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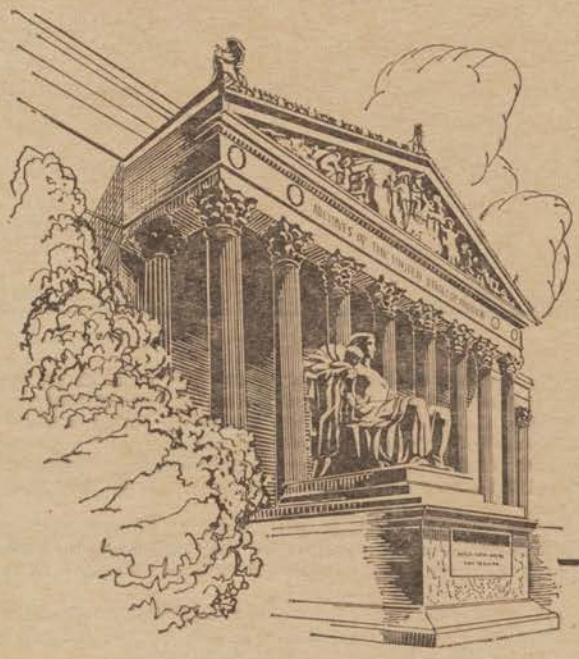

FEDERAL REGISTER

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A cumulative guide is published separately at the end of each month. The guide lists the parts and sections affected by documents published since January 1, 1966, and specifies how they are affected.

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Title 3—THE PRESIDENT

Executive Order 11311

CARRYING OUT PROVISIONS OF THE BEIRUT AGREEMENT OF 1948 RELATING TO AUDIO-VISUAL MATERIALS

By virtue of the authority vested in me as President of the United States, including the provisions of the Joint Resolution of October 8, 1966, Public Law 89–634, and section 301 of Title 3 of the United States Code, I hereby order and proclaim that—

1. Pursuant to section 3(b) of the Joint Resolution, the amendments to the Tariff Schedules of the United States made by section 3(a) of the Joint Resolution shall apply with respect to articles entered, or withdrawn from warehouse, for consumption, on and after January 1, 1967.

2. Pursuant to the "Agreement for Facilitating the International Circulation of Visual and Auditory Materials of an Educational, Scientific and Cultural Character", made at Beirut in 1948, the Joint Resolution, and headnote 1 to schedule 8, part 6 of the Tariff Schedules of the United States, the United States Information Agency is hereby designated as the agency to carry out the provisions of the Agreement and related protocol, and to make any determinations and to prescribe any regulations required by headnote 1.

LYNDON B. JOHNSON

THE WHITE HOUSE,
October 14, 1966.

[F.R. Doc. 66-11337; Filed, Oct. 14, 1966; 3:11 p.m.]

Executive Order 11312

DESIGNATING THE SECRETARY OF STATE TO PERFORM FUNCTIONS RELATING TO CERTAIN OBJECTS OF CULTURAL SIGNIFICANCE IMPORTED INTO THE UNITED STATES FOR TEMPORARY DISPLAY OR EXHIBITION

By virtue of the authority vested in me by the Act of October 19, 1965, 79 Stat. 985, entitled "An Act to render immune from seizure under judicial process certain objects of cultural significance imported into the United States for temporary display or exhibition, and for other purposes," and as President of the United States, it is ordered as follows:

SECTION 1. The Secretary of State is hereby designated and empowered to perform the functions conferred upon the President by the above-mentioned Act and shall be deemed to be authorized, without the approval, ratification, or other action of the President, (1) to determine that any work of art or other object to be imported into the United States within the meaning of the Act is of cultural significance, (2) to determine that the temporary exhibition or display of any such work of art or other object in the United States is in the national interest, and (3) to cause public notices of the determinations referred to above to be published in the FEDERAL REGISTER.

SEC. 2. The Secretary of State, in carrying out this order, may consult with the Secretary of the Smithsonian Institution and with such other officers and such agencies of the Government as may be appropriate.

SEC. 3. The Secretary of State is hereby authorized to delegate within the Department of State the functions conferred upon him by this order.

LYNDON B. JOHNSON

THE WHITE HOUSE,
October 14, 1966.

[F.R. Doc. 66-11338; Filed, Oct. 14, 1966; 3:11 p.m.]

Executive Order 11313

PROVIDING THAT CERTAIN OFFICERS MAY ACT AS POSTMASTER GENERAL

By virtue of the authority vested in me by Section 3347 of Title 5 of the United States Code and Section 301 of Title 3 of the United States Code, and as President of the United States, it is ordered as follows:

SECTION 1. In the event of a vacancy in the office of Postmaster General or during the absence or disability of the Postmaster General, the Deputy Postmaster General shall act as Postmaster General.

SEC. 2. During any period when, by reason of absence, disability, or vacancy in office, neither the Postmaster General nor the Deputy Postmaster General is available to exercise the powers or perform the duties of the office of Postmaster General, an Assistant Postmaster General or the General Counsel of the Post Office Department, in such order as the Postmaster General may from time to time prescribe in writing, shall act as Postmaster General. If no such order of succession is in effect at that time, they shall act as Postmaster General in the order in which they shall have taken office as Assistant Postmasters General or General Counsel.

SEC. 3. The following are hereby superseded:

(1) Executive Order No. 10154 of August 22, 1950.

(2) Executive Order No. 10558 of September 8, 1954.

(3) Executive Order No. 10686 of November 1, 1956.

LYNDON B. JOHNSON

THE WHITE HOUSE,
October 15, 1966.

[F.R. Doc. 66-11383; Filed, Oct. 17, 1966; 10:26 a.m.]

Executive Order No. 11314

CREATING A BOARD OF INQUIRY TO REPORT ON CERTAIN LABOR DISPUTES AFFECTING THE MILITARY JET ENGINE INDUSTRY, MILITARY AIRCRAFT INDUSTRY, MILITARY ARMAMENT INDUSTRY AND MILITARY ELECTRONICS INDUSTRY OF THE UNITED STATES

WHEREAS, there have existed certain labor disputes between General Electric Company and certain of its employees represented by: International Union of Electrical Radio and Machine Workers, AFL–CIO; International Association of Machinists and Aerospace Workers, AFL–CIO; International Union, United Automobile, Aerospace and Agricultural Implement Workers of America, AFL–CIO; International Union, Allied Industrial Workers of America, AFL–CIO; International Brotherhood of Electrical Workers, AFL–CIO; Sheet Metal Workers' International Association, AFL–CIO; American Federation of Technical Engineers, AFL–CIO; American Flint Glass Workers' Union of North America, AFL–CIO; United Electrical Radio and Machine Workers of America; United Association of Journeymen and Apprentices of the Plumbing and Pipe Fitting Industry of the United States and Canada, AFL–CIO; United Steelworkers of America, AFL–CIO; International Union of Operating Engineers, AFL–CIO; International Brotherhood of Teamsters, Chauffeurs, Warehousemen and Helpers of America; Pattern Makers' League of North America, AFL–CIO; International Brotherhood of Firemen and Oilers, AFL–CIO; Syracuse Draftsmens Union; and

WHEREAS, although a tentative resolution of these disputes was arrived at by the parties, or some of them, nevertheless there is a strike at the Evendale, Ohio, plant of General Electric Company by Local No. 647 of the International Union of the United Automobile, Aerospace and Agricultural Implement Workers of America, AFL–CIO, and Locals 34 and 912 of the International Association of Machinists and Aerospace Workers, AFL–CIO, and there exists a threat that there will be further strikes at General Electric Company plants by one or more of the aforesaid international unions or local units thereof; and

WHEREAS, the existing strike at the Evendale, Ohio, plant of General Electric Company will, in my opinion, if permitted to continue, affect a substantial part of the military jet engine industry, which industry is engaged in trade, commerce, transportation, transmission, or communication among the several states or with foreign nations, or engaged in the production of goods for commerce, and which strike, if permitted to continue, will imperil the national safety; and

WHEREAS, threatened strikes at other General Electric Company plants will, in my opinion, if allowed to occur, affect a substantial part of the military jet engine industry, military aircraft industry, military armament industry and military electronics industry, which industries are engaged in trade, commerce, transportation, transmission, or communication among the several states or with foreign nations, or engaged in the production of goods for commerce, and which threatened strikes, if permitted to occur, will imperil the national safety;

NOW THEREFORE by virtue of the authority vested in me by Section 206 of the Labor Management Relations Act of 1947 (61 Stat. 155; 29 U.S.C. 176), I hereby create a Board of Inquiry, consisting of Mr. David L. Cole, Chairman, Mr. John Dunlop and Mr. Jacob Seidenberg, whom I appoint to inquire into the issues involved in these disputes.

The Board shall have powers and duties as set forth in Title II of such Act. The Board shall report to the President in accordance with the provisions of Section 206 of such Act. With respect to the dispute giving rise to the strike at Evendale, Ohio, plant it shall report on or before October 18th, 1966, and with respect to the dispute or disputes resulting in any other such strike, it shall report as soon as possible.

Upon the submission of its report or reports, the Board shall continue in existence to perform such other functions as may be required under such Act.

LYNDON B. JOHNSON

THE WHITE HOUSE,
October 17, 1966.

[F.R. Doc. 66-11415; Filed, Oct. 17, 1966; 1:07 p.m.]

Rules and Regulations

Title 7—AGRICULTURE

Chapter IX—Consumer and Marketing Service (Marketing Agreements and Orders; Fruits, Vegetables, Nuts), Department of Agriculture

PART 984—WALNUTS GROWN IN CALIFORNIA, OREGON, AND WASHINGTON

Control Percentages for 1966–67 Marketing Year

Notice was published in the September 30, 1966, issue of the FEDERAL REGISTER (31 F.R. 12795) regarding a proposal to establish control percentages applicable to walnuts grown in California, Oregon, and Washington for the marketing year beginning August 1, 1966. The percentages are based on recommendations of the Walnut Control Board and other available information in accordance with the applicable provisions of the marketing agreement, as amended, and Order No. 984, as amended (7 CFR Part 984), regulating the handling of walnuts grown in California, Oregon, and Washington, effective under the Agricultural Marketing Agreement Act of 1937, as amended (7 U.S.C. 601–674).

The notice afforded interested persons opportunity to submit written data, views, or arguments with respect to the proposal. None were submitted within the prescribed time.

After consideration of all relevant matters presented, including those in the notice, the information and recommendations submitted by the Board, and other available information, it is found that to establish marketable and surplus percentages as hereinafter set forth will tend to effectuate the declared policy of the act.

Therefore, the marketable and surplus percentages for walnuts handled during the 1966–67 marketing year are established as follows:

§ 984.214 Marketable and surplus percentages for walnuts during the 1966–67 marketing year.

The marketable and surplus percentages during the marketing year beginning August 1, 1966, shall be as follows:

	District 1	District 2
Marketable	90	95
Surplus	10	5

It is further found that good cause exists for not postponing the effective time of this action until 30 days after publication in the FEDERAL REGISTER (5 U.S.C. 1003(c)) in that: (1) The relevant provisions of said amended marketing agreement and this part require that marketable and surplus percentages designated for a particular marketing year shall be applicable to all walnuts handled during such year; and (2) the current marketing year began on August 1, 1966, and the percentages established herein will automatically apply to all such walnuts beginning with such date.

(Secs. 1–19, 48 Stat. 31, as amended; 7 U.S.C. 601–674)

Dated: October 12, 1966.

PAUL A. NICHOLSON,
Deputy Director, Fruit and Vegetable Division, Consumer and Marketing Service.

[F.R. Doc. 66–11301; Filed, Oct. 17, 1966; 8:46 a.m.]

Title 14—AERONAUTICS AND SPACE

Chapter I—Federal Aviation Agency

SUBCHAPTER E—AIRSPACE

[Airspace Docket No. 66–SO–80]

PART 71—DESIGNATION OF FEDERAL AIRWAYS, CONTROLLED AIRSPACE, AND REPORTING POINTS

Alteration of Control Zones and Transition Area

Correction

In F.R. Doc. 66–10763, appearing at page 12943 of the issue for Wednesday, October 5, 1966, the fifth line of paragraph seven should be corrected to read "234° radial. Because of the redefining".

[Airspace Docket No. 66–WA–28]

PART 71—DESIGNATION OF FEDERAL AIRWAYS, CONTROLLED AIRSPACE, AND REPORTING POINTS

Revocation of Reporting Points

The purpose of this amendment to Part 71 of the Federal Aviation Regulations is to revoke the Copper, Alaska, Intersection as a low altitude reporting point.

Air traffic control requirements periodically change with regard to specific reporting points due to modifications of operating procedures or alteration to airway configurations. Recent changes obviate the requirement for the Copper Intersection as a low altitude reporting point.

Since this amendment is procedural in nature and does not involve the designation of airspace, notice and public procedure hereon are unnecessary.

In consideration of the foregoing, Part 71 of the Federal Aviation Regulations is amended, effective 0001 e.s.t., December 8, 1966, as hereinafter set forth.

Section 71.211 (31 F.R. 2289) is amended by deleting: "Copper INT: INT Homer, Alaska, 269°, King Salmon, Alaska, 051° radials."

(Sec. 307(a), Federal Aviation Act of 1958; 49 U.S.C. 1348)

Issued in Washington, D.C., on October 11, 1966.

H. B. HELSTROM,
Chief, Airspace and Air Traffic Rules Division.

[F.R. Doc. 66–11291; Filed, Oct. 17, 1966; 8:45 a.m.]

[Airspace Docket No. 66–WE–37]

PART 71—DESIGNATION OF FEDERAL AIRWAYS, CONTROLLED AIRSPACE, AND REPORTING POINTS

Designation, Revocation and Alteration of Federal Airways

On August 11, 1966, a notice of proposed rule making was published in the FEDERAL REGISTER (31 F.R. 10695) stating that the Federal Aviation Agency was considering an amendment to Part 71 of the Federal Aviation Regulations that would alter the VOR airway structure in the Phoenix/Prescott/Winslow/Flagstaff, Ariz., area.

Interested persons were afforded an opportunity to participate in the proposed rule making through the submission of comments. All comments received were favorable.

In consideration of the foregoing, Part 71 of the Federal Aviation Regulations is amended, effective 0001 e.s.t., December 8, 1966, as hereinafter set forth.

Section 71.123 (31 F.R. 2009, 2717, 6484) is amended as follows:

a. In V–105 ", including an E alternate via INT of Phoenix 004° and Prescott 135° radials" is deleted.

b. In V–291 "Peach Springs, Ariz.," is deleted and "12 AGL Flagstaff, Ariz., including an 12 AGL N alternate from Winslow to Flagstaff via INT Winslow 292° and Flagstaff 063° radials." is substituted therefor.

c. V–327 is added:

V–327 From Phoenix, Ariz., 12 AGL via INT of Phoenix 004° and Flagstaff, Ariz., 187° radials; 12 AGL Flagstaff.

(Sec. 307(a), Federal Aviation Act of 1958; 49 U.S.C. 1348)

Issued in Washington, D.C., on October 11, 1966.

H. B. HELSTROM,
Chief, Airspace and Air Traffic Rules Division.

[F.R. Doc. 66–11292; Filed, Oct. 17, 1966; 8:45 a.m.]

[Airspace Docket No. 66-SO-81]

PART 71—DESIGNATION OF FEDERAL AIRWAYS, CONTROLLED AIRSPACE, AND REPORTING POINTS

Alteration of Transition Area

The purpose of this amendment to Part 71 of the Federal Aviation Regulations is to alter the Waycross, Ga., transition area.

The Waycross transition area is described in § 71.181 (31 F.R. 2149). An extension to the 700-foot portion is described as "* * * within 2 miles each side of the Waycross, Ga., VOR 100° radial, extending from the 5-mile radius area to the Waycross VOR 207° and 027° radials * * *." An extension to the 1,200-foot portion is described as "* * * and that airspace extending upward from 1,200 feet above the surface within 8 miles N and 5 miles S of the Waycross VOR 297° radial, extending from the VOR to 12 miles NW * * *."

Because of an error in the description, it is necessary to alter the transition area by redesignating the 700-foot extension predicated on the 100° radial to the 099° radial; redesignate the radials, 207° and 027°, that limit the extension to the 206° and 026° radials; and redesignate the 1,200-foot extension predicated on the 297° radial to the 296° radial.

Since this amendment is editorial in nature and imposes no additional burden on the public, notice and public procedure hereon are unnecessary.

In consideration of the foregoing, Part 71 of the Federal Aviation Regulations is amended, effective immediately, as hereinafter set forth.

In § 71.181 (31 F.R. 2149) the Waycross, Ga., transition area is amended to read:

WAYCROSS, GA.

