MARYLAND—OZONE
[8-Hour standard]

Designated area	Designation [a]		Category/classification	
	Date [1]	Type	Date [1]	Type
Baltimore, MD:				
Anne Arundel County		Nonattainment		Subpart 2/Moderate. [4]
City of Baltimore		Nonattainment		Subpart 2/Moderate. [4]
Baltimore County		Nonattainment		Subpart 2/Moderate. [4]
Carroll County		Nonattainment		Subpart 2/Moderate. [4]
Harford County		Nonattainment		Subpart 2/Moderate. [4]
Howard County		Nonattainment		Subpart 2/Moderate. [4]
* * * * *				

[a] Includes Indian Country located in each county or area, except as otherwise specified.
[1] This date is June 15, 2004, unless otherwise noted.
* * * *
[4] Attainment date extended to June 15, 2011.

* * * * *

[FR Doc. 2011–5631 Filed 3–10–11; 8:45 am]
BILLING CODE 6560–50–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 410, 416, and 419

[CMS–1504–CN]

RIN 0938–AP41

Medicare Program: Changes to the Hospital Outpatient Prospective Payment System and CY 2011 Payment Rates; Changes to the Ambulatory Surgical Center Payment System and CY 2011 Payment Rates; Changes to Payments to Hospitals for Graduate Medical Education Costs; Corrections

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule; correction.

SUMMARY: This document corrects technical errors that appeared in the final rule published on November 24, 2010, entitled "Medicare Program: Hospital Outpatient Prospective Payment System and CY 2011 Payment Rates; Ambulatory Surgical Center Payment System and CY 2011 Payment Rates; Payments to Hospitals for Graduate Medical Education Costs; Physician Self-Referral Rules and Related Changes to Provider Agreement Regulations; Payment for Certified Registered Nurse Anesthetist Services Furnished in Rural Hospitals and Critical Access Hospitals."

DATES: *Effective Date:* This document is effective on January 1, 2011.

FOR FURTHER INFORMATION CONTACT: Division of Outpatient Care, (410) 786–0378.

SUPPLEMENTARY INFORMATION:

I. Background

In FR Doc. 2010–27926 of November 24, 2010 (75 FR 71800) (hereinafter referred to as the CY 2011 OPPS/ASC final rule), there were several technical and typographic errors that we describe in the "Summary of Errors" section and correct in the "Correction of Errors" section below. In addition to correcting errors in the preamble and Addendum B, this correction notice corrects errors in Addenda AA and BB to the CY 2011 OPPS/ASC final rule. Most of the changes to these Addenda are based on changes to the practice expense (PE) relative value units (RVUs) and the conversion factor (CF) for the Medicare Physician Fee Schedule (MPFS) for CY 2011. In the January 11, 2011 CY 2011 MPFS correction notice (76 FR 1670), we corrected errors in the November 29, 2010 Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2011 final rule with comment period (hereinafter referred to as the CY 2011 MPFS final rule) to the PE RVUs and the CF for the CY 2011 MPFS (75 FR 73170). The revised ASC payment system uses the PE RVUs and the CF for the MPFS as part of the office-based and ancillary radiology payment methodology. This correction notice updates the CY 2011 OPPS/ASC final rule to include these corrections.

The provisions in this correction document are effective as if they had been included in the CY 2011 OPPS/ASC final rule appearing in the CY 2011 OPPS/ASC final rule. Accordingly, the corrections are effective January 1, 2011.

II. Summary of Errors

A. Errors in the November 24, 2010 Final Rule

In the CY 2011 OPPS/ASC final rule, we have identified a number of technical and typographic errors. Specifically, on page 71913, we are correcting the inadvertent inclusion of the word "stated" and deleting this word from the description of the public comment in the preamble section entitled "Revision/Removal of Neurostimulator Electrodes (APC 0687)." On pages 71915 and 71916, we incorrectly stated the number of single and total claims used in the ratesetting process for APCs 0664 and 0667, in the "Proton Beam Therapy (APCs 0664 and 0667)" section of the preamble. Specifically, on page 71915 we incorrectly stated that 11,963 single claims out of 12,995 total claims were used in the ratesetting process for APC 0664. On page 71916, we also incorrectly stated that 2,799 single claims out of 3,081 total claims were used in the ratesetting process for APC 0667. We are changing this section to correctly state that we used 10,943 single claims out of 11,895 total claims in the ratesetting process for APC 0664 and that we used 2,569 single claims out of 2,831 total claims in the ratesetting

