV, the charges for observation services are not billed separately but are added to the APV rate to recover all expenses.

[13] Family members of active duty personnel, retirees and their family members, and survivors shall be charged elective cosmetic surgery rates. Elective cosmetic surgery procedure information is contained in section IV. The patient shall be charged the rate as specified in the CY 2003 reimbursable rates. The charges for elective

cosmetic surgery are at the full reimbursement rate (designated as the ''Other'' rate) for inpatient care services based on the cost per DRG or CPT. The patient is responsible for the cost of the implant(s) and the prescribed cosmetic surgery rate. (**Note:** The implants and procedures used for the augmentation mammaplasty are in compliance with Federal Drug Administration guidelines.)

ATTACHMENT 1.—FY 2003 ADJUSTED STANDARDIZED AMOUNTS (ASA) BY MILITARY TREATMENT FACILITY

DMIS ID	MTF name	Serv	Full rate	IAR rate	IMET rate	TPC rate
0003	Lyster AH—Ft. Rucker	A	$7,032	$6,676	$4,007	$7,032
0005	Bassett ACH—Ft. Wainwright	A	7,794	7,399	4,441	7,794
0006	3 Med Grp—Elmendorf AFB	F	7,624	7,237	4,344	7,624
0009	56th Med Grp—Luke AFB	F	6,734	6,421	3,514	6,734
0014	60th Med Grp—Travis AFB	F	10,529	9,995	6,000	10,529
0024	NH Camp Pendleton	N	8,189	7,808	4,274	8,189
0028	NH Lemoore	N	7,554	7,171	4,304	7,554
0029	NMC San Diego	N	10,268	9,790	5,359	10,268
0030	NH Twentynine Palms	N	6,820	6,502	3,559	6,820
0032	Evans ACH—Ft. Carson	A	7,564	7,181	4,310	7,564
0033	10th Med Grp—USAF Academy	F	7,574	7,190	4,316	7,574
0035	NH Groton	N	7,575	7,191	4,316	7,575
0037	Walter Reed AMC—Washington DC	A	10,415	9,930	5,435	10,415
0038	NH Pensacola	N	9,119	8,656	5,196	9,119
0039	NH Jacksonville	N	8,580	8,180	4,477	8,580
0042	96th Med Grp—Eglin AFB	F	9,580	9,095	5,459	9,580
0045	6th Med Grp—MacDill AFB	F	6,748	6,434	3,521	6,748
0047	Eisenhower AMC—Ft. Gordon	A	9,312	8,839	5,306	9,312
0048	Martin ACH—Ft. Benning	A	8,315	7,893	4,738	8,315
0049	Winn ACH—Ft. Stewart	A	7,564	7,180	4,310	7,564
0052	Tripler AMC—Ft. Shafter	A	10,248	9,728	5,839	10,248
0053	366th Med Grp—Mtn Home AFB	F	7,560	7,176	4,308	7,560
0055	375th Med Grp—Scott AFB	F	8,671	8,268	4,525	8,671
0056	NH Great Lakes	N	6,802	6,486	3,550	6,802
0060	Blanchfield ACH—Ft. Campbell	A	7,025	6,669	4,003	7,025
0061	Ireland ACH—Ft. Knox	A	6,620	6,311	3,454	6,620
0064	Bayne-Jones ACH—Ft. Polk	A	6,987	6,633	3,981	6,987
0066	89th Med Grp—Andrews AFB	F	8,944	8,527	4,667	8,944
0067	NNMC Bethesda	N	10,397	9,913	5,426	10,397
0073	81st Med Grp—Keesler AFB	F	10,103	9,591	5,757	10,103
0075	Wood ACH—Ft. Leonard Wood	A	7,179	6,815	4,091	7,179
0078	55th Med Grp—Offutt AFB	F	9,972	9,466	5,682	9,972
0079	99th Med Grp—Nellis AFB	F	6,763	6,448	3,529	6,763
0086	Keller ACH—West Point	A	8,234	7,816	4,692	8,234
0089	Womack AMC—Ft. Bragg	A	8,079	7,669	4,604	8,079
0091	NH Camp LeJeune	N	7,352	6,980	4,190	7,352

Beginning May 1, 2003, the rates prescribed herein superceded those established by the Director of the Office of Management and Budget, December 9, 2002 (FR Doc. 02–31024). 6

Joshua B. Bolten,

Director, Office of Management and Budget.

[FR Doc. 03–27360 Filed 10–30–03; 8:45 am]

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SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–48706; File No. SR–Amex–2003–65]

Self-Regulatory Organizations; Notice of Filing of Proposed Rule Change and Amendment No. 1 Thereto by the American Stock Exchange LLC Relating to Enhanced Corporate Governance Requirements Applicable to Listed Companies

October 27, 2003.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 (''Act''),[1] and Rule 19b–4 thereunder,[2] notice is hereby given that on June 23, 2003, the American Stock Exchange LLC (''Amex'' or ''Exchange'') filed with the Securities and Exchange Commission (''Commission'' or ''SEC'') the proposed rule change as described in Items I, II, and III below, which Items have been prepared by the Exchange. On September 9, 2003, the Exchange filed Amendment No. 1 to the proposed rule change.[3] The Commission is publishing this notice to solicit comments on the proposed rule change, as amended, from interested persons.

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] *See* Letter from Claudia Crowley, Vice President, Listing Qualifications, Amex, to Nancy Sanow, Assistant Director, Division of Market Regulations, Commission, dated September 5, 2002 (''Amendment No. 1''). In Amendment No. 1, Amex added p;roposed rule language to paragraph (c) of Section 801 to clarify that although the corporate governance requirements contained in Part 8 are not applicable to passive business organizations (such as royalty trusts) or to derivatives and special purpose securities listed pursuant to Amex Rules 1000, 10000A and 1200 and Sections 106, 107 and 118B, issuers of such securities are required to comply with Sections 121 and 803 to the extent required by Rule 10A–3 under the Act.