That airspace extending upward from 700 feet above the surface within a 5-mile radius of Waycross-Ware County Airport (latitude 31°14'55" N., longitude 82°23'48" W.); within 2 miles each side of the Waycross, Ga., VOR 099° radial, extending from the 5-mile radius area to the Waycross VOR 206° and 026° radials; and that airspace extending upward from 1,200 feet above the surface within 8 miles N and 5 miles S of the Waycross VOR 296° radial, extending from the VOR to 12 miles NW.

(Sec. 307(a), Federal Aviation Act of 1958; 49 U.S.C. 1348(a))

Issued in East Point, Ga., on October 7, 1966.

JAMES G. ROGERS,
Director, Southern Region.

[F.R. Doc. 66-11293; Filed, Oct. 17, 1966; 8:45 a.m.]

[Regulatory Docket No. 7672; Amdt. 73-1]

PART 73—SPECIAL USE AIRSPACE

Prohibited Areas

The purpose of these amendments to Part 73 of the Federal Aviation Regulations is to establish Subpart C—Prohibited Areas, change the boundaries of Prohibited Area P-56 as described in Executive Order 10126, and include the redescribed P-56 in the new subpart.

In keeping with its continuing policy of reexamining restrictions on the public use of airspace, the FAA has reviewed the airspace affected by Executive Order 10126 and has determined that it is possible to reduce the size of the prohibited area involved.

Concurrently, the Executive Office of the President has advised that it has no objection to this alteration.

The insertion of the revised description of P-56 in Subpart C of Part 73 does not change the present prohibition of flight therein. No person may navigate an aircraft within the Prohibited Area unless authorization is first obtained from the Administrator of the Federal Aviation Agency.

Due to the length and complexity of the descriptions of prohibited areas, they and all subsequent changes thereto will not be carried in the publication, Federal Aviation Regulations, Part 73, Special Use Airspace. Such descriptions and subsequent changes will be published in the FEDERAL REGISTER and will be included on appropriate aeronautical charts.

Since these amendments return airspace to the public for use, or are editorial in nature, notice and public procedure thereon are unnecessary and they may be made effective in less than 30 days after publication.

In consideration of the foregoing, Part 73 of the Federal Aviation Regulations is amended, effective immediately, as follows:

§ 73.1 [Amended]

1. In Subpart A—General, § 73.1 *Applicability* is amended by adding "and Subpart C" after the words "Subpart B".

§ 73.15 [Amended]

2. In Subpart B § 73.15(a) is amended by deleting "part" and substituting "subpart" therefor.

§ 73.21 [Amended]

3. In Subpart B the center heading preceding § 73.21 is deleted.

4. Following Subpart B, add:

Subpart C—Prohibited Areas

Sec.
73.81 Applicability.
73.83 Restrictions.
73.85 Using agency.

DESCRIPTIONS OF DESIGNATED PROHIBITED AREAS

73.87 P-56, District of Columbia.

AUTHORITY: The provisions of this Subpart C issued under secs. 307, 1501, Federal Aviation Act of 1958; 49 U.S.C. 1348, 1301.

Subpart C—Prohibited Areas

§ 73.81 Applicability.

This subpart designates prohibited areas and prescribes limitations on the operation of aircraft therein.

§ 73.83 Restrictions.

No person may operate an aircraft within a prohibited area unless authorization has been granted by the using agency.

§ 73.85 Using agency.

For the purpose of this subpart, the using agency is the agency, organization or military command that established the requirement for the prohibited area.

NOTE: Sections 73.87 through 73.99 are reserved for descriptions of designated prohibited areas.[1]

DESCRIPTIONS OF DESIGNATED PROHIBITED AREAS

§ 73.87 P-56, District of Columbia.

BOUNDARIES:

A. Beginning at the southwest corner of the Lincoln Memorial (latitude 38°53'20" N.; longitude 77°03'03" W.);

Thence via a 327° bearing, 0.6 mile, to the intersection of New Hampshire Avenue and Rock Creek and Potomac Parkway NW. (latitude 38°53'45" N.; longitude 77°03'24" W.);

Thence northeast along New Hampshire Avenue, 0.6 mile, to Washington Circle, at the intersection of New Hampshire Avenue and K Street NW. (latitude 38°54'08" N.; longitude 77°03'02" W.);

Thence east along K Street, 2.5 miles, to the railroad overpass between First and Second Streets NE. (latitude 38°54'08" N.; longitude 77°00'14" W.);

Thence southeast via a 158° bearing, 0.7 mile, to the southeast corner of Stanton Square, at the intersection of Massachusetts Avenue and Sixth Street NE. (latitude 38°53'35" N.; longitude 76°59'57" W.);

Thence southwest via a 211° bearing, 0.8 mile, to the Capitol Power Plant at the intersection of New Jersey Avenue and E Street SE. (latitude 38°52'59" N.; longitude 77°00'25" W.);

Thence west via a 265° bearing, 0.7 mile, to the intersection of the Southwest Freeway (Interstate Route 95) and Sixth Street SW., extended (latitude 38°52'56" N.; longitude 77°01'13" W.);

Thence north along Sixth Street, 0.4 mile, to the intersection of Sixth Street and Independence Avenue SW. (latitude 38°53'15" N.; longitude 77°01'13" W.);

Thence west along the north side of Independence Avenue, 0.8 mile, to the intersection of Independence Avenue and 15th Street SW. (latitude 38°53'16" N.; longitude 77°02'02" W.);

Thence west along the southern lane of Independence Avenue, 0.4 mile to the west end of the Kutz Memorial Bridge over the Tidal Basin (latitude 38°53'12" N.; longitude 77°02'28" W.);

Thence west via a 285° bearing, 0.6 mile, to the southwest corner of the Lincoln Memorial, the point of beginning.

B. That area within a one-half mile radius from the center of the U.S. Naval Observatory located between Wisconsin and Massachusetts Avenues at 34th Street NW. (latitude 38°55'17" N.; longitude 77°04'02" W.).

Designated altitudes: Surface to unlimited.

Time of designation: Continuous.

Using agency: Administrator, Federal Aviation Agency, Washington, D.C.

(Secs. 307, 1501, Federal Aviation Act of 1958; 49 U.S.C. 1348 and 1301)

Issued in Washington, D.C., on October 11, 1966.

WILLIAM F. MCKEE,
Administrator.

[F.R. Doc. 66-11294; Filed, Oct. 17, 1966; 8:45 a.m.]

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[1] The airspace descriptions in this part and their subsequent changes are published in the FEDERAL REGISTER. Due to their complexity and length, they will not be included in this publication of Part 73.

SUBCHAPTER I—AIRPORTS

[Docket No. 7673; Amdt. 151-15]

PART 151—FEDERAL AID TO AIRPORTS

Additional Technical Guidelines

Appendix I sets forth the list of Advisory Circulars providing technical guidelines that are made mandatory by § 151.72 of the Federal Aviation Regulations (14 CFR 151.72). The purpose of this amendment is to add to Appendix I to Part 151 an additional Advisory Circular, AC 150/5335-1, "Airport Taxiways"; to cancel AC 150/5340-4 and replace it with AC 150/5340-4A; and to cancel AC 150/5345-1 and replace it with AC 150/5345-1A.

This rule-making action is taken on the authority of sections 2 through 15, and 17 through 20 of the Federal Airport Act (49 U.S.C. 1101-1114, 1116-1119), and under the delegation of authority to the Director, Airports Service in § 151.72(b) of the Federal Aviation Regulations (14 CFR 151.72(b)). Since this amendment relates to public grants and benefits, notice and public procedure thereon are not required.

In consideration of the foregoing, effective November 17, 1966, Part 151, Appendix I, subsection (a), "Circulars available free of charge", is amended as follows:

1. By inserting Advisory Circular 150/5335-1, "Airport Taxiways", immediately following the listing of Advisory Circular 150/5330-2, "Runway/Taxiway Widths and Lengths", and preceding the listing of Advisory Circular 150/5340-1A, "Marking of Serviceable Runways and Taxiways".

2. By deleting AC 150/5340-4, "Installation Details for In-Runway Lighting", and inserting in its place AC 150/5340-4A, "Installation Details for Centerline and Touchdown Zone Lighting Systems".

3. By deleting AC 150/5345-1, "Approved Airport Lighting Equipment", and inserting in its place AC 150/5345-1A, "Approved Airport Lighting Equipment".

Issued in Washington, D.C., on October 10, 1966.

CHESTER G. BOWERS,
Acting Director, Airports Service.

[F.R. Doc. 66-11295; Filed, Oct. 17, 1966; 8:45 a.m.]

Title 16—COMMERCIAL PRACTICES

Chapter I—Federal Trade Commission

[Docket No. 8629 o.]

PART 13—PROHIBITED TRADE PRACTICES

Rabiner & Jontow, Inc.

Subpart—Discriminating in price under section 2, Clayton Act—Payment for services or facilities for processing or sale under 2(d): § 13.824 *Advertising expenses;* § 13.825 *Allowances for services or facilities.*

(Sec. 6, 38 Stat. 721; 15 U.S.C. 46. Interpret or apply sec. 2, 49 Stat. 1526; 15 U.S.C. 13) [Cease and desist order, Rabiner & Jontow, Inc., New York, N.Y., Docket 8629, Sept. 19, 1966]

Order requiring a New York City manufacturer of ladies' coats and suits to cease discriminating among its competing retail customers in paying promotional allowances in violation of section 2(d) of the Clayton Act.

The order to cease and desist, is as follows:

Now, therefore, it is ordered, That respondent Rabiner & Jontow, Inc., a corporation, its officers, directors, agents, representatives, and employees, directly or through any corporate or other device, in the course of its business in commerce, as "commerce" is defined in the Clayton Act, as amended, do forthwith cease and desist from:

Paying or contracting for the payment of anything of value to, or for the benefit of, any customer of the respondent as compensation or in consideration for advertising or promotional services, or any other service or facility furnished by or through such customer in connection with the handling, sale or offering for sale of wearing apparel products manufactured, sold or offered for sale by respondent, unless such payment or consideration is made available on proportionally equal terms to all other customers competing with such favored customer in the distribution or resale of such products.

By "Final Order" further order requiring report of compliance is as follows:

It is further ordered, That respondent shall, within sixty (60) days after service upon it of this order, file with the Commission a report, in writing, setting forth in detail the manner and form in which it has complied with the order to cease and desist.

Issued: September 19, 1966.

By the Commission.

[SEAL] JOSEPH W. SHEA,
Secretary.

[F.R. Doc. 66-11309; Filed, Oct. 17, 1966; 8:46 a.m.]

PART 15—ADMINISTRATIVE OPINIONS AND RULINGS

Promotional Assistance Plans Must Be Reasonable and Nondiscriminatory

§ 15.94 Promotional assistance plans must be reasonable and nondiscriminatory.

(a) The Commission issued an advisory opinion regarding the obligations of a supplier in offering alternatives to his basic plan for providing promotional assistance to his competing, retailer-customers by placing advertisements on shopping carts.

(b) The requesting party, a promoter, had a basic promotional assistance plan which some competing retailer-customers of suppliers participating in the plan were functionally unable to use because the retailer-customers did not have or use shopping carts. The plan provided that such competing retailer-customers were to be offered a reasonably usable alternative way of obtaining the proportionally equal assistance to which they are entitled under the provisions of section 2 (d) and (e) of the Robinson-Patman amendment to the Clayton Act.

(c) The question presented was whether a retailer-customer, whose business operation was such that he was functionally able to use and benefit from the basic—shopping cart—plan could demand the alternative form of assistance, if he so desired.

(d) In its opinion, the Commission stated that whether a supplier's promotional assistance plans are reasonable and nondiscriminatory in their application is essentially a question of fact. The Commission held that if the retailer-customer was able, in fact, to use and benefit from the basic plan offered, but rejected same, the supplier need not offer such retailer-customer the alternative plan. The Commission pointed out that the burden of proof on this issue of fact as it may arise in particular cases will rest upon the supplier. The Commission added that if a competing retailer-customer is unable to use the basic plan, because of the nature of his business operation, he must be offered an alternative plan. However, if he rejects the alternative plan for reasons of his own and said plan could be reasonably used to his benefit, then, the supplier would incur no liability for declining to offer another alternative.

(38 Stat. 717, as amended; 15 U.S.C. 41-58; 49 Stat. 1526; 15 U.S.C. 13, as amended)

Issued: October 17, 1966.

By direction of the Commission.

[SEAL] JOSEPH W. SHEA,
Secretary.

[F.R. Doc. 66-11306; Filed, Oct. 17, 1966; 8:46 a.m.]

PART 15—ADMINISTRATIVE OPINIONS AND RULINGS

Foreign Origin; Computers

§ 15.95 Foreign origin; computers.

The Commission issued an Advisory Opinion to the effect that it would be improper to use the "Made in U.S.A." designation in labeling or advertising a computer of which 23 percent of the factory cost was accounted for by imported parts and 77 percent was accounted for by domestically produced parts, assembling and factory testing in the United States.

(38 Stat. 717, as amended; 15 U.S.C. 41-58)

Issued: October 17, 1966.

By direction of the Commission.

[SEAL] JOSEPH W. SHEA,
Secretary.

[F.R. Doc. 66-11307; Filed, Oct. 17, 1966; 8:46 a.m.]

Title 19—CUSTOMS DUTIES

Chapter I—Bureau of Customs, Department of the Treasury

[T.D. 66-224]

PART 4—VESSELS IN FOREIGN AND DOMESTIC TRADES

Coastwise Transportation of Empty Cargo Vans and Shipping Tanks by Swedish Vessels

On the basis of information obtained and furnished by the Department of State, it is found that the Government of Sweden extends to vessels of the United States in ports of Sweden privileges reciprocal to those provided for in § 4.93(a) of the Customs Regulations. Vessels of Sweden are therefore entitled to the privileges granted by this section.

Accordingly, § 4.93(b) of the Customs Regulations is amended by the insertion of "Sweden" in appropriate alphabetical order in the list of countries in that section.

(R.S. 161, as amended, 251, sec. 624, 46 Stat. 759, sec. 2, 23 Stat. 118, as amended, sec. 27, 41 Stat. 999, as amended; 5 U.S.C. 22, 19 U.S.C. 66, 1624, 46 U.S.C. 2, 883)

[SEAL] LESTER D. JOHNSON,
Commissioner of Customs.

Approved: October 11, 1966.

TRUE DAVIS,
Assistant Secretary of the Treasury.

[F.R. Doc. 66-11303; Filed, Oct. 17, 1966; 8:46 a.m.]

Title 20—EMPLOYEES' BENEFITS

Chapter III—Social Security Administration, Department of Health, Education, and Welfare

[Reg. No. 5]

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED (1965 ------)

Subpart J—Conditions of Participation; Hospitals

In the matter of proposing regulations relating to conditions of participation by hospitals in the Health Insurance for the Aged program (Title XVIII of the Social Security Act, as amended); on February 15, 1966, a notice of proposed rule making was published in the FEDERAL REGISTER (31 F.R. 2748). Interested parties were given the opportunity to submit written views or arguments within 30 days after publication of such notice.

All of the written comments submitted were considered, and modifications have been made in the proposed regulations accordingly. In addition, changes in the proposed regulations which are editorial and clarifying in nature were made throughout the sections. Discussion of the more significant changes follows:

(1) Section 405.1001 was amended by adding a paragraph (g) which gives recognition to the American Osteopathic Association hospital accreditation program, and stipulates that periodic reevaluation of the implementation of the American Osteopathic Association accreditation program will be undertaken.

(2) Section 405.1027 has been changed to indicate, more precisely, the role of the consulting pharmacist and the functions of the pharmacy and therapeutics committee, and also, to indicate more clearly that it is acceptable for a hospital to dispense combination drugs.

(3) In § 405.1031 there has been added revised language designed to indicate more clearly the services which may appropriately be available in a rehabilitation department, and to clarify who can serve as the director of a separate physical or occupational therapy department. Additionally, language of paragraph (d) (3) and (4) was modified to more clearly define the qualifications of required personnel where physical and/or occupational therapy services are offered.

Chapter III, Title 20 is amended by adding thereto Subpart J of Part 405 to read as set forth below. The addition of Subpart J of Part 405, Title 20, shall be effective upon publication in the FEDERAL REGISTER.

Dated: October 3, 1966.

[SEAL] ROBERT M. BALL,
Commissioner of Social Security.

Approved: October 8, 1966.