process for APC 0667. Also, on page 71916 in the "Proton Beam Therapy (APCs 0664 and 0667)" section of the preamble, we incorrectly stated that there were modest declines in the final CY 2011 payment rates for proton therapy compared to the CY 2010 rates. The statement should have indicated that there were modest increases in the final CY 2011 payment rates for proton therapy compared to the CY 2010 rates. Therefore, we are correcting the statement. Furthermore, we are correcting a typographical error on page 71949 that mistakenly listed A0542 instead of A9542 in our response to public comment in the "Packaging of Payment for Diagnostic Radiopharmaceuticals, Contrast Agents, and Implantable Biologicals (Policy—Packaged Drugs and Devices)" section of preamble. On page 72019, we are correcting our inadvertent omission of HCPCS code G0010 and the information associated with it from Table 48B, which is located in the "Payment for Preventive Services" section of preamble. Specifically, with respect to service Hepatitis B vaccine, we are adding HCPCS code G0010 in Table 48B, column two, which is titled "CY 2011 CPT/HCPCS code." We are also adding in Table 48B, column three, titled "Long descriptor," the long descriptor for HCPCS code G0010 which is "Administration of hepatitis B vaccine." We are also adding in Table 48B, column four, titled "USPSTF," a series of periods which are used to indicate that HCPCS code G0010 has a USPSTF rating of A. In addition, in Table 48B, column five, entitled "CY 2010 coinsurance deductible," we are adding language for HCPCS code G0010 which is used to indicate that the coinsurance and deductible are not waived for CY 2010. Finally, in Table 48B, column six, entitled "CY 2011 coinsurance deductible," we are adding language for HCPCS code G0010 which is used to indicate that the coinsurance and deductible are waived for CY 2011. On page 72060, we are correcting the typographical error that mistakenly listed CY 2008 instead of CY 2009 in the "Calculation of the ASC Conversion Factor and ASC Payment Rates" section of preamble. On pages 72125 and 72126, we are correcting the inadvertent numbering error of 3 title headings in the "Effects of OPPS Changes in This Final Rule With Comment Period" section of the rule. Specifically, we are revising the numbering of the following title headings: "Estimated Effect of This Final Rule With Comment Period on Beneficiaries; Conclusion; and Accounting Statement".

On page 72481, we are also correcting the status indicator assignment for HCPCS code G0010 in Addendum B and the information associated with this code. Specifically, on page 72481, we are changing the status indicator of HCPCS code G0010 from "B" to "S" and are indicating that it is assigned to APC 0436 with a relative weight of 0.3826, that is has a payment rate of $26.35, and that it has a minimum unadjusted copayment of $5.27.

In addition, in the CY 2011 OPPS/ASC final rule, we published Addendum AA on pages 72279 through 72331 and Addendum BB on pages 72518 through 72541. As required under § 416.171(d), the revised ASC payment system limits payment for office-based procedures and covered ancillary radiology services to the lesser of the ASC rate calculated under the ASC standard ratesetting methodology or the amount calculated by multiplying the nonfacility PE RVUs for the service by the CF under the MPFS. However, the MPFS CF and PE RVUs listed for some CPT/HCPCS codes in Addendum B to the CY 2011 MPFS final rule (75 FR 73630) were incorrect due to certain technical errors and, consequently, have been corrected in a January 11, 2011 correction notice to the CY 2011 MPFS final rule (76 FR 1670). Since the ASC payment amounts for office-based procedures and covered ancillary radiology services are determined using the amounts in the MPFS final rule, we must correct the CY 2011 payment amounts for ASC procedures and services using the corrected MPFS amounts. Additionally, we are correcting an inadvertent error that mistakenly listed a Payment Indicator (PI) of "A2" instead of "G2" for certain surgical codes in Addenda AA. Specifically, we are revising CPT codes 20005 (Incision and drainage of soft tissue abscess, subfascial (that is, involves the soft tissue below the deep fascia)) on page 72286, 49421 (Insertion of tunneled intraperitoneal catheter for dialysis, open) on page 72315; 64708 (Neuroplasty, major peripheral nerve, arm or leg, open; other than specified) on page 72325; 64712 (Neuroplasty, major peripheral nerve, arm or leg, open; sciatic nerve) on page 72325; 64713 (Neuroplasty, major peripheral nerve, arm or leg, open; brachial plexus) on page 72325; 64714 (Neuroplasty, major peripheral nerve, arm or leg, open; lumbar plexus) on page 72325; and 69801 (Labyrinthotomy, with perfusion of vestibuloactive drug(s); transcanal) on page 72330 to reflect a PI of "G2". The correct PIs are reflected in revised Addendum AA to this correction notice and are posted on the CMS Web site at: *http://www.cms.gov/ASCPayment.*