WILBUR J. COHEN,
Acting Secretary of Health, Education, and Welfare

Subpart J—Conditions of Participation; Hospitals

AUTHORITY: The provisions of this Subpart J issued under secs. 1102, 1861 (c), (f), and (g), 1864 and 1871; 49 Stat. 647, as amended; 79 Stat. 314-316, 79 Stat. 326; 79 Stat. 331; 42 U.S.C. 1302, 1395 et seq.

§ 405.1001 General.

(a) In order to participate as a hospital in the health insurance program for the aged, an institution must be a "hospital" within the meaning of section 1861(e) of the Act. This section of the law states a number of specific requirements which must be met by participating hospitals and authorizes the Secretary of Health, Education, and Welfare to prescribe other requirements considered necessary in the interest of health and safety of beneficiaries.

Section 1861. For purposes of this title—

* * * * *

(e) The term "hospital" (except for purposes of section 1814(d), subsection (a)(2) of this section, paragraph (7) of this subsection, and subsections (i) and (n) of this section) means an institution which—

(1) is primarily engaged in providing, by or under the supervision of physicians, to inpatients, (a) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or (b) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

(2) maintains clinical records on all patients;

(3) has bylaws in effect with respect to its staff of physicians;

(4) has a requirement that every patient must be under the care of a physician;

(5) provides 24-hour nursing service rendered or supervised by a registered professional nurse, and has a licensed practical nurse or registered professional nurse on duty at all times;

(6) has in effect a hospital utilization review plan which meets the requirements of subsection (k);

(7) in the case of an institution in any State which State or applicable local law provides for the licensing of hospitals, (a) is licensed pursuant to such law or (b) is approved, by the agency of such State or locality responsible for licensing hospitals, as meeting the standards established for such licensing; and

(8) meets such other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the institution, except that such other requirements may not be higher than the comparable requirements prescribed for the accreditation of hospitals by the Joint Commission on Accreditation of Hospitals (subject to the second sentence of sec. 1863). For purposes of subsection (a)(2), such term includes any institution which meets the requirements of paragraph (1) of this subsection. For purposes of sections 1814(d) (including determination of whether an individual received inpatient hospital services for purposes of such section), and subsections (i) and (n) of this section, such term includes any institution which meets the requirements of paragraphs (1), (2), (3), (4), (5), and (7) of this subsection. Notwithstanding the preceding provisions of this subsection, such term shall not, except for purposes of subsection (a)(2), include any institution which is primarily for the care and treatment of mental diseases or tuberculosis unless it is a tuberculosis hospital (as defined in subsection (g)) or unless it is a psychiatric hospital (as defined in subsection (f)). The term "hospital" also includes a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Mass., but only with respect to items and services ordinarily furnished by such institution to inpatients, and payment may be made with respect to services provided by or in such an institution only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of the conditions, limitations, and requirements otherwise applicable) as may be provided in regulations. For provisions deeming certain requirements of this subsection to be met in the case of accredited institutions, see section 1865.

(b) The requirements included in the statute and those additional health and safety requirements prescribed by the Secretary are set forth in the Conditions of Participation for Hospitals. A hospital which meets all of the specific statutory requirements and which is found to be in substantial compliance with the additional conditions prescribed by the Secretary may, if it so desires, agree to become a participating hospital.

(c) Although the Secretary, in general, may not establish requirements that are higher than the comparable requirements prescribed for accreditation by the Joint Commission on Accreditation of Hospitals, he may, at the request of a State, approve higher health and safety requirements for that State. Also, where a State or political subdivision imposes higher requirements on institutions as a condition for the purchase of services under a State plan approved under Title I, XVI, or XIX of the Social Security Act, the Secretary is required to impose like requirements as a condition to the payment for services in such institutions in that State or subdivision. Hospitals currently accredited by the Joint Commission on Accreditation of Hospitals will be deemed to meet all of the Conditions for Participation, except the requirement for utilization review and, in the case of tuberculosis and psychiatric hospitals, the additional staffing and medical records requirements considered necessary for the provision of intensive care. Consequently, a JCAH approved general hospital will be able to establish eligibility to participate by furnishing adequate evidence that it has an effective utilization review plan. Ordinarily, a written description of the plan and a certification by the hospital that it is either currently in effect or that it will be in effect no later than the first day on which a hospital expects to become a participating provider of services, will constitute sufficient evidence to support a finding that the utilization review plan of such hospital is or is not in conformity with statutory requirements for such a plan.

(d) Likewise, hospitals currently accredited by the American Osteopathic Association, as specified in the next sentence, will be deemed to meet all of the Conditions of Participation, except the requirement for utilization review and, in the case of tuberculosis and psychiatric hospitals, the additional staffing and medical records requirements considered necessary for the provision of intensive care. Hospitals so accredited will be deemed to meet such conditions if their most recent accreditation survey was conducted after March 1966 or they were most recently evaluated for accreditation under standards in effect after the issuance by the American Osteopathic Association of its revised standards for hospital accreditation of November 1965. Recognition of the American Osteopathic Association accreditation program as provided for in this paragraph will be continued so long as there is continued assurance that hospitals accredited under the program meet the Conditions of Participation.

(e) Attention is invited to the requirements of Title VI of the Civil Rights Act of 1964 (78 Stat. 252; P.L. 88-352) which provides that no person in the United States shall, on the ground of race, color, or national origin be excluded from participation in, be denied the benefits of, or be subject to discrimination under any program or activity receiving Federal financial assistance (sec. 601), and to the implementing regulation issued by the Secretary of Health, Education, and Welfare with the approval of the President (Part 80 of this subtitle).

§ 405.1002 Conditions of participation; general.

For an institution to be eligible for participation in the program, it must meet the statutory requirements of section 1861(e) and there must be a finding of substantial compliance on the part of the institution with all the other conditions. These conditions which are set forth in § 405.1020 through § 405.1040 are requirements related to the quality of care and the adequacy of the services and facilities which the institution provides. They represent essential functions to be performed by the institution and its staff in order to satisfy the requirements for participation. It will not be unusual for hospitals to differ in the manner in which these functions are performed. Variations in the type and size of hospitals and the nature and scope of services offered will be reflected in differences in the details of organization, staffing, and facilities. However, the test is whether there is substantial compliance with each of the conditions.

§ 405.1003 Standards; general.

As a basis for a determination as to whether or not there is substantial compliance with the prescribed conditions in the case of any particular hospital, a series of standards, almost all interpreted by explanatory factors, are listed under each condition. These standards represent a broad range and variety of activities which hospitals may undertake or be pursuing in order to carry out the functions embodied in the conditions. Reference to these standards will enable the State agency surveying a hospital to document the activities of the hospital, to establish the nature and extent of the hospital's deficiencies, if any, with respect to any particular function, and to assess the hospital's need for improvement in relation to the prescribed conditions. In substance, the application of the standards, together with the explanatory factors, will indicate the extent and degree to which a hospital is complying with each condition.

§ 405.1004 Certification by State agency.

(a) Title XVIII of the Social Security Act provides that the services of State agencies operating under agreements with the Secretary will be used by the Secretary in determining whether institutions meet the Conditions of Participation. Pursuant to these agreements, State agencies will certify to the Secretary findings as to whether the facilities and services of the hospital substantially meet the conditions. The Secretary, on the basis of such certifications from the State agency, will determine whether or not an institution is a hospital eligible to participate in the health insurance program as a provider of services.

(b) The certifications by the State agency represent recommendations to the Secretary. Notice of determination of eligibility or noneligibility made by the Secretary on the basis of a State agency certification will be sent to the institution concerned by the Social Security Administration after such review and professional consultation with the Public Health Service as may be required. If it is determined that the institution does not comply with the conditions of participation, the institution has a right to appeal from such determination and request a hearing.

§ 405.1005 Principles for the evaluation of hospitals to determine whether they meet the conditions of participation.

Hospitals (except tuberculosis and psychiatric hospitals, see § 405.1036 et seq.)

will be considered in substantial compliance with the Conditions of Participation upon acceptance by the Secretary of findings, adequately documented and certified to by the State agency, showing that:

(a) The hospital is:

(1) Accredited by the Joint Commission on Accreditation of Hospitals or accredited by the American Osteopathic Association as set forth in § 405.1001(d), and

(2) Has established a utilization review plan meeting the statutory requirements of section 1861(k) and such plan is in effect or will be put into effect no later than the first day a hospital expects to become a participating provider of services, or

(b) The hospital meets the specific statutory requirements of section 1861(e) and is found to be operating in accordance with all Conditions of Participation with no significant deficiencies, or

(c) The hospital meets the specific statutory requirements of section 1861(e) but is found to have deficiencies with respect to one or more Conditions of Participation which:

(1) It is making reasonable plans and efforts to correct, and

(2) Notwithstanding the deficiencies, is rendering adequate care and without hazard to the health and safety of individuals being served, taking into account special procedures or precautionary measures which have been or are being instituted.

§ 405.1006 Time limitations on certifications of substantial compliance.

(a) All initial certifications by the State agency to the effect that a hospital is in substantial compliance with the Conditions of Participation will be for a period of 2 years, beginning with July 1, 1966, or, if later, with the date on which the hospital is first found to be in substantial compliance with the Conditions. Ordinarily, a resurvey will be scheduled to be conducted not later than the 24th month of a 2-year period of certification; however, the resurvey may be conducted earlier than the scheduled time if the circumstances warrant it. State agencies may visit or resurvey institutions where necessary to ascertain continued compliance or to accommodate to periodic or cyclical survey programs. A State finding and certification to the Secretary that an institution is no longer in compliance may occur within a 2-year or subsequent period of certification.

(b) If a hospital is certified by the State agency as in substantial compliance under the provisions of § 405.1005 (c) the following information will be incorporated into the finding and, if the Secretary determines that the hospital is eligible to participate in the program as a provider of services, into a notice of eligibility to the hospital:

(1) A statement of the deficiencies which were found, and

(2) A description of progress which has been made and further action which is being taken to remove the deficiencies, and

(3) A scheduled time for a re-survey of the institution to be conducted not later than the 18th month (or earlier, depending on the nature of the deficiencies) of the period of certification.

§ 405.1007 Certification of noncompliance.

(a) The State agency will certify that an institution is not in compliance with the conditions of participation, or, where a determination of eligibility has been made, that an institution is no longer in compliance where:

(1) The institution is not in compliance with one or more of the statutory requirements of section 1861(e), or

(2) The institution has deficiencies of such character as to seriously limit the capacity of the institution to render adequate care or which place health and safety of individuals in jeopardy, and consultation to the institution has demonstrated that there is no early prospect of such significant improvement as to establish substantial compliance as of a later beginning date, or

(3) After a previous period or part thereof for which the institution was certified under circumstances outlined in § 405.1005(c), there is a lack of progress toward a removal of deficiencies which the State agency finds are adverse to the health and safety of individuals being served.

(b) If, on the basis of a State agency certification, it is determined by the Secretary that a hospital is not in compliance with the conditions of participation, or that a hospital is no longer in compliance and the participation agreement is terminated, the hospital may request that the determination be reviewed.

§ 405.1008 Criteria for determining substantial compliance.

Findings made by a State agency as to whether a hospital is in substantial compliance with the Conditions of Participation require a thorough evaluation of the degree to which operation of a hospital demonstrates adequate performance of the functions which are embodied in the conditions. The State evaluation will take into consideration:

(a) The degree to which each standard, as well as the total set of standards relating to a Condition of Participation, are met; and

(b) When there is a deficiency in meeting a standard: (1) Whether the deficiency is one concerning the statutory requirements which must be met by all hospitals (section 1861(e) of the Act;

(2) Whether the deficiency creates a serious hazard to health and safety; and

(3) Whether the hospital is making reasonable plans and efforts to correct the deficiency within a reasonable period.

§ 405.1009 Documentation of findings.

Where the State agency certification to the Secretary is that an institution is not in compliance with the Conditions of Participation, such documentation is to include a report of all consultation which has been undertaken in an effort to assist the institution to comply with the conditions, a report of the institution's responses with respect to the consultation, and the State agency's assessment of the prospects for such improvements as to enable the institution to achieve substantial compliance with the conditions.

§ 405.1010 Authorization for special certification in areas where necessary to providing access to hospital care.

(a) Where, by reason of factors such as isolated location or absence of sufficient facilities in an area, the denial of eligibility of an institution to participate would seriously limit the access of beneficiaries to participating hospitals, an institution may, upon recommendation by the State agency, be approved by the Secretary as a provider of services. Such approvals will be granted only where there are no deficiencies of such character and seriousness as to place health and safety of individuals in jeopardy. An institution receiving this special approval shall furnish information showing the extent to which it is making the best use of its resources to improve its quality of care. Re-surveys of such institutions will be made at least annually.

(b) Each case will have to be decided on its individual merits, and while the degree and extent of compliance will vary, the institution must, as a minimum, meet all of the statutory conditions in section 1861(e) (1)–(7) of the Act, in addition to meeting such other requirements as the Secretary finds necessary under section 1861(e)(8) of the Act.

§ 405.1011 Provision of emergency services by nonparticipating hospitals.

An institution which has not been determined by the Secretary as being in compliance with all of the Conditions, or which is not accepted to become a participating hospital may, nevertheless, be paid under the program for emergency services furnished provided it meets the requirements of section 1861(e) (1), (2), (3), (4), (5), and (7) of the Act, as amended.

§ 405.1020 Condition of participation—compliance with State and local laws.

The hospital is in conformity with all applicable State and local laws.

(a) *Standard; licensure of hospital.* The hospital, in any State in which State or applicable local law provides for the licensing of hospitals, is (1) licensed pursuant to such law, or (2) approved, by the agency of the State or locality responsible for licensing hospitals, as meeting the standards established for such licensing.

(b) *Standard; licensure or registration of personnel.* Staff of the hospital is licensed or registered in accordance with applicable laws.

(c) *Standard; conformity with other laws.* The hospital is in conformity with laws relating to fire and safety, to communicable and reportable diseases, to postmortem examinations, and to other relevant matters.

§ 405.1021 Condition of participation—Governing body.

The hospital has an effective governing body legally responsible for the conduct of the hospital as an institution. However, if a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital carry out the functions herein pertaining to the governing body.

(a) *Standard; bylaws.* The governing body has adopted bylaws in accordance with legal requirements. The factors explaining the standard are as follows:

(1) The bylaws are in writing and available to all members of the governing body.

(2) The bylaws:

(i) Stipulate the basis upon which members are selected, their term of office, and their duties and requirements;

(ii) Specify to whom responsibilities for operation and maintenance of the hospital, including evaluation of hospital practices, may be delegated; and the methods established by the governing body for holding such individuals responsible;

(iii) Provide for the designation of necessary officers, their terms of office and their duties, and for the organization of the governing body into essential committees;

(iv) Specify the frequency with which meetings will be held;

(v) Provide for the appointment of members of the medical staff; and

(vi) Provide mechanisms for the formal approval of the organization, bylaws, rules and regulations of the medical staff and its departments in the hospital.

(b) *Standard; meetings.* The governing body meets at regular, stated intervals. The factors explaining the standard are as follows:

(1) Meetings are held frequently enough for the governing body to carry on necessary planning for growth and development and to evaluate the conduct of the hospital, including the care and treatment of patients, the control, conservation and utilization of physical and financial assets, and the procurement and direction of personnel.

(2) Minutes of meetings reflect pertinent business conducted, and are regularly distributed to members of the governing body.

(c) *Standard; committees.* The governing body appoints committees. There should be an Executive Committee and others as indicated for special purposes. The factors explaining the standard are as follows:

(1) The number and types of committees appointed are consistent with the size and scope of activities of the hospital.

(2) An Executive Committee, or the governing body as a whole, coordinates the activities and general policies of the various hospital departments and special committees established by the governing body.

(3) Written minutes or reports, which reflect business conducted by the Executive Committee, are maintained for review and analysis by the governing body.

(4) Other committees, including finance, joint conference, and building and maintenance, function in a manner consistent with their duties as assigned by the governing body and maintain written minutes or reports which reflect the enactment of such duties. If such other committees are not appointed, a member or members of the governing body assume those duties normally assigned to such committees.

(d) *Standard; liaison.* The governing body has established a formal means of liaison with the medical staff by a joint conference committee or other appropriate mechanism. The factors explaining the standard are as follows:

(1) A direct and effective method of communication with the medical staff is established on a formal, regular basis, and is documented in written minutes or reports which are distributed to designated members of the governing body and active medical staff.

(2) Such effective liaison is a responsibility of the Joint Conference Committee, the Executive Committee, or designated members of the governing body.

(e) *Standard; medical staff.* The governing body appoints members of the medical staff. The factors explaining the standard are as follows:

(1) A formal procedure is established, governed by written rules and regulations, covering the application for medical staff membership and the method of processing application.

(2) The procedure related to the submission and processing of applications involves the administrator, credentials committee of the medical staff or its counterpart, and the governing body, all functioning on a regular basis.

(3) Selection of physicians and definition of their medical privileges, both for new appointments and reappointments, are based on written, defined criteria.

(4) Actions taken on applications for medical staff appointments by the governing body are put in writing and retained.

(5) Written notification of applicants is made by either the governing body or its designated representative.

(6) Applicants selected for medical staff appointment sign an agreement to abide by the rules, regulations, and bylaws of the hospital.

(7) There is a procedure for appeal and hearing by the governing body or other designated committee if the applicant or medical staff feels the decision is unfair or wrong.

(f) *Standard; qualified hospital administrator.* The governing body appoints a qualified hospital administrator or other chief executive officer. The factors explaining the standard are as follows:

(1) The administrator has had actual experience of a suitable kind, nature and duration in hospital administration.

(2) Preferably the administrator has had formal training in a graduate program in hospital administration approved for membership in the Association of University Programs in Hospital Administration.

(g) *Standard; administrator duties.* The administrator acts as the executive officer of the governing body, is responsible for the management of the hospital, and provides liaison among the governing body, medical staff, nursing staff, and other departments of the hospital. The factors explaining the standard are as follows:

(1) In discharging his duties, the administrator keeps the governing body fully informed of the conduct of the hospital through annual, monthly, or written reports and by attendance at meetings of the governing body.

(2) The administrator organizes the day-to-day functions of the hospital through appropriate departmentalization and delegation of duties.

(3) The administrator establishes formal means of accountability on the part of subordinates to whom he has assigned duties.

(4) To maintain sufficient liaison between the governing body, medical and nursing staffs and other departments, the administrator holds interdepartmental and departmental meetings, where appropriate, attends or is represented at such meetings on a regular basis, and reports to such departments as well as the governing body the pertinent activities of the hospital.

(5) The administrator has sufficient freedom from other responsibilities to permit adequate attention to the management and administration of the hospital.

(h) *Standard; all patients under physician's care.* The governing body is responsible for establishing a policy which requires that every patient must be under the care of a physician. The factors explaining the standard are as follows:

(1) Patients are admitted to the hospital only on the recommendation of a physician.

(2) A member of the house staff or other physician is on duty or on call at all times and available within 15 to 20 minutes at the most.

(i) *Standard; physical plant.* The governing body is responsible for providing a physical plant equipped and staffed to maintain the needed facilities and services for patients. The factors explaining the standard are as follows:

(1) The governing body receives periodic written reports from appropriate intramural and extramural sources about the adequacy of the physical plant, equipment and personnel, as well as any deficiencies.

(2) A member, members, or committee of the governing body is assigned primary responsibility for this aspect in the conduct of the hospital.

(3) In order to provide a suitable physical plant which is well-equipped and staffed, the governing body is responsible for raising funds or otherwise arranging for the availability of funds, adopting a budget for the institution, and approving schedules of charges.

§ 405.1022 Condition of participation—Physical environment.

The buildings of the hospital are constructed, arranged, and maintained to insure the safety of the patient, and provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

(a) *Standard; buildings.* The buildings of the hospital are solidly constructed with adequate space and safeguards for each patient. The factors explaining the standard are as follows:

(1) The physical facility has current approvals following inspection by appropriate State and/or local authorities.

(2) The condition of the physical plant and the over-all hospital environment are developed and maintained in such a manner that the safety and well-being of patients are assured.

(3) The physical plant provides:

(i) Facilities for the physical separation of all isolation patients, particularly those with communicable diseases, and facilities for hand washing and for carrying out good medical and nursing isolation techniques;

(ii) Proper facilities for handling contaminated linens;

(iii) Adequate floor space per bed; in the absence of State or local requirements regarding space per bed, there is at least one hundred square feet of floor area per bed in a private room and eighty square feet per bed in multiple patient rooms;

(iv) Facilities for emergency power and lighting in at least the operating, recovery, intensive care, and emergency rooms and stairwells; in all other areas not serviced by the emergency supply source, battery lamps and flashlights are available; and

(v) Facilities for emergency gas and water supply.

(4) There is regular inspection and cleaning of air intake sources, screens, and filters, with special attention given to "high risk" areas.

(5) Proper facilities are maintained and techniques used for incineration of infectious wastes, as well as sanitary disposal of all other wastes.

(6) Kitchens and dishwashing facilities located outside the dietary department comply with the standards specified for the dietary department.

(7) Corridors and passageways are free of obstacles.

(8) A person is designated responsible for services and for the establishment of practices and procedures in each of the following areas—plant maintenance, laundry operations, and the supervision and training of general housekeeping personnel.

(b) *Standard; fire control.* The hospital provides fire protection by the elimination of fire hazards; the installation of necessary safeguards such as extinguishers, sprinkling devices, and fire barriers to insure rapid and effective fire control; and the adoption of written fire control plans rehearsed three times a year by key personnel. The factors explaining the standard are as follows:

(1) The hospital has:

(i) Written evidence of regular inspection and approval by State or local fire control agencies;

(ii) Fire-resistant buildings, and equipment as close to fireproof as possible;

(iii) Stairwells kept closed by fire doors or equipped with unimpaired automatic closing devices;

(iv) An annual check of fire extinguishers for type, replacement, and renewal dates;

(v) Sprinkler systems at least for trash and laundry chutes, paint and carpenter shops, and most storage areas, and fire detection equipment for bulk storage areas;

(vi) Conductive floors with the required equipment and ungrounded electrical circuits in areas subject to explosion hazards;

(vii) Proper routine storage and prompt disposal of trash;

(viii) "No Smoking" signs prominently displayed, where appropriate, with rules governing the ban on smoking in designated areas of the hospital enforced and obeyed by all personnel; and

(ix) Fire regulations prominently posted and all fire codes rigidly observed and carried out.

(2) Written fire control plans contain provisions for prompt reporting of all fires; extinguishing fires; protection of patients, personnel and guests; evacuation; and cooperation with fire fighting authorities.

(3) There are rigidly enforced written rules and regulations governing proper routine methods of handling and storing explosive agents, particularly in operating rooms and laboratories, and governing the provision of oxygen therapy.

(c) *Standard; sanitary environment.* The hospital provides a sanitary environment to avoid sources and transmission of infections. The factors explaining the standard are as follows:

(1) An infection committee, composed of members of the medical and nursing staffs and administration, is established and responsible for investigating, controlling and preventing infections in the hospital. Its responsibilities include:

(i) The establishment of written infection control measures; and

(ii) The establishment of techniques and systems for discovering and reporting infections in the hospital.

(2) Written procedures govern the use of aseptic techniques and procedures in all areas of the hospital.

(3) To keep infections at a minimum, such procedures and techniques are regularly reviewed by the infection committee, particularly those concerning food handling, laundry practices, disposal of environmental and patient wastes, traffic control and visiting rules in high risk areas, sources of air pollution, and routine culturing of autoclaves and sterilizers.

(4) There is a method of control used in relation to the sterilization of supplies and water, and a written policy requiring sterile supplies to be reprocessed at specified time periods.

(5) Formal provisions are made to educate and orient all appropriate personnel in the practice of aseptic techniques such as handwashing and scrubbing practices, proper grooming, masking and dressing care techniques, disinfecting and sterilizing techniques, and the handling and storage of patient care equipment and supplies.

(6) There are measures which control the indiscriminate use of preventive antibiotics in the absence of infection, and the use of antibiotics in the presence of infection is based on necessary cultures and sensitivity tests.

(7) Continuing education is provided to all hospital personnel on the cause, effect, transmission, prevention, and elimination of infections.

(8) A continuing process is enforced for inspection and reporting of any hospital employee with an infection who may be in contact with patients, their food or laundry.

(d) *Standard; diagnostic and therapeutic facilities.* The hospital provides adequate diagnostic and therapeutic facilities. The factors explaining the standard are as follows:

(1) Facilities are located for the convenience and safety of patients.

(2) Facilities are available which allow all routine preadmission, admission and discharge procedures to be done as prescribed by the medical staff in bylaws, rules and regulations of the hospital.

(3) Diagnostic and therapeutic facilities, supplies, and equipment permit an acceptable level of patient care to be provided by the medical and nursing staffs.

(4) The extent and complexity of such facilities are determined by the services that the hospital attempts to offer.

§ 405.1023 Condition of participation—Medical staff.

The hospital has a medical staff organized under bylaws approved by the governing body, and responsible to the governing body of the hospital for the quality of all medical care provided patients in the hospital and for the ethical and professional practices of its members.

(a) *Standard; responsibilities toward policies.* The medical staff is responsible for support of medical staff and hospital policies. The factors explaining the standard are as follows:

(1) Medical staff members participate on various staff committees. Committee records verify that committee meetings are attended by the majority of committee members.

(2) There are prescribed enforced disciplinary procedures for infraction of hospital and medical policies.

(b) *Standard; autopsies.* The medical staff attempts to secure autopsies in all cases of unusual deaths and of medical-legal and educational interest. It is recommended that a minimum of 20 percent of all terminal cases be autopsied. The factors explaining the standard are as follows:

(1) The hospital has an autopsy rate consistent with the needs of its ongoing staff education program.

(2) Autopsy reports are distributed to the attending physician and become a part of the patient's record. Whenever possible, they are utilized in conference.

(3) The autopsy is performed by a pathologist or physician versed in autopsy procedure and protocol.

(c) *Standard; consultations.* The medical staff has established policies concerning the holding of consultations:

(1) The status of consultant is determined by the medical staff on the basis of an individual's training, experience, and competence. A consultant must be well qualified to give an opinion in the field in which his opinion is sought.

(2) Except in an emergency, consultations with another qualified physician are required in cases on all services in which, according to the judgment of the attending physician: (i) The patient is not a good medical or surgical risk, (ii) the diagnosis is obscure, (iii) there is doubt as to the best therapeutic measures to be utilized, or (iv) there is a question of criminal action.

(3) A satisfactory consultation includes examination of the patient and the record. A written opinion signed by the consultant must be included in the medical record. When operative procedures are involved, the consultation note, except in an emergency, shall be recorded prior to operation.

(4) The patient's physician is responsible for requesting consultations when indicated. It is the duty of the medical staff, through its chiefs of service and executive committee, to make certain that members of the staff do not fail in the matter of calling consultants as needed.

(5) Routine procedures such as an X-ray examination, electrocardiogram determination, tissue examination, and proctoscopic and cystoscopic procedures are not normally considered to be consultations.

(d) *Standard; staff appointments.* Staff appointments are made by the governing body, taking into account recommendations made by the active staff. The factors explaining the standard are as follows:

(1) The governing body has the legal right to appoint the medical staff and the moral obligation to appoint only those physicians who are judged by their fellows to be of good character and qualified and competent in their respective fields.

(2) Reappointments are made periodically, and recorded in the minutes of the governing body. Reappointment policies provide for a periodic appraisal of each member of the staff, including consideration of his physical and mental capabilities. Recommendations for reappointments are noted either in the credential committee or medical staff meetings' minutes.

(3) Temporary staff privileges (for example, locum tenens) are granted for a limited period if the physician is otherwise properly qualified for such.

(e) *Standard; staff qualifications.* Members of the staff are qualified legally, professionally, and ethically for the positions to which they are appointed. The factors explaining the standard are as follows:

(1) To select its members and delineate privileges, the hospital medical staff has a system, based on definite workable standards, to evaluate each applicant by its credentials committee (or in small hospitals, committee-of-the-whole) which makes recommendations to the medical staff and to the governing body.

(2) Privileges are extended to duly licensed qualified physicians to practice in the appropriate fields of general practice, internal medicine, surgery, pediatrics, obstetrics, gynecology, and other recognized and accepted fields according to individual qualifications.

(3) Criteria for selection are individual character, competence, training, experience, and judgment.

(4) Under no circumstances is the accordance of staff membership or professional privileges in the hospital dependent solely upon certification, fellowship, or membership in a specialty body or society. All qualified candidates are considered by the credentials committee.

(5) The scope of privileges to be accorded the physician is indicated. The privileges of each staff member are specifically stated or the medical staff defines a classification system. If a system involving classification is used, the scope of the divisions is well defined, and the standards which must be met by the applicant are clearly stated for each category.

(f) *Standard; active staff.* Regardless of any other categories having privileges in the hospital, there is an active staff, properly organized, which performs all the organizational duties pertaining to the medical staff. These include:

(1) Maintenance of the proper quality of all medical care and treatment in the hospital;

(2) Organization of the medical staff, including adoption of rules and regulations for its government (which require the approval of the governing body), election of its officers or recommendations to the governing body for appointment of the officers, and recommendations to the governing body upon all appointments to the staff and grants of hospital privileges; and

(3) Making other recommendations to the governing body upon matters within the purview of the medical staff.

(g) *Standard; other staff.* In larger hospitals, and in some smaller hospitals, the medical staff may include one or more of the following categories in addition to the active staff, but this in no way modifies the duties and responsibilities of the active staff.

(1) *Honorary staff.* The honorary staff is composed of former active staff, retired or emeritus, and other physicians of reputation whom it is desired to honor.

(2) *Consulting staff.* The consulting staff is composed of recognized specialists willing to serve in such capacity. A member of the consulting staff may also be a member of the active staff, but only if the two appointments are made.

(3) *Associate staff.* The associate staff is composed of those members who use the hospital infrequently or those less experienced members undergoing a period of probation before being considered for appointment to the active staff.

(4) *Courtesy staff.* The courtesy staff is composed of those who desire to attend patients in the hospital but who, for some reason not disqualifying, are ineligible for appointment in another category of the staff.

(h) *Standard; staff officers.* There are such officers as may be necessary for the government of the staff. These officers are members of the active staff and are elected by the active staff, unless this is precluded by hospital policy. The factors explaining the standard are as follows:

(1) The officers are elected from and by the active staff or appointed in accordance with hospital policy on the basis of ability and willingness to assume responsibility and devote time to the office.

(2) Where officers are elected, all election rules are carefully spelled out in the bylaws. The election is an open one and most preferably by secret ballot.

(3) The chief of staff:

(i) Has direct responsibility for the organization and administration of the medical staff, in accordance with the terms of the medical staff constitution, bylaws, rules, and regulations;

(ii) In all medico-administrative matters, acts in coordination and cooperation with the hospital administrator in giving effect to the policies adopted by the governing body; and

(iii) Is responsible for the functioning of the clinical organization of the hospital and keeps or causes to be kept careful supervision over the clinical work in all departments.

(i) *Standard; bylaws.* Bylaws are adopted to govern and enable the medical staff to carry out its responsibilities. The factors explaining the standard are as follows:

(1) The bylaws of the medical staff are a precise and clear statement of the policies under which the medical staff regulates itself.

(2) Medical staff bylaws, rules and regulations include the following:

(i) A descriptive outline of medical staff organization;

(ii) A statement of the necessary qualifications which physicians must possess to be privileged to work in the hospital, and of the duties and privileges of each category of medical staff;

(iii) A procedure for granting and withdrawing privileges to physicians;

(iv) A mechanism for appeal of decisions regarding medical staff membership and privileges;

(v) A definite and specific statement forbidding the practice of the division of fees under any guise whatsoever;

(vi) Provision for regular meetings of the medical staff;

(vii) Provision for keeping accurate and complete clinical records;

(viii) A statement to the effect that the physician in charge of the patient is responsible for seeing that all tissue removed at operation is delivered to the hospital pathologist, and that a routine examination and report is made of such tissue;

(ix) Provision for routine examination of all patients upon admission and recording of preoperative diagnosis prior to surgery;

(x) A ruling permitting a surgical operation only on consent of the patient or his legal representative, except in emergencies;

(xi) A statement providing that, except in emergency, consultation is required as outlined above;

(xii) A regulation requiring that physicians' orders be recorded and signed; and

(xiii) If dentists and oral surgeons are to be admitted to staff membership, the necessary qualifications, status, privileges and rights of this group are stated in the bylaws.

(j) *Committees—General.* The structure of committee organization is a decision to be made by the medical staff as long as the required committee functions are carried out. A small staff may wish to function as a committee of the whole. Others may wish to combine committee functions in two or three committees.

(k) *Standard; executive committee.* The executive committee (or its equivalent) coordinates the activities and general policies of the various departments, acts for the staff as a whole under such limitations as may be imposed by the staff, and receives and acts upon the reports of the medical records, tissue, and such other committees as the medical staff may designate. The factors explaining the standard are as follows:

(1) The committee meets at least once a month, exclusive of the summer months, and maintains a permanent record of its proceedings and actions.

(2) Committee membership is made up of the officers of the medical staff, chiefs of major departments or services, and one or more members elected at large from the active medical staff.