We are making several corrections to the graduate medical education (GME) payments. Specifically, on page 72165 and page 72223, respectively, we are making insertions for words that were inadvertently omitted and deletions for words that were inadvertently included. On page 72230, we are making 5 corrections to the table titled "LIST OF TEACHING HOSPITALS THAT HAVE CLOSED ON OR AFTER MARCH 23, 2008 AND BEFORE AUGUST 3, 2010". These changes include changing Muhlenberg Regional Medical Center's CBSA from 35620 to 35084, adding Cherry Hospital and attending information to the table, as depicted below, changing the IME cap for Touro Rehabilitation Center from "2.99" to "0.00", and changing the IME cap for Mid-Missouri Mental Health Center from "1.25" to "0.00".

In addition, on page 72331, Addendum AA should have included footnotes containing two notes and an explanation of the single and double asterisks at the end of a HCPCS code. Specifically, the footnotes should have indicated that—(1) the amount of beneficiary coinsurance associated with the ASC payment system is 20 percent of the total payment amount and the coinsurance and deductible are waived for most preventive services; (2) the assignment of a PI for an office-based procedure ("P2" or "P3") is based on a comparison of the final rates according to the ASC standard ratesetting methodology and the MPFS for the same service and a statement that, at the time the information was compiled, the current law required a negative update to the CY 2011 MPFS payment rates; (3) the single asterisk at the end of a HCPCS code means that the office-based designation is temporary because there is insufficient claims data but that this designation will be reconsidered when new claims data become available; and (4) the double asterisks at the end of a HCPCS code indicate that the coinsurance and deductible are waived for this preventive service.

On page 72541, Addendum BB should have included footnotes containing two notes and an explanation of the double asterisk at the end of a HCPCS code. Specifically, the footnotes should have indicated that—(1) the amount of beneficiary coinsurance associated with the ASC payment system is 20 percent of the total payment amount and the coinsurance and deductible are waived for most preventive services; (2) the assignment of a PI for a radiology service ("Z2" or "Z3") is based on a

comparison of the final rates according to the ASC standard ratesetting methodology and for the same service the MPFS and a statement that, at the time the information was compiled, the current law required a negative update to the CY 2011 MPFS payment rates; and (3) the double asterisks at the end of a HCPCS code indicate that the coinsurance and deductible are waived for this preventive service. These changes are reflected in the revised Addenda.

The payment rates presented in this correction notice in Addenda AA and BB will not be used for payment because these payment rates do not reflect the statutory change which occurred after publication of the CY 2011 OPPS/ASC and MPFS final rules, namely section 101 of the Medicare and Medicaid Extenders Act of 2010, signed into law December 15, 2010 (Pub. L. 111–309), provided for a zero percent update to the Physician Fee Schedule.

III. Correction of Errors in the November 24, 2010 Final Rule

In FR Doc. 2010–27926 we are making the following corrections:

1. On page 71913, in the second column, in line 24, the word "stated" is removed.

2. On page 71915, in the third column, fourth full paragraph in—

a. Line 16, the number "11,963" is corrected to read "10,943".

b. Line 17, the number "12,995" is corrected to read "11,895".

3. On page 71916, in the first column, first partial paragraph in—

a. Line 1, the number "2,799" is corrected to read "2,569".

b. Line 2, the number "3,081" is corrected to read "2,831".

4. On page 71916, in the first column, first full paragraph, in line 6, the word "declines" is corrected to read "increases".

5. On page 71949, in the second column, in line 18 from the bottom of the page, the code "A0542" is corrected to read "A9542".

6. On page 72019 in Table 48B, under service "Hepatitis B Vaccine" is corrected to include the following table insertion after CY 2011 CPT/HCPCS code "90747.":

G0010	Administration of hepatitis B vaccine	.....	Not Waived	Waived

7. On page 72060, in the first column, first partial paragraph in line 14, the year "CY 2008" is corrected to read "CY 2009".

8. On page 72125, in the first column, the title of the heading, "Estimated Effect of This Final Rule With Comment Period on Beneficiaries" is renumbered from "6" to "5".