(3) Its functions and responsibilities include:

(i) Considering and recommending action to the administrator on all matters which are of a medical-administrative nature;

(ii) Investigating any reports of breach of ethics by members of the medical staff, as referred to this committee by the credentials committee; and

(iii) Acting as the program committee for staff meetings, unless this responsibility is delegated to a specific committee.

(l) *Standard; credentials committee.* The credentials committee (or its equivalent) reviews applications for appointment and reappointment to all categories of the staff. It delineates the privileges to be extended to the applicant and makes appropriate recommendations to the governing body according to the procedure outlined in the hospital's medical staff bylaws. The factors explaining the standard are as follows:

(1) The committee makes recommendations for initial appointment, hospital privileges, promotions, and demotions.

(2) The committee is advisory and investigative and makes recommendations only. It is not given disciplinary or punitive powers.

(m) *Standard; joint conference committee.* The joint conference committee (or its equivalent) is a medico-administrative advisory committee and the official means of liaison among the medical staff, the governing body, and the administrator. In the absence of a joint conference committee, a formal means of liaison between the governing body and medical staff is established. The factors explaining the standard are as follows:

(1) A formal means of liaison exists even where there is medical staff representation on the governing body.

(2) The committee meets at least four times per year and maintains a permanent record of its minutes.

(3) Purposes of the committee include:

(i) Communications to keep the governing body, medical staff, and administration cognizant of pertinent actions taken or contemplated by one or the other;

(ii) Consideration of plans for growth; and

(iii) Consideration of issues affecting medical care which arise in the operation and affairs of the hospital.

(n) *Standards; medical records committee.* The medical records committee (or its equivalent) supervises the maintenance of medical records at the required standard of completeness. On the basis of documented evidence, the committee also reviews and evaluates the quality of medical care given the patient. The factors explaining the standard are as follows:

(1) The committee meets at least once a month exclusive of the summer months, and submits a written report to the executive committee.

(2) The committee's members represent a cross section of the clinical services. In large hospitals, each major clinical department may have its own committee.

(3) Membership is staggered so that experienced committee physicians are always included. Senior residents may serve on this committee.

(4) Review of the record for completeness can be performed for the most part by the medical record librarian. In addition, on-the-spot scanning of current inpatient records for completeness is done on the floors.

(5) The quality of patient care is evaluated from the documentation on the chart. In some hospitals, this function may be given to an "audit" or "evaluation" committee.

(6) The committee:

(i) Makes recommendations to the medical staff for the approval of, use of, and any changes in form or format of the medical record;

(ii) Advises and recommends policies for medical record maintenance and supervises the medical records to insure that details are recorded in the proper manner and that sufficient data are present to evaluate the care of the patient;

(iii) Insures that there is proper filing, indexing, storage, and availability of all patient records; and

(iv) With the aid of legal counsel, advises and develops policies to guide the medical record librarian, medical staff, and administration so far as matters of privileged communication and legal release of information are concerned.

(o) *Standard; tissue committee.* The tissue committee (or its equivalent) reviews and evaluates all surgery performed in the hospital on the basis of agreement or disagreement among the preoperative, postoperative, and pathological diagnosis, and on the acceptability of the procedure undertaken. The factors explaining the standards are as follows:

(1) The committee meets at least once a month, exclusive of the summer months, and submits a written report to the executive committee.

(2) This committee's work includes continuing education through such mechanisms as utilization of its findings in the form of hypothetical cases or review of cases by category at staff meetings or publishing in coded form physicians' standings in the hospital regarding percentage of cases in which normal tissue is removed.

(p) *Standard; meetings.* Meetings of the medical staff are held to review, analyze, and evaluate the clinical work of its members; the number and frequency of medical staff meetings are determined by the active staff and clearly stated in the bylaws of the staff and attendance, recments for each individual member of the staff and for the total attendance at each meeting are clearly stated in the bylaws of the staff and attendance records are kept, adequate minutes of all meetings are kept; the method adopted to insure adequate evaluation of clinical practice in the hospital is determined by the medical staff and clearly stated in the bylaws. Any one of the following three methods will fulfill this requirement: Monthly meetings of the active staff; monthly departmental conferences in those hospitals where the clinical services are well organized and each department is large enough to meet as a unit; or monthly meetings of the medical records and tissue committees at which the quality of medical work is adequately appraised, action is taken by the executive committee, and reports are made to the active staff. The factors explaining the standard are as follows:

(1) Absence of a staff member from more than the specified percentage of regular meetings for the year, unless excused by the executive committee for just cause such as absence from the community or sickness, is considered as resignation from the active medical staff.

(2) Staff and departmental meetings are held for the purpose of reviewing the

medical care of patients within the hospital and those recently discharged.

(3) Minutes of such meetings give evidence of the following:

(i) A review of the clinical work done by the staff on at least a monthly basis; this includes consideration of selected deaths, unimproved cases, infections, complications, errors in diagnosis, results of treatment, and review of transfusions;

(ii) Consideration of the hospital statistical report on admissions, discharge, clinical classifications of patients, autopsy rates, hospital infections, and other pertinent hospital statistics;

(iii) Short synopsis of each case discussed;

(iv) Names of discussants; and

(v) Duration of meeting.

(q) *Standard; departments.* (1) Division of the staff into services or departments to fulfill medical staff responsibilities promotes efficiency and is recommended in general hospitals with 75 or more beds. Each autonomous service or department is organized and functions as a unit.

(2) Medical staff members of each service or department are qualified by training and demonstrated competence and are granted privileges commensurate with their individual abilities.

(3) In those hospitals where the review and evaluation of clinical practice are done by committees of the medical staff or by monthly meetings of the entire staff, departmental meetings are optional. In those hospitals where the clinical review is done by the departments, each service or department meets at least once a month. Records of these meetings are kept and become part of the records of the medical staff.

(r) *Standard; chief of service or department.* The chief of services or department is a member of the service or department qualified by training, experience, and administrative ability for the position. He is responsible for the administration of the department, for the general character of the professional care of patients, and for making recommendations as to the qualifications of its members. He also makes recommendations to the administration as to the planning of hospital facilities, equipment, routine procedures, and any other matters concerning patient care. The factors explaining the standard are as follows:

(1) Selection of each chief of service by the governing body is never made without first obtaining reliable medical advice.

(2) Duties and responsibilities of the chief include in addition to those cited above:

(i) Responsibility for arranging and expediting inpatient and outpatient departmental programs embracing organization, educational activities, supervision, and evaluation of the clinical work ;

(ii) Responsibility for enforcement of the hospital medical staff bylaws, rules, and regulations, with special attention to those pertaining to his department;

(iii) Cooperation with the hospital administration with respect to the purchase of supplies and equipment and in formulating special regulations and policies applicable to his department, such as standing orders and techniques;

(iv) Maintaining the quality of the medical records in his department; and

(v) Represents his department, in a medical advisory capacity, to the administration and governing body.

§ 405.1024 Condition of participation—Nursing department.

The hospital has an organized nursing department. A licensed registered professional nurse is on duty at all times and professional nursing service is available for all patients at all times.

(a) *Standard; organization.* There is a well-organized departmental plan of administrative authority with delineation of responsibilities and duties of each category of nursing personnel. The factor explaining the standard is as follows: The delineation of responsibilities and duties for each category of the nursing staff may be in the form of a written job description for each category.

(b) *Standard; Licensed registered professional nurse.* There is an adequate number of licensed registered professional nurses to meet the following minimum staff requirements: Director of the department; Assistants to the director for evening and night services; Supervisory and staff personnel for each department or nursing unit to insure the immediate availability of a registered professional nurse for bedside care of any patient when needed; and Registered professional nurse on duty at all times and available for all patients on a 24-hour basis. *The factors explaining the standard are as follows:* (1) The staffing pattern insures the availability of registered professional nursing care for all patients on a 24-hour basis every day.

(2) If a licensed practical nurse or nursing aide is on duty during the evening and night hours in a ward with patiets who do not generally need skilled nursing care, there is a registered professional nurse supervisor who makes frequent rounds and is immediately available to give skilled nursing care when needed. She is free to render bedside care and is not occupied in the operating room, delivery room, or emergency room for long periods of time.

(3) The ratio of registered professional nurses to patients together with the ratio of registered professional nurses to other nursing personnel is adequate to provide proper supervision of patient care and staff performance, taking into consideration the characteristics of the patient load.

(4) A registered professional nurse assigns the nursing care of each patient to other nursing personnel in accordance with the patient's needs and the preparation and competence of the nursing staff available.

(c) *Standard; other nursing personnel.* There are other nursing personnel in sufficient numbers to provide nursing care not requiring the service of a registered professional nurse. The training and supervision of these personnel are continually planned and carried out to enable them to perform effectively the duties which are assigned to them.

(d) *Standard; non-floor services.* There are adequate nursing personnel for the surgical suite, clinics, and other services of the hospital in keeping with their size and degree of activity. The factors explaining the standard are as follows:

(1) A registered professional nurse is in charge of the operating rooms.

(2) Surgical technicians and licensed practical nurses may be permitted to serve as "scrub nurses" under the direct supervision of a registered professional nurse; they are not permitted to function as circulating nurses in the operating rooms.

(e) *Standard; qualifications.* Individuals selected for the nursing staff are qualified by education, experience, and demonstrated ability for the positions to which they are appointed. The factors explaining the standard are as follows:

(1) The director of nursing makes decisions relative to the selection and promotion of nursing personnel based on their qualifications and capabilities and recommends the termination of employment when this is necessary.

(2) The educational and experiential qualifications of the director of nursing, her assistants, and supervisors are commensurate with the size and complexity of the hospital.

(3) The functions and qualifications of nursing personnel are clearly defined in relation to the duties and responsibilities delegated to them.

(4) There is a procedure to insure that hospital nursing personnel, for whom licensure is required, do have valid and current licensure.

(5) Personnel records including application forms and verification of credentials are on file.

(6) New employees are oriented to the hospital, nursing service, and their jobs.

(f) *Standard; working relationships.* There are well established working relationships with other services of the hospital, both administrative and professional. The factors explaining the standard are as follows:

(1) Registered professional nurses confer with the physicians relative to patient care.

(2) Interdepartmental policies affecting nursing service and nursing care to patients are made jointly with the director of nursing.

(3) There are established procedures for scheduling laboratory and X-ray examinations, for ordering, securing, and maintaining supplies and equipment needed for patient care, for ordering diets, etc.

(g) *Standard; evaluation and review of nursing care.* There is constant review and evaluation of the nursing care provided for patients and there are written nursing care procedures and written nursing care plans for patients. The factors explaining the standard are as follows:

(1) Nursing care policies and procedures are written and consistent with generally accepted practice and are reviewed and revised as necessary to keep pace with best practice and new knowledge.

(2) A registered professional nurse plans, supervises, and evaluates the nursing care for each patient.

(3) Nursing care plans are kept current daily. Plans indicate nursing care needed, how it is to be accomplished, and methods, approaches and modifications necessary to insure best results for the patient.

(4) Nursing notes are informative and descriptive of the nursing care given and include information and observations of significance so that they contribute to the continuity of patient care.

(5) Only (i) a licensed physician or a registered professional nurse or (ii) a licensed practical nurse, a student nurse in an approved school of nursing, or a psychiatric technician, when these three classes of personnel are under the direct supervision of a registered professional nurse, is permitted to administer medications, and in all instances, in accordance with the Nurse Practice Act of the State.

(6) All medical orders are in writing and signed by the physician. Telephone orders are used sparingly, are given only to the registered professional nurse, and are signed or initialed by the physician as soon as possible.

(7) Blood transfusions and intravenous medications are administered in accordance with State law. If administered by registered professional nurses, they are administered only by those who have been specially trained for this duty.

(8) There is an effective hospital procedure for reporting transfusion reactions and adverse drug reactions.

(h) *Standard; staff meetings.* Meetings of the registered professional nursing staff are held at least monthly to discuss patient care, nursing service problems, and administrative policies. The pattern for meetings may be by clinical departments, by categories of the staff, or by the staff as a whole. Minutes of all meetings are kept. The factors explaining the standard are as follows:

(1) Minutes reflect the purpose of the staff meetings; e.g., review and evaluation of nursing care, ways of improving nursing service, discussion or nursing care plans for individual patients, consideration of specific nursing techniques and procedures, establishment and/or interpretation of nursing department policies, interpretation of administrative and medical staff policies, reports of meetings, etc.

(2) Minutes are available to staff members either individually or are maintained in a central place.

§ 405.1025 Condition of participation—Dietary department.

The hospital has an organized dietary department directed by qualified personnel. However, a hospital which has a contract with an outside food management company may be found to meet this condition of participation if the company has a therapeutic dietician who serves, as required by scope and complexity of the service, on a full-time, part-time, or consultant basis to the hospital, provided the company maintains the minimum standards as listed herein and provides for constant liaison with the hospital medical staff for recommendations on dietetic policies affecting patient treatment.

(a) *Standard; organization.* There is an organized department directed by qualified personnel and integrated with other departments of the hospital. There is a qualified dietician, full-time or on a consultation basis, and, in addition, administrative and technical personnel competent in their respective duties. The factors explaining the standard are as follows:

(1) There are written policies and procedures for food storage, preparation, and service developed by a qualified dietician (preferably meeting the American Dietetic Association's standards for qualification).

(2) The department is under the supervision of a qualified dietician who is responsible for quality food production, service, and staff education. The dietician serves on a full-time basis if possible or, in smaller hospitals, on a regular part-time supervising or consulting basis.

(3) In the absence of a full-time dietician, there is a qualified person serving as full-time director of the department who is responsible for the daily management aspects of the department and a dietician visits the hospital at intervals to supervise and instruct personnel.

(4) The number of professional dieticians is adequate considering the size of the facility and the scope and complexity of dietary functions.

(5) Supervisors, other than dieticians, are assigned in numbers and with ability to provide a satisfactory span of control to meet the needs of the physical facilities and the organization as well as coverage for all hours of departmental operation.

(6) The number of personnel, such as cooks, bakers, dishwashers, and clerks, is adequate to perform effectively all defined functions.

(7) Written job descriptions of all dietary employees are available.

(8) There is an inservice training program for dietary employees which includes the proper handling of food and personal grooming.

(b) *Standard; facilities.* Facilities are provided for the general dietary needs of the hospital. These include facilities for the preparation of special diets. Sanitary conditions are maintained in the storage, preparation, and distribution of food. The factors explaining the standard are as follows:

(1) All dietary areas are appropriately located, adequate in size, well lighted, ventilated and maintained.

(2) The type, size, and layout of equipment provides for ease of cleaning, optimal work-flow and adequate food production to meet the scope and complexity of the regular and therapeutic diet requirements of the patients.

(3) Equipment and work areas are clean and orderly. Effective procedures for cleaning all equipment and work areas are followed consistently to safeguard the health of the patient.

(4) Lavatories specifically for handwashing, with hot and cold running water, soap and approved disposable towels, are conveniently located throughout the department for use by food handlers.

(5) There are procedures to control dietary employees with infections and open lesions. Routine health examinations at least meet local, State, or Federal codes for food service personnel.

(6) The dietary department is routinely inspected and approved by State or local health agencies as a food handling establishment. Written reports of the inspection are on file at the hospital with notation made by the hospital of action taken to comply with recommendations.

(7) Dry or staple food items are stored at least 12 inches off the floor in a ventilated room which is not subject to sewage or waste water back-flow, or contamination by condensation, leakage, rodents or vermin.

(8) All perishable foods are refrigerated at the appropriate temperature and in an orderly and sanitary manner.

(9) Foods being displayed or transported are protected from contamination and held at proper temperatures in clean containers, cabinets or serving carts.

(10) Dishwashing procedures and techniques are well developed, understood, and carried out in compliance with the State and local health codes and with periodic check on:

(i) Detergent dispenser operation;

(ii) Washing, rinsing, and sanitizing temperatures and cleanliness of machine and jets;

(iii) Routine bacterial counts on dishes, flatware, glasses, utensils and equipment; and

(iv) Thermostatic controls.

(11) All garbage and kitchen refuse which is not disposed of through a disposal is kept in leakproof nonabsorbent containers with close fitting covers and is disposed of daily in a manner that will not permit transmission of disease, a nuisance, or a breeding place for flies. All garbage containers are thoroughly cleaned inside and out each time emptied.

(c) *Standard; diets.* There is a systematic record of diets, correlated, when appropriate, with the medical records. The factors explaining the standard are as follows:

(1) Therapeutic diets are prescribed in written orders on the chart by the physician and are instructive, accurate, and complete as possible; for example, bland low residue diet or, if a diabetic diet is ordered, the exact amounts of carbohydrate, protein, and fat allowed are noted.

(2) Nutrition needs are met in accordance with the current Recommended Dietary Allowances of the Food and Nutrition Board, National Research Council, and in accordance with physician's orders.

(3) The dietician has available an up-to-date manual of regimens for all therapeutic diets, approved jointly by the dietician and medical staff, which is available to dietary supervisory personnel. Diets served to patients are in compliance with these established diet principles.

(4) The dietician correlates and integrates the dietary aspects of patient care with the patient and patient's chart through such methods as patient instruction and recording diet histories and participates appropriately in ward rounds and conferences, sharing specialized knowledge with others of the medical team.

(d) *Standard; conferences.* Departmental and interdepartmental conferences are held periodically. The factors explaining the standard are as follows:

(1) The director of dietetics attends and participates in meetings of heads of departments and functions as a key member of the hospital staff.

(2) The director of dietetics has regularly scheduled conferences with the administrator or his designee to keep him informed, seek his counsel, and present program plans for mutual consideration and solution.

(3) Conferences are held regularly within the department at all levels of responsibility to disseminate information, interpret policy, solve problems, and develop procedures and program plans.

§ 405.1026 Condition of participation—Medical record department.

The hospital has a medical record department with administrative responsibility for medical records. A medical record is maintained, in accordance with accepted professional principles, for every patient admitted for care in the hospital.

(a) *Standard; records maintained.* A medical record is maintained for every patient admitted for care in the hospital. Such records are kept confidential. The factors explaining the standard are as follows:

(1) Only authorized personnel have access to the record.

(2) Written consent of the patient is presented as authority for release of medical information.

(3) Medical records generally are not removed from the hospital environment except upon subpoena.

(b) *Standard; preservation.* Records are preserved, either in the original or by microfilm, for a period of time not less than that determined by the statute of limitations in the respective State.

(c) *Standard; personnel.* Qualified personnel adequate to supervise and conduct the department are provided. The factors explaining the standard are as follows:

(1) Preferably a registered medical record librarian heads the department. If such a professionally qualified person is not in charge of medical records, a qualified consultant or trained part-time medical record librarian organizes the department, trains the regular personnel, and makes periodic visits to the hospital to evaluate the records and the operation of the department.

(2) A sufficient number of regular full-time and part-time employees are available so that medical record services may be provided as needed. In some hospitals this can mean around-the-clock coverage.

(d) *Standard; identification; filing.* A system of identification and filing to insure the prompt location of a patient's medical record is maintained. The factors explaining the standard are as follows:

(1) Index cards bear at least the full name of the patient, the address, the birthdate, and the medical record number.

(2) Filing equipment and space are adequate to house the records and facilitate retrieval.

(3) A unit record is maintained so that both in- and out-patient treatment are in one folder.

(e) *Standard; centralization of reports.* All clinical information pertaining to a patient's stay is centralized in the patient's record. The factors explaining the standard are as follows:

(1) The original of all reports is filed in the medical record.

(2) All reports or records are completed and filed within a period consistent with good medical practice and not longer than 15 days following discharge.

(f) *Standard; indices.* Records are indexed according to disease, operation, and physician and are kept up-to-date. For indexing, any recognized system may be used. The factors explaining the standard are as follows:

(1) As additional indices become appropriate due to advances in medicine, their use is adopted.

(2) The index lists on a card (or other systematic record) for a specific disease or operation, according to a recognized nomenclature, all essential data on each patient having that particular condition. "Essential data" includes at least the medical record number of the patient so that the record may be located. All conditions for which the patient is treated during the hospitalization are so indexed.

(3) In hospitals using automatic data processing, indexes may be kept on punch cards or reproduced on sheets kept in books.

(4) Diagnoses and operations are expressed in terminology which describes the morbid condition both as to site and etiological factors or the method of procedure.

(5) Indexing is current within six months following discharge of the patient.

(g) *Standard; content.* The medical records contain sufficient information to justify the diagnosis and warrant the treatment and end results. The medical records contain the following information: Identification data; chief complaint; present illness; past history; family history; physical examination; provisional diagnosis; clinical laboratory reports; X-ray reports; consultations; treatment, medical and surgical; tissue report; progress notes; final diagnosis; discharge summary; autopsy findings. The factors explaining the standards are as follows:

(1) The chief complaint includes a concise statement of complaints which led the patient to consult his physician and the date of onset and duration of each.

(2) The physical examination statement includes all positive and negative findings resulting from an inventory of systems.

(3) The provisional diagnosis is an impression (diagnosis) reflecting the examining physician's evaluation of the patient's condition based mainly on physical findings and history.

(4) A consultation report is a written opinion signed by the consultant, including his findings on physical examination of the patient.

(5) All diagnostic treatment procedures are recorded in the medical record.

(6) Tissue reports include a report of microscopic findings if hospital regulations require that microscopic examination be done. If only gross examination is warranted a statement that the tissue has been received and a gross description are made by the laboratory and filed in the medical record.

(7) Progress notes give a chronological picture of the patient's progress and are sufficient to delineate the course and results of treatment. The condition of the patient determines the frequency with which they are made.

(8) A definitive final diagnosis is expressed in terminology of a recognized system of disease nonmenclature.

(9) The discharge summary is a recapitulation of the significant findings and events of the patient's hospitalization and his condition on discharge.

(10) Autopsy findings in a complete protocol are filed in the record when an autopsy is performed.

(11) A chronological summary of the patient's record is maintained in the front of the chart.

(h) *Standard; authorship.* Only members of the medical staff and the house staff are competent to write or dictate medical histories and physical examinations.

(i) *Standard; signature.* Records are authenticated and signed by a licensed physician. The factors explaining the standards are as follows:

(1) Every physician signs the entries which he himself makes.

(2) A single signature on the face sheet of the record does not suffice to authenticate the entire record.

(3) In hospitals with house staff, the attending physician countersigns at least the history and physical examination and summary written by the house staff.

(j) *Standard; promptness of record completion.* Current records and those on discharged patients are completed promptly. The factors explaining the standard are as follows:

(1) Current records are completed within 24–48 hours following admission.

(2) Records of patients discharged are complete within 15 days following discharge.

(3) If a patient is readmitted within a month's time for the same condition, reference to the previous history with an interval note and physical examination suffices.

§ 405.1027 Condition of participation—Pharmacy or drug room.

The hospital has a pharmacy directed by a registered pharmacist or a drug room under competent supervision. The pharmacy or drug room is administered in accordance with accepted professional principles.

(a) *Standard; pharmacy supervision.* There is a pharmacy directed by a registered pharmacist or a drug room under competent supervision. The factors explaining the standard are as follows:

(1) The pharmacist is trained in the specialized functions of hospital pharmacy.

(2) The pharmacist is responsible to the administration of the hospital for developing, supervising, and coordinating all the activities of the pharmacy department.

(3) If there is a drug room with no pharmacist, prescription medications are dispensed by a qualified pharmacist elsewhere, and only storing and distributing are done in the hospital. A consulting pharmacist assists in drawing up the correct procedures, rules, and regulations, for the distribution of drugs, and visits the hospital on a regularly scheduled basis in the course of his duties. Wherever possible the pharmacist, in dispensing drugs, works from the prescriber's original order or a direct copy.

(b) *Standard; physical facilities.* Facilities are provided for the storage, safeguarding, preparation, and dispensing of drugs. The factors explaining the standard are as follows:

(1) Drugs are issued to floor units in accordance with approved policies and procedures.

(2) Drug cabinets on the nursing units are routinely checked by the pharmacist. All floor stocks are properly controlled.

(3) There is adequate space for all pharmacy operations and the storage of drugs at a satisfactory location provided with proper lighting, ventilation, and temperature controls.

(4) If there is a pharmacy, equipment is provided for the compounding and dispensing of drugs.

(5) Special locked storage space is provided to meet the legal requirements for storage of narcotics, alcohol, and other prescribed drugs.

(c) *Standard; personnel.* Personnel competent in their respective duties are provided in keeping with the size and activity of the department. The factors explaining the standard are as follows:

(1) The pharmacist is assisted by an adequate number of additional registered pharmacists and such other personnel as the activities of the pharmacy may require to insure quality pharmaceutical services.

(2) The pharmacy, depending upon the size and scope of its operations, is staffed by the following categories of personnel:

(i) Chief pharmacist.

(ii) One or more assistant chief pharmacists.

(iii) Staff pharmacists.

(iv) Pharmacy residents (where a program has been activated).

(v) Nonprofessionally trained pharmacy helpers.

(vi) Clerical help.

(3) Provision is made for emergency pharmaceutical services.

(4) If the hospital does not have a staff pharmacist, a consulting pharmacist has overall responsibility for control and distribution of drugs and a designated individual(s) has responsibility for day-to-day operation of the pharmacy.

(d) *Standard; records.* Records are kept of the transactions of the pharmacy (or drug room) and correlated with other hospital records where indicated. Such special records are kept as are required by law. The factors explaining the standard are as follows:

(1) The pharmacy establishes and maintains, in cooperation with the accounting department, a satisfactory system of records and bookkeeping in accordance with the policies of the hospital for:

(i) Maintaining adequate control over the requisitioning and dispensing of all drugs and pharmaceutical supplies, and

(ii) Charging patients for drugs and pharmaceutical supplies.

(2) A record of the stock on hand and of the dispensing of all narcotic drugs is maintained in such a manner that the disposition of any particular item may be readily traced.

(3) Records for prescription drugs dispensed to each patient (inpatients and outpatients) are maintained in the pharmacy or drug room containing the full name of the patient and the prescribing physician, the prescription number, the name and strength of the drug, the date of issue, the expiration date for all timedated medications, the lot and control number of the drug, the name of the manufacturer (or trademark) and (unless the physician directs otherwise) the name of the medication dispensed.

(4) The label of each out-patient's individual prescription medication container bears the lot and control number of the drug, the name of the manufacturer (or trademark) and (unless the physician directs otherwise) the name of the medication dispensed.

(e) *Standard; control of toxic or dangerous drugs.* Policies are established to control the administration of toxic or dangerous drugs with specific reference to the duration of the order and the dosage. The factors explaining the standard are as follows:

(1) The medical staff has established a written policy that all toxic or dangerous medications, not specifically prescribed as to time or number of doses, will be automatically stopped after a reasonable time limit set by the staff.

(2) The classifications ordinarily thought of as toxic or dangerous drugs are narcotics, sedatives, anticoagulants, antibiotics, oxytocics, and cortisone products.

(f) *Standard; committee.* There is a committee of the medical staff to confer with the pharmacist in the formulation of policies. The factors explaining the standard are as follows:

(1) A pharmacy and therapeutics committee (or equivalent committee), composed of physicians and pharmacists, is established in the hospital. It represents the organizational line of communication and the liaison between the medical staff and the pharmacist.

(2) The committee assists in the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, and safety procedures, and all other matters relating to drugs in hospitals.

(3) The committee performs the following specific functions:

(i) Serves as an advisory group to the hospital medical staff and the pharmacist on matters pertaining to the choice of drugs;

(ii) Develops and reviews periodically a formulary or drug list for use in the hospital;

(iii) Establishes standards concerning the use and control of investigational drugs and research in the use of recognized drugs;

(iv) Evaluates clinical data concerning new drugs or preparations requested for use in the hospital;

(v) Makes recommendations concerning drugs to be stocked on the nursing unit floors and by other services; and

(vi) Prevents unnecessary duplication in stocking drugs and drugs in combination having identical amounts of the same therapeutic ingredients.

(4) The committee meets at least quarterly and reports to the medical staff.

(g) *Standard; drugs to be dispensed.* Therapeutic ingredients of medications dispensed are included (or approved for inclusion) in the United States Pharmacopoeia, National Formulary, United States Homeopathic Pharmacopoeia, New Drugs, or Accepted Dental Remedies (except for any drugs unfavorably evaluated therein), or are approved for use by the pharmacy and drug therapeutics committee (or equivalent committee) of the hospital staff. The factors explaining the standard are as follows:

(1) The pharmacist, with the advice and guidance of the pharmacy and therapeutics committee, is responsible for specifications as to quality, quantity, and source of supply of all drugs.

(2) There is available a formulary or list of drugs accepted for use in the hospital which is developed and amended at regular intervals by the pharmacy and therapeutics committee (or equivalent committee) with the cooperation of the pharmacist (consulting or otherwise) and the administration.

(3) The pharmacy or drug room is adequately supplied with preparations so approved.

§ 405.1028 Condition of participation—Laboratories.

The hospital has a well organized, adequately supervised clinical laboratory with the necessary space, facilities and equipment to perform those services commensurate with the hospital's needs for its patients. Anatomical pathology services and blood bank services are available either in the hospital or by arrangement with other facilities.

(a) *Standard; adequacy of laboratory services.* Clinical laboratory services adequate for the individual hospital are maintained in the hospital. The factors explaining the standard are as follows:

(1) The extent and complexity of service are commensurate with the size, scope, and nature of the hospital, and the demands of the medical staff upon the laboratory.

(2) Basic laboratory services necessary for routine examinations are available regardless of the size, scope, and nature of the hospital.

(3) Necessary space, facilities and equipment to perform both the basic minimum and all other services are provided by the hospital.

(4) All equipment is in good working order, routinely checked, and precise in terms of calibration.

(b) *Standard; clinical laboratory examinations.* Provision is made to carry out adequate clinical laboratory examinations including chemistry, microbiology, hematology, serology, and clinical microscopy. The factors explaining the standard are as follows:

(1) Some or all of these services may be provided under arrangements by the hospital with a laboratory which is:

(i) Part of a hospital approved for participation in the Health Insurance for the Aged program; or

(ii) Approved to provide these services as an independent laboratory under the Supplementary Medical Insurance for the Aged program.

(2) In the case of work performed by an outside laboratory, the original report from this laboratory is contained in the medical record.

(c) *Standard; availability of facilities and services.* Facilities and services are available at all times. The factors explaining the standard are as follows:

(1) Adequate provision is made for assuring the availability of emergency laboratory services, either in the hospital or under arrangements with a laboratory which meets one or more of the alternatives listed under paragraph (b) (1) of this section. Such services are available 24 hours a day, 7 days a week, including holidays.

(2) Where services are provided by an outside laboratory, the conditions, procedures, and availability of work done are in writing and available in the hospital.

(d) *Standard; personnel.* Personnel adequate to supervise and conduct the services are provided. The factors explaining the standard are as follows:

(1) Services are under the supervision of a physician with training and experience in clinical laboratory services or a laboratory specialist qualified by a doctoral degree.

(2) The laboratory does not perform procedures and tests which are outside the scope of training of the laboratory personnel.

(3) There is a sufficient number of clinical laboratory technologists, preferably registered by the American Society of Clinical Pathology, to promptly and proficiently perform the tests requested of the laboratory.

(e) *Standard; routine examinations.* Routine examinations required on all admissions are determined by the medical staff. These include at least a urinalysis and a hemoglobin or hematocrit. The factors explaining the standard are as follows:

(1) Required tests upon admission, as approved by the medical staff, are consistent with the scope and nature of the hospital.

(2) The required list of tests is in written form and available to all members of the medical staff.

(f) *Standard; laboratory report.* Signed reports are filed with the patient's medical record and duplicate copies kept in the department. The factors explaining the standard are as follows:

(1) The laboratory director is responsible for the laboratory report.

(2) There is a procedure for assuring that all tests are ordered by a physician.

(g) *Standard; pathologist services.* Services of a pathologist are provided as indicated by the needs of the hospital. The factors explaining the standard are as follows:

(1) Services are under the direct supervision of a pathologist on a full-time, regular part-time or regular consultative basis. If the latter pertains, the hospital provides for, at a minimum, monthly consultative visits by a pathologist.

(2) The pathologist participates in staff, departmental and clinicopathologic conferences.

(3) The pathologist is responsible for the qualifications of his staff and their inservice training.

(h) *Standard; tissue examination.* All tissues removed at operation are sent for examination. The extent of examination is determined by the pathology department. The factors explaining the standard are as follows:

(1) All tissues removed from patients at surgery are macroscopically, and if necessary, microscopically examined by the pathologist.

(2) The pathologist or designated physcian, in his absence, is responsible for verifying the receipt of tissues for examinations.

(3) A list of tissues which routinely require microscopic examination is developed in writing by the pathologist or designated physician with the approval of the medical staff.

(4) A tissue file is maintained in the hospital.

(5) In the absence of a pathologist or suitable physician substitute, there is an established plan for sending to a pathologist outside the hospital all tissues requiring examination.

(i) *Standard; reports of tissue examination.* Signed reports of tissue examinations are filed with the patient's medical record and duplicate copies kept in the department. The factors explaining the standard are as follows:

(1) All reports of macro and microscopic examinations performed are signed by the pathologist or designated physician.