9. On page 72125, in the third column, title of the heading, "Conclusion" is renumbered from "7" to "6".

10. On page 72126, in the first column, title of the heading, "Accounting Statement" is renumbered from "8" to "7".

11. On page 72165, in the first column, in the first full paragraph, in lines 1 through 17, the first sentence is corrected to read as follows:

"In response to the commenter who asked for clarification as to whether, if a hospital received FTE cap slots through participation in a Medicare GME affiliated group but was training below its cap adjusted under the Medicare GME affiliation agreement during its reference cost reporting period would it face a cap reduction, we are clarifying that the hospital that received the cap slots, not the hospital that loaned the cap slots, would receive a cap reduction, that is, the hospital that received the slots but is training below its adjusted cap would receive a cap reduction".

12. On page 72223, in the first column, in the first full paragraph, in lines 14 through 23 the sentence starting with the word "Therefore," is corrected as follows:

"Therefore, because applications under section 5506 are program-specific, we believe that a hospital that is applying for slots for use in a geriatrics program should not be precluded from also applying for slots for other programs (although the requests for those other programs, even other primary care or surgery programs, would fall under other Ranking Criteria)."

13. On page 72230, the table titled "LIST OF TEACHING HOSPITALS THAT HAVE CLOSED ON OR AFTER MARCH 23, 2008 AND BEFORE AUGUST 3, 2010" is being republished to read as follows:

LIST OF TEACHING HOSPITALS THAT HAVE CLOSED ON OR AFTER MARCH 23, 2008 AND BEFORE AUGUST 3, 2010

Provider No.	Provider name	Terminating date	DGME cap	IME cap	Sec. 422 Increase/ decrease DGME	Sec. 422 Increase/ decrease IME	CBSA
01–0064	Physicians Carraway Medical Ctr	11/01/2008	65.08	65.08	−4.5	−4.5	13820
03–0017	Mesa General Hospital	05/31/2008	20.52	13.33	0.00	0.00	38060
14–0075	Michael Reese Hospital	06/11/2009	199.52	200.82	0.00	0.00	16974
15–0029	St. Joseph Hospital Mishawaka	07/01/2008	13.43	7.68	−3.79	−1.23	43780
19–3034	Touro Rehabilitation Center	12/31/2009	3.20	0.00	0.00	0.00	35380
26–4011	Mid-Missouri Mental Health Center	06/30/2009	5.33	0.00	0.00	0.00	17860
31–0063	Muhlenberg Regional Medical Center	08/13/2008	30.17	30.17	0.00	0.00	35084
31–0088	William B Kessler Memorial Hospital	03/12/2009	2.00	2.00	0.00	0.00	12100
33–0133	Cabrini Medical Center	06/16/2008	134.01	124.1	−21.36	−23.83	35644
33–0357	Caritas Health Care, Inc.	03/06/2009	190.23	190.23	−9.40	−9.40	35644
33–0390	North General Hospital	07/10/2010	57.17	54.29	−6.23	−4.08	35644
34–4003	Cherry Hospital	09/01/2008	1.00	0.00	0.00	0.00	24140
39–0023	Temple East Hospital	06/28/2009	2.36	2.36	0.00	0.00	37964
39–0169	Geisinger South Wilkes-Barre	07/10/2009	4.00	3.33	0.98	1.67	42540
42–0006	Charleston Memorial Hospital	11/25/2008	40.88	40.83	0.00	0.00	16700

14. On page 72481, in Addendum B for HCPCS code G0010, in—

a. Column 4, the SI code "B" is corrected to read "S".

b. Column 5, the APC code "0436" is added.

c. Column 6, the relative weight "0.3826" is added.

d. Column 7, the payment rate "$26.35" is added.

e. Column 9, the minimum unadjusted copayment $5.27" is added.

Corrections to the Addenda in AA and BB

Addendum AA—Final ASC Covered Surgical Procedures for CY 2011 (Including Surgical Procedures for Which Payment is Packaged) and

Addendum BB—Final ASC Covered Ancillary Services Integral to Covered Surgical Procedures for CY 2011 (Including Ancillary Services for Which Payment is Packaged)

Changes to the MPFS impacted multiple CPT/HCPCS codes on Addenda AA and BB. Therefore, we are republishing Addenda AA and BB in their entirety to take into account the updated CY 2011 MPFS information and the corrected PIs for the seven HCPCS codes. We note that the revised rates continue to reflect the negative update to the MPFS for CY 2011 based on current law at the time of publication of the CY 2011 MPFS final rule and the corrections to the PE RVUs and CFs. See attached charts.

We also are adding the following footnotes to the conclusion of Addendum AA:

Note 1: The Medicare program payment is 80 percent of the total payment amount and beneficiary coinsurance is 20 percent of the total payment amount. Section 4104, as amended by section 10406, of the Affordable Care Act waives coinsurance and deductible for most preventive services, identified with a double asterisk (**).