(2) Provision is made for the prompt filing of examination results in the patient's medical record and notification of the physician requesting the examination.

(3) Duplicate copies of the examination reports are filed in the laboratory in a manner which permits ready identification and accessibility.

(j) *Standard; blood and blood products.* Facilities for procurement, safekeeping and transfusion of blood and blood products are provided or readily available. The factors explaining the standard are as follows:

(1) The hospital maintains, as a minimum, proper blood storage facilities under adequate control and supervision of the pathologist or other authorized physician.

(2) For emergency situations the hospital maintains at least a minimum blood supply in the hospital at all times, can obtain blood quickly from community blood banks or institutions, or has an up-to-date list of donors and equipment necessary to bleed them.

(3) Where the hospital depends on outside blood banks, there is an agreement governing the procurement, transfer and availability of blood which is reviewed and approved by the medical staff, administration and governing body.

(4) There is provision for prompt blood typing and cross-matching, and for laboratory investigation of transfusion reactions, either through the hospital or by arrangements with others on a continuous basis, under the supervision of a physician.

(5) Blood storage facilities in the hospital have an adequate alarm system, which is regularly inspected and is otherwise safe and adequate.

(6) Records are kept on file indicating the receipt and disposition of all blood provided to patients in the hospital.

(7) Samples of each unit of blood used at the hospital are retained according to the instructions of the committee indicated in subparagraph (8) of this paragraph for further testing in the event of reactions. Blood not so retained which has exceeded its expiration date is disposed of promptly.

(8) A committee of the medical staff or its equivalent reviews all transfusions of blood or blood derivatives and makes recommendations concerning policies governing such practices.

(9) The review committee investigates all transfusion reactions occurring in the hospital and makes recommendations to the medical staff regarding improvements in transfusion procedures.

§ 405.1029 Condition of participation—Radiology department.

The hospital has diagnostic X-ray facilities available. If therapeutic X-ray services are also provided, they, as well

as the diagnostic services, meet professionally approved standards for safety and personnel qualifications.

(a) *Standard; radiological services.* The hospital maintains or has available radiological services according to needs of the hospital. For example, the hospital has diagnostic X-ray facilities available in the hospital building proper or in an adjacent clinic or medical facility that is readily accessible to the hospital patients, physicians, and personnel.

(b) *Standard; hazards for patients and personnel.* The radiology department is free of hazards for patients and personnel. The factors explaining the standard are as follows:

(1) Proper safety precautions are maintained against fire and explosion hazards, electrical hazards, and radiation hazards.

(2) Periodic inspection is made by local or State health authorities or a radiation physicist, and hazards so identified are promptly corrected.

(3) Radiation workers are checked periodically for amount of radiation exposure by the use of exposure meters or badge tests.

(4) With fluoroscopes, attention is paid to modern safety design and good operating procedures; records are maintained of the output of all fluoroscopes.

(5) Regulations based on medical staff recommendations are established as to the administration of the application and removal of radium element, its disintegration products, and other radioactive isotopes.

(c) *Standard; personnel.* Personnel adequate to supervise and conduct the services are provided, and the interpretation of radiological examinations is made by physicians competent in the field. The factors explaining the standard are as follows:

(1) The hospital has a qualified radiologist, either full-time or part-time on a consulting basis, both to supervise the department and to interpret films that require specialized knowledge for accurate reading. If the hospital is small, and a radiologist cannot come to the hospital regularly, selected X-ray films are sent to a radiologist for interpretation.

(2) If the activities of the radiology department extend to radiotherapy, the physician in charge is appropriately qualifield.

(3) The amount of qualified radiologist and technologist time is sufficient to meet the hospital's requirements. A technologist is on duty or on call at all times.

(4) The use of all X-ray apparatus is limited to personnel designated as qualified by the radiologist or by an appropriately constituted committee of the medical staff. The same limitation applies to personnel applying and removing radium element, its disintegration products, and radioactive isotopes. The use of fluoroscopes is limited to physicians.

(d) *Standard; signed reports.* Signed reports are filed with the patient's record and duplicate copies kept in the department. The factors explaining the standard are as follows:

(1) Requests by the attending physician for X-ray examination contain a concise statement of reason for the examination.

(2) Reports of interpretations are written or dictated and signed by the radiologist.

(3) X-ray reports and roentgenographs are preserved or microfilmed in accordance with the statute of limitations.

§ 405.1030 Condition of participation—Medical library.

The hospital has modern textbooks and current periodicals relative to the clinical services offered.

(a) *Standard; hospital library needs.* The hospital maintains a medical library according to the needs of the hospital.

(b) *The factors explaining the standard are as follows:* (1) The medical library is located in or adjacent to the hospital building and its contents are organized, easily accessible, and available at all times to the medical and nursing staffs.

(2) The library contains modern textbooks in basic sciences and other current textbooks, journals, and magazines pertinent to the clinical services maintained in the hospital.

§ 405.1031 Condition of participation—Complementary departments.

Participation is not limited to hospitals which have surgery, anesthesiology, dental, or rehabilitation departments or services, but if these departments or services are present, there are effective policies and procedures, relating to the staff and the functions of the service(s) in order to assure the health and safety of the patients.

(a) *Standard; Department of Surgery.* The Department of surgery has effective policies and procedures regarding surgical privileges, maintenance of the operating rooms, and evaluation of the surgical patient. The factors explaining the standard are as follows:

(1) Surgical privileges are delineated for all physicians doing surgery in accordance with the competencies of each physician. A roster of physicians specifying the surgical privileges of each is kept in the confidential files of the operating room supervisor and in the files of the hospital administrator.

(2) In any procedure with unusual hazard to life, there is present and scrubbed as first assistant a physician designated by the credentials committee as being qualified to assist in major surgery.

(3) Second and third assistants at major operations, and first assistants at lesser operations may be nurses, aides, or technicians if designated by the hospital authorities as having sufficient training to properly and adequately assist at such procedures.

(4) The operating room register is complete and up-to-date.

(5) There is a complete history and physical work-up in the chart of every patient prior to surgery (whether the surgery is major or minor). If such has been transcribed, but not yet recorded in the patient's chart, there is a statement to that effect and an admission note by the physician in the chart.

(6) A properly executed consent form for operation is in the patient's chart prior to surgery.

(7) There are adequate provisions for immediate post-operative care.

(8) An operative report describing techniques and findings is written or dictated immediately following surgery and signed by the surgeon.

(9) All infections of clean surgical cases are recorded and reported to the administration. A procedure exists for the investigation of such cases.

(10) The operating rooms are supervised by an experienced registered professional nurse.

(11) The following equipment is available in the operating suites: call-in system, cardiac monitor, resuscitator, defibrillator, aspirator, thoracotomy set, and tracheotomy set.

(12) The operating room suite and accessory services are so located that traffic in and out can be and is controlled and there is no through traffic.

(13) Precautions are taken to eliminate hazards of explosions including use of shoes with conductive soles and prohibition of nylon garments.

(14) Rules and regulations and/or policies related to the operating rooms are available and posted.

(b) (1) *Standard; Department of Anesthesia.* The Department of Anesthesia has effective policies and procedures regarding staff privileges, the administration of anesthetics, and the maintenance of strict safety controls. There is required for every patient:

(i) Preanesthetic physical examination by a physician with findings recorded within 48 hours of surgery;

(ii) Anesthetic record on special form;

(iii) Postanesthetic follow-up, with findings recorded, by an anesthesiologist or nurse anesthetist.

(2) *The factors explaining the standard are as follows:*

(i) The Department of Anesthesia is responsible for all anesthetics administered in the hospital.

(ii) In hospitals where there is no Department of Anesthesia, the Department of Surgery assumes the responsibility for establishing general policies and supervising the administration of anesthetics.

(iii) The director of the Department of Anesthesia preferably is also the director in charge of inhalation therapy. In any event, the inhalation therapy service is under the supervision of a qualified physician or physicians.

(iv) If anesthetics are not administered by a qualified anesthesiologist, they are administered by a physician anesthetist or a registered nurse anesthetist under the supervision of the operating physician. The hospital staff designates those persons qualified to administer anesthetics and delineates what the person is qualified to do.

(v) The postanesthetic follow-up note is written 3 to 24 hours after the operation, notes any postoperative abnormalities or complications, and states the blood pressure, the pulse, the presence or absence of the swallowing reflex and cyanosis, and the general condition of the patient.

(vi) Safety precautions include:

(*a*) Shockproof and sparkproof equipment;

(*b*) Humidity control;

(*c*) Proper grounding;

(*d*) Safety regulations posted;

(*e*) Storage of flammable anesthetic and oxidizing gases meet the standards of the National Fire Protection Association Code.

(c) (1) *Standard; Department of Dentistry and dental staff.* According to the procedure established for the appointment of the medical staff, one or more dentists may be appointed to the dental staff. If the dental service is organized, its organization is comparable to that of other services or departments. Whether or not the dental service is organized as a department, the following requirements are met:

(i) Members of the dental staff are qualified legally, professionally, and ethically for the positions to which they are appointed.

(ii) Patients admitted for dental services are admitted by the dentist either to the Department of Dentistry or, if there is no department, to an organized clinical service.

(iii) There is a physician in attendance who is responsible for the medical care of the patient throughout the hospital stay. A medical survey is done and recorded by a member of the medical staff before dental surgery is performed.

(2) *The factors explaining the standard are as follows:*

(i) There are specific bylaws concerning the dental staff written as combined medical-dental staff bylaws or as separate or adjunct dental bylaws.

(ii) The staff bylaws, rules and regulations specifically delineate the rights and privileges of the dentists.

(iii) Complete records, both medical and dental, are required on each dental patient and shall be a part of the hospital records.

(d) *Standard; Rehabilitation, Physical Therapy, and Occupational Therapy Department.* The Rehabilitation, Physical Therapy, and Occupational Therapy Departments have effective policies and procedures relating to the organization and functions of the service(s) and are staffed by qualified therapists. The factors explaining the standard are as follows:

(1) There may be a rehabilitation department, including both physical and occupational therapy and which may also include other rehabilitation services such as speech therapy, vocational counseling, and other appropriate services or there may be separate physical and/or occupational therapy departments.

(2) The department head has the necessary knowledge, experience, and capabilities to properly supervise and administer the department. A rehabilitation department head is a physiatrist or other physician with pertinent experience. If separate physical or occupational therapy departments are maintained, the department head is a qualified physical or occupational therapist (as is appropriate) or a physician with pertinent experience.

(3) If physical therapy services are offered, the services are given by or under the supervision of a qualified physical therapist. A qualified physical therapist is a graduate of a program in physical therapy approved by the Council on Medical Education of the American Medical Association (in collaboration with the American Physical Therapy Association) or its equivalent. Additional properly trained and supervised personnel are sufficient to meet the needs of the department.

(4) If occupational therapy services are offered, the services are given by or under the supervision of a professional registered occupational therapist (OTR). Other properly trained and supervised personnel, such as certified occupational therapy assistants (COTA) and aides, are sufficient to meet the needs of the department.

(5) Facilities and equipment for physical and occupational therapy are adequate to meet the needs of the services and are in good condition.

(6) Physical therapy or occupational therapy is given in accordance with a physician's orders, and such orders are incorporated in the patient's record.

(7) Complete records are maintained for each patient provided such services and are part of the patient's record.

§ 405.1032 Condition of participation—Outpatient department.

Participation is not limited to hospitals which have organized outpatient departments, but if they are present, there are effective policies and procedures relating to the staff, functions of the service, and outpatient medical records and adequate facilities in order to assure the health and safety of the patients.

(a) *Standard; organization.* The Outpatient Department is organized into sections (clinics) the number of which depends on the size and the degree of departmentalization of the medical staff, available facilities, and the needs of the patients for whom it accepts responsibility. The factors explaining the standard are as follows:

(1) The outpatient department has appropriate cooperative arrangements and communications with community agencies such as other outpatient departments, public health nursing agencies, the department of health, and welfare agencies.

(2) Clinics are integrated with corresponding inpatient services.

(3) Clinics are maintained for the following purposes:

(i) Care of ambulatory patients unrelated to admission or discharge,

(ii) Study of preadmission patients,

(iii) Followup of discharged hospital patients.

(4) Patients, on their initial visit to the department, receive a general medical evaluation and patients under continuous care receive an adequate periodic reevaluation.

(5) Established medical screening procedures are employed routinely.

(b) *Standard; personnel.* There are such professional and nonprofessional personnel as are required for efficient operation. The factors explaining the standard are as follows:

(1) There is a physican responsible for the professional services of the department. Either this physician or a qualified administrator is responsible for administrative services.

(2) A registered professional nurse is responsible for the nursing services of the department.

(3) The number and type of other personnel employed reflect the volume and type of work carried out and the type of patient served in the outpatient department.

(c) *Standard; facilities.* Facilities are provided to assure the efficient operation of the department. The factors explaining the standard are as follows:

(1) The number of examination and treatment rooms is adequate in relation to the volume and nature of work performed.

(2) Suitable facilities for necessary laboratory tests are available either through the hospital or some other facility approved to provide these services as an independent laboratory under the Supplementary Medical Insurance for the Aged program.

(d) *Standard; medical records.* Medical records are maintained, and correlated with other hospital medical records. The factors explaining the standard are as follows:

(1) The outpatient medical record is filed in a location which insures ready accessibility to the physicians, nurses, and other personnel of the department.

(2) The outpatient medical record is integrated with the patient's overall hospital record.

(3) Information contained in the medical record is complete and sufficiently detailed relative to the patient's history, physical examination, laboratory and other diagnostic tests, diagnosis, and treatment to facilitate continuity of care.

(e) *Standard; liaison conferences.* Conferences, both departmental and interdepartmental, are conducted to maintain close liaison between the various sections within the department and with other hospital services. The factors explaining the standard are as follows:

(1) Minutes of staff and/or departmental meetings indicate that a review of selected outpatient cases takes place and that there is integration of hospital inpatient and outpatient services.

(2) The outpatient department has close working relationships with the medical social service department.

§ 405.1033 Condition of participation—Emergency service or department.

The hospital has at least a procedure for taking care of the occasional emer-

gency case it might be called upon to handle. Participation is not limited to hospitals which have organized emergency services or departments, but if they are present, there are effective policies and procedures relating to the staff, functions of the service, and emergency room medical records and adequate facilities in order to assure the health and safety of the patients.

(a) *Standard; organization and direction.* The department or service is well organized, directed by qualified personnel, and integrated with other departments of the hospital. The factors explaining the standard are as follows:

(1) There are written policies which are enforced to control emergency room procedures.

(2) The policies and procedures governing medical care provided in the emergency service or department are established by and are a continuing responsibility of the medical staff.

(3) The emergency service is supervised by a qualified member of the medical staff and nursing functions are the responsibility of a registered professional nurse.

(4) The administrative functions are a responsibility of a member of the hospital administration.

(b) *Standard; facilities.* Facilities are provided to assure prompt diagnosis and emergency treatment. The factors explaining the standard are as follows:

(1) Facilities are separate and independent of the operating rooms.

(2) The location of the emergency service is in close proximity to an exterior entrance of the hospital.

(3) Diagnostic and treatment equipment, drugs, supplies, and space, including a sufficient number of treatment rooms, are adequate in terms of the size and scope of services provided.

(c) *Standard; medical and nursing personnel.* There are adequate medical and nursing personnel available at all times. The factors explaining the standard are as follows:

(1) The medical staff is responsible for insuring adequate medical coverage for emergency services.

(2) Qualified physicians are regularly available at all times for the emergency service, either on duty or on call.

(3) A physician sees all patients who arrive for treatment in the emergency service.

(4) Qualified nurses are available on duty at all times and in sufficient number to deal with the number and extent of emergency services.

(d) *Standard; medical records.* Adequate medical records on every patient are kept. The factors explaining the standard are as follows:

(1) The emergency room record contains:

(i) Patient identification.

(ii) History of disease or injury.

(iii) Physical findings.

(iv) Laboratory and X-ray reports, if any.

(v) Diagnosis.

(vi) Record of treatment.

(vii) Disposition of the case.

(viii) Signature of a physician.

(2) Medical records for patients treated in the emergency service are organized by a medical record librarian or her equivalent.

(3) Where appropriate, medical records of emergency services are integrated with those of the inpatient and outpatient services.

(4) A proper method of filing records is maintained.

(5) At a minimum, emergency service medical records are kept for as long a time as required in a given State's statute of limitations.

§ 405.1034 Condition of participation—Social work department.

Participation is not limited to hospitals which have social work departments, but if they are present, there are effective policies and procedures relating to the staff and the functions of the service.