Note 2: Payment indicators for "office-based" procedures (P2, P3) are based on a comparison of the final rates according to the ASC standard ratesetting methodology and the MPFS. At the time we compiled this Addendum, current law requires a negative update to the MPFS payment rates for CY 2011. For a discussion of those rates, we refer readers to the CY 2011 MPFS final rule.

*: Asterisked codes(*) indicate that the procedure's "office-based" designation is temporary because we have insufficient claims data. We will reconsider this designation when new claims data become available.

**: Double-asterisked codes(*) indicate that the coinsurance and deductible are waived under section 4104, as amended by section 10406, of the Affordable Care Act, which waives coinsurance and deductible for most preventive services.

We are adding the following footnotes to the conclusion of Addendum BB:

Note 1: The Medicare program payment is 80 percent of the total payment amount and beneficiary coinsurance is 20 percent of the total payment amount. Section 4104, as amended by section 10406, of the Affordable Care Act waives the coinsurance and deductible for most preventive services, identified with a double asterisk (**).

Note 2: Payment indicators for radiology services (Z2, Z3) are based on a comparison of the final rates according to the ASC standard ratesetting methodology and the MPFS. At the time we compiled this Addendum, current law required a negative update to the MPFS payment rates for CY 2011. For a discussion of those rates, we refer readers to the CY 2011 MPFS final rule.

**: Defined as a preventive service with no coinsurance or deductible. Section 4104, as amended by section 10406, of the Affordable Care Act waives the coinsurance and deductible for most preventive services

IV. Waiver of Proposed Rulemaking and Delay in Effective Date

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** to provide a period for public comment before the provisions of a rule take effect, in accordance with the Administrative Procedure Act (APA) (5 U.S.C. 553(b)). We also ordinarily provide a 30-day delay in the effective date of the provisions of a rule in accordance the APA (5 U.S.C. 553(d)). However, we can waive both the notice and comment procedures and the 30-day delay in the effective date if the Secretary finds, for good cause, that it is impracticable, unnecessary or contrary to the public interest to follow the notice and comment procedures or to comply with the 30-day delay in the effective date, and incorporates a statement of the findings and the reasons therefore in the notice.

Therefore, for reasons noted below, we find good cause to waive proposed rulemaking and the 30-day delayed effective date for the technical corrections in this notice. This notice merely provides technical corrections to the CY 2011 OPPS/ASC final rule that was effective on January 1, 2011 and does not make substantive changes to the policies or payment methodologies that were adopted in that final rule. As a result, this notice is intended to ensure that the CY 2011 OPPS/ASC final rule with comment period accurately reflects the policies adopted in the final rule. Since the provisions of the CY 2011 OPPS/ASC final rule were promulgated previously through notice and comment rulemaking and this notice merely conforms the document to the final policies of the CY 2011 OPPS/ASC final rule with comment period, we believe it is unnecessary to undergo further notice and comment procedures. In addition, we believe it is in the public interest to have the correct information and to have it as soon as possible and not delay its dissemination. For the reasons stated above, we find that both notice and comment procedures and the 30-day delay in effective date for this correction document are unnecessary and contrary to the public interest. Therefore, we find there is good cause to waive notice and comment procedures and the 30-day delay in effective date for this correction document.

(Catalog of Federal Domestic Assistance Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: March 4, 2011.

Dawn L. Smalls,

Executive Secretary to the Department.

[FR Doc. 2011–5674 Filed 3–10–11; 8:45 am]

BILLING CODE 4120–01–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Parts 1 and 63

[IB Docket No. 04–47; FCC 07–118]

Modifications of the Rules and Procedures Governing the Provisions of International Telecommunications Service

AGENCY: Federal Communications Commission.

ACTION: Final rule; announcement of effective date.

SUMMARY: In this document, the Commission announces that the Office of Management and Budget (OMB) has approved, for a period of three years, the information collection requirements international telecommunications service regulations. The information collection requirements were approved on February 18, 2011 by OMB.

DATES: The amendments to 47 CFR 63.19(a)(1) and (a)(2) and 47 CFR 63.24(c), published at 72 FR 54363, September 25, 2007, are effective on March 11, 2011.

FOR FURTHER INFORMATION CONTACT: For additional information, please contact Cathy Williams, *cathy.williams@fcc.gov* or on (202) 418–2918.

SUPPLEMENTARY INFORMATION: This document announces that, on February 18, 2011, OMB approved, for a period of three years, the information collection requirements contained in 47 CFR 63.19(a)(1) and (a)(2) and 47 CFR