(a) *Standard; organization, direction, and personnel.* The department is well organized and directed by a qualified medical social worker. The factors explaining the standard are as follows:

(1) Preferably, social services are organized on a departmental level, responsible to the administration of the institution, and social workers in the institution are responsible to the department director, regardless of the unit to which they are assigned.

(2) The social service staff includes social workers, social work assistants, and clerical personnel. The social workers are qualified by a master's degree from an accredited school of social work. The social work assistants are qualified by a bachelor's degree, preferably with a social welfare sequence, and are given training on the job for specific assignments and responsibilities.

(3) The number of social workers and social work assistants is adequate to meet patient needs for patient care planning.

(4) Planning for patient care includes participation by the social service department as indicated to enable the patient to make full use of inpatient, outpatient, or extended care or home health services in the community.

(b) *Standard; departmental integration.* The department is integrated with other departments of the hospital, and departmental and interdepartmental conferences are held periodically. The factors explaining the standard are as follows:

(1) Department staff participate in ward rounds, medical staff seminars, nursing staff conferences, and in conferences with individual physicians and nurses concerned with the care of the patient.

(2) The department communicates to appropriate administrative and professional personnel information on community programs and developments which may affect the hospital program.

(3) The department participates in appropriate education, training, and orientation programs for nurses, medical students, interns and residents, and hospital administartive residents, as well as in inservice training programs.

(c) *Standard; records of social work services.* Records of social service activity related to individual patients are kept, and are available only to the professional personnel concerned. The factors explaining the standard are as follows:

(1) Functions and activities recorded include:

(i) Medicosocial study of referred hospitalized and OPD patients;

(ii) Evaluation of financial status of patient;

(iii) Follow-up of discharged patients;

(iv) Social therapy and rehabilitation of patients;

(v) Environmental investigations for the attending physicians; and

(vi) Cooperative activities with community agencies.

(2) Significant social service summaries are entered promptly in the patient's central medical record for the benefit of all staff involved in the care of the patient.

(3) More detailed records are kept by the department to meet the needs of student or staff training, research, and review by supervisors or consultants.

(d) *Standard; facilities.* Facilities are provided which are adequate for the personnel of the department, easily accessible to patients and to the medical staff, and which assure privacy for interviews.

§ 405.1035 Condition of participation—Utilization review plan.

(a) *Condition.* The hospital has in effect a plan for utilization review which applies at least to the services furnished by the hospital to inpatient; who are entitled to benefits under Title XVIII of the Act. An acceptable utilization review plan provides for: (1) The review, on a sample or other basis, of admissions, duration of stays, and professional services furnished; and (2) review of each case of continuous extended duration.

(b) *General.* (1) There are many types of plans which can fulfill the requirements of Title XVIII of the Act. Hospitals wishing to establish their eligibility to participate should submit a written description of their utilization review plan and a certification that it is currently in effect or that it will be in effect no later than the first day on which the hospital expects to become a participating provider of services. Ordinarily this will constitute sufficient evidence to support a finding that the utilization review plan of the hospital is or is not in conformity with the statutory requirements.

(2) The review plan of a hospital should have as its over-all objective the maintenance of high quality patient care, and an increase in effective utilization of hospital services to be achieved through an educational approach involving study of patterns of care, and the encouragement of appropriate utilization. It is contemplated that a review of the medical necessity of admissions and durations of stay, for example, would take into account alternative use and availability of out-of-hospital facilities and services. The review of professional services furnished might include study of such conditions as overuse or underuse of services, logical substantiation of diagnoses,

proper use of consultation, and whether required diagnostic workup and treatment are initiated and carried out promptly. Review of lengths of stay might consider not only medical necessity, but the effect that hospital staffing may have on duration of stay, whether assistance is available to the physician in arranging for discharge planning, and the availability of out-of-hospital facilities and services which will assure continuity of care.

(3) Costs incurred in connection with the implementation of the utilization review plan are includable in reasonable costs and are reimbursable to the hospital to the extent that such costs relate to health insurance program beneficiaries. For example, costs may include expenses incurred for the purchase of data from organizations outside the hospital which compile statistics, profiles, and study results on utilization of hospital facilities and services.

(c) *Standard; approval and operation of plan.* The operation of the utilization review plan is a responsibility of the medical profession. The plan in the hospital has the approval of the medical staff as well as that of the governing body.

(d) *Standard; written description of plan.* The hospital has a currently applicable, written description of its utilization review plan. Such description includes:

(1) The organization and composition of the committee(s) which will be responsible for the utilization review function;

(2) Frequency of meetings;

(3) The type of records to be kept;

(4) The method to be used in selecting cases on a sample or other basis;

(5) The definition of what constitutes the period or periods of extended duration;

(6) The relationship of the utilization review plan to claims administration by a third party;

(7) Arrangements for committee reports and their dissemination;

(8) Responsibilities of the hospital's administrative staff.

(e)(1) *Standard; conduct of function by committees.* The utilization review function is conducted by one or a combination of the following:

(i) By a staff committee or committees of the hospital, each of which is composed of two or more physicians, with or without the inclusion of other professional personnel; or

(ii) By a committee(s) or group(s) outside the hospital composed as in (i) above which is established by the local medical society and some or all of the hospitals and extended care facilities in the locality; or

(iii) Where a committee(s) or group(s) as described in (i) or (ii) above has not been established to carry out all the utilization review functions prescribed by Title XVIII, by a committee(s) or group(s) composed in as (i) above, and sponsored and organized in such manner as approved by the Secretary of Health, Education, and Welfare.

(2) *The factors explaining the standard are as follows:* (i) The medical care appraisal and educational aspects of review on a sample or other basis, and the review of long-stay cases need not be done by the same committee or group.

(ii) Existing staff committees may assume the review responsibility stipulated in the plan. In smaller hospitals, all of these functions may be carried out by a committee of the whole or a medical care appraisal committee.

(iii) The committee(s) is broadly representative of the medical staff and at least one member does not have a direct financial interest in the hospital.

(f) *Standard; reviews.* (1) Reviews are made, on a sample or other basis, of admissions, duration of stays, and professional services furnished, with respect to the medical necessity of the services, and for the purpose of promoting the most efficient use of available health facilities and services. Such reviews emphasize identification and analysis of patterns of patient care in order to maintain consistent high quality. The review is accomplished by considering data obtained by any one or any combination of the following:

(i) By use of services and facilities of external organizations which compile statistics, design profiles, and produce other comparative data; or

(ii) By cooperative endeavor with the fiscal intermediary(ies) in the locality; or

(iii) By internal studies of medical records.

(2) *The factors explaining the standard are as follows:* (i) Review of cases, based on diagnostic categories, include diagnoses of special relevance to the aged group.

(ii) Some review functions are carried out on a continuing basis.

(iii) Reviews include a sample of recertifications of medical necessity, as made for purposes of the Health Insurance for the Aged Program.

(g) *Standard; extended duration cases.* Reviews are made of each health insurance beneficiary case of continuous extended duration. The hospital utilization review plan specifies the number of continuous days of hospital stay following which a review is made to determine whether further inpatient hospital services are medically necessary. The plan may specify a different number of days for different classes of cases. Reviews for such purpose are made no later than the seventh day following the last day of the period of extended duration specified in the plan. No physician has review responsibility for any extended stay cases in which he was professionally involved. If physician members of the committee decide, after opportunity for consultation is given the attending physician by the committee, and considering the availability and appropriateness of out-of-hospital facilities and services, that further inpatient stay is not medically necessary, there is notification in writing within 48 hours to the institution, the attending physician and the patient or his representative. The factor explaining the standard is as follows:

Because there are significant divergences in opinion among individual physicians in respect to evaluation of medical necessity for inpatient hospital services, the judgment of the attending physician in an extended stay case is given great weight, and is not rejected except under unusual circumstances.

(h) *Standard; records.* Records are kept of the activities of the committee, and reports are regularly made by the committee to the executive committee of the medical staff and relevant information and recommendations are reported through usual channels to the entire medical staff and the governing body of the hospital. The factors explaining the standard are as follows:

(1) The hospital administration studies and acts upon administrative recommendations made by the committee.

(2) A summary of the number and types of cases reviewed, and the findings, are part of the records.

(3) Minutes of each committee meeting are maintained.

(4) Committee action in extended stay cases is recorded, with cases identified only by hospital case number.

(i) *Standard; administrative staff responsibilities.* The committee(s) having responsibility for utilization review functions have the support and assistance of the hospital's administrative staff in assembling information, facilitating chart reviews, conducting studies, exploring ways to improve procedures, maintaining committee records, and promoting the most efficient use of available health services and facilities. The factors explaining the standard are as follows:

(1) With respect to each of these activities, an individual or department is designated as being responsible for the particular service.

(2) In order to encourage the most efficient use of available health services and facilities, assistance to the physician in timely planning for posthospital care is initiated as promptly as possible, either by hospital staff, or by arrangement with other agencies. For this purpose, the hospital makes available to the attending physician current information on resources available for continued out-of-hospital care of patients and arranges for prompt transfer of appropriate medical and nursing information in order to assure continuity of care upon discharge of a patient.

§ 405.1036 Special rules and exceptions applying to psychiatric and tuberculosis hospitals.

(a) The conditions of participation for psychiatric and tuberculosis hospitals are similar to those for other hospitals, though differing in some respects due to their different purpose. To provide assurance that the program while paying for active treatment in psychiatric and tuberculosis hospitals would avoid paying for care that is merely custodial, the conditions of participation require that the hospital be accredited by the Joint Commission on Accreditation of Hospitals, that its clinical records be sufficient to permit the Secretary to deter-

mine the degree and intensity of treatment furnished to beneficiaries, and that it meet staffing requirements the Secretary finds necessary for carrying out an active treatment program. A distinct part of an institution can be considered a psychiatric or a tuberculosis hospital if it meets the conditions even though the institution of which it is a part does not, and if the distinct part meets requirements equivalent to the accreditation requirements of the JCAH, it could qualify under the program even though the institution is not accredited.

(b) A distinct part of an institution will be considered to meet requirements equivalent to the accreditation requirements of the JCAH if it is found to be in substantial compliance with the conditions of participation contained in §§ 405.1020 through 405.1035.

(c) In addition, psychiatric hospitals (or distinct parts thereof) must meet the requirements of section 1861(f) of the Act and be in substantial compliance with the conditions of participation contained in §§ 405.1037 and 405.1038 and tuberculosis hospitals (or distinct parts thereof) must meet the requirements of section 1861(g) of the Act and be in substantial compliance with the conditions of participation contained in §§ 405.1039 and 405.1040.

§ 405.1037 Condition of participation—Special medical record requirements for psychiatric hospitals.

The medical records maintained by a psychiatric hospital permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the institution.

(a) *Standard; medical records.* Medical records stress the psychiatric components of the record including history of findings and treatment rendered for the psychiatric condition for which the patient is hospitalized. The factors explaining the standard are as follows:

(1) The identification data includes the patient's legal status.

(2) A provisional or admitting diagnosis is made on every patient at the time of admission and includes the diagnoses of intercurrent diseases as well as the psychiatric diagnoses.

(3) The complaint of others regarding the patient is included as well as the patient's comments.

(4) The psychiatric evaluation, including a medical history, contains a record of mental status and notes the onset of illness, the circumstances leading to admission, attitudes, behavior, estimate of intellectual functioning, memory functioning, orientation, and an inventory of the patient's assets in descriptive, not interpretative, fashion.

(5) A complete neurological examination is recorded at the time of the admission physical examination, when indicated.

(6) The social service records, including reports of interviews with patients, family members and others, provide an assessment of home plans and family attitudes, and community resource contacts as well as a social history.

(7) Reports of consultations, psychological evaluations, reports of electroencephalograms, dental records and reports of special studies are included in the record.

(8) The individual comprehensive treatment plan is recorded, based on an inventory of the patient's strengths as well as his disabilities, and includes a substantiated diagnosis in the terminology of the American Psychiatric Association's Diagnostic and Statistical Manual, short-term and long-range goals, and the specific treatment modalities utilized as well as the responsibilities of each member of the treatment team in such a manner that it provides adequate justification and documentation for the diagnoses and for the treatment and rehabilitation activities carried out.

(9) The treatment received by the patient is documented in such a manner and with such frequency as to assure that all active therapeutic efforts such as individual and group psychotherapy, drug therapy, milieu therapy, occupational therapy, recreational therapy, industrial or work therapy, nursing care and other therapeutic interventions are included.

(10) Progress notes are recorded by the physician, nurse, social worker and, when appropriate, others significantly involved in active treatment modalities. Their frequency is determined by the condition of the patient but should be recorded at least weekly for the first 2 months and at least once a month thereafter and should contain recommendations for revisions in the treatment plan as indicated as well as precise assessment of the patient's progress in accordance with the original or revised treatment plan.

(11) The discharge summary includes a recapitulation of the patient's hospitilization and recommendations from appropriate services concerning follow-up or aftercare as well as a brief summary of the patient's condition on discharge.

(12) The psychiatric diagnoses contained in the final diagnoses are written in the terminology of the American Psychiatric Association's Diagnostic and Statistical Manual.

§ 405.1038 Condition of participation—Special staff requirements for psychiatric hospitals.

The hospital has staff adequate in number and qualifications to carry out an active program of treatment for individuals who are furnished services in the institution.

(a) *Standard; personnel; facilities.* Inpatient psychiatric facilities (psychiatric hospitals, distinct parts of psychiatric hospitals or inpatient components of community mental health centers) are staffed with the number of qualified professional, technical and supporting personnel, and consultants required to carry out an intensive and comprehensive treatment program that includes evaluation of individual needs, establishment of treatment and rehabilitation goals, and implementation, directly or by arrangement, of a broad range therapeutic program including, at least, professional psychiatric, medical, surgical, nursing, social work, psychological and activity therapies as required to carry out an individual treatment plan for each patient. The factors explaining the standard are as follows:

(1) Qualified professional, technical, and consultant personnel are available to evaluate each patient at the time of admission, including diagnosis of any intercurrent disease. Services necessary for such evaluation include laboratory, radiological and other diagnostic tests, obtaining psychosocial data, carrying out psychiatric and psychological evaluations, and completing a physical examination, including a complete neurological examination when indicated, shortly after admission.

(2) The number of qualified professional personnel, including consultants and technical and supporting personnel, is adequate to assure representation of the disciplines necessary to establish short-range and long-term goals; and to plan, carry out, and periodically revise a written individualized treatment program for each patient based on scientific interpretation of:

(i) Degree of physical disability and indicated remedial or restorative measures, including nutrition, nursing, physical medicine, and pharmacological therapeutic interventions;

(ii) Degree of psychological impairment and appropriate measures to be taken to relieve treatable distress and to compensate for nonreversible impairments where found;

(iii) Capacity for social interaction and appropriate nursing measures and milieu therapy to be undertaken, including group living experiences, occupational and recreational therapy, and other prescribed rehabilitative activities to maintain or increase the individual's capacity to manage activities of daily living;

(iv) Environmental and physical limitations required to safeguard the individual's health and safety with a plan to compensate for these deficiencies and to develop the individual's potential for return to his own home, a foster home, an extended care facility, a community mental health center, or another alternative facility to full-time hospitalization.

(b) *Standard; director of inpatient psychiatric services; medical staff.* Inpatient psychiatric services are under the supervision of a clinical director, service chief or equivalent who is qualified to provide the leadership required for an intensive treatment program, and the number and qualifications of physicians are adequate to provide essential psychiatric services. The factors explaining the standard are as follows:

(1) The clinical director, service chief or equivalent is certified by the American Board of Psychiatry and Neurology, or meets the training and experience requirements for examination by the Board ("Board eligible"). In the event the psychiatrist in charge of the clinical program is Board eligible, there is evi-

dence of consultation given to the clinical program on a continuing basis from a psychiatrist certified by the American Board of Psychiatry and Neurology.

(2) The medical staff is qualified legally, professionally and ethically for the positions to which they are appointed.

(3) The number of physicians is commensurate with the size and scope of the treatment program.

(4) Residency training is under the direction of a properly qualified psychiatrist.

(c) *Standard; availability of physicians and other personnel.* Physicians and other appropriate professional personnel are available at all times to provide necessary medical and surgical diagnostic and treatment services, including specialized services. If medical and surgical diagnostic and treatment services are not available within the institution, qualified consultants or attending physicians are immediately available or a satisfactory arrangement has been established for transferring patients to a general hospital certified under the Health Insurance for the Aged Program.

(d) *Standard; nursing services.* Nursing services are under the direct supervision of a registered professional nurse who is qualified by education and experience for the position; and the number of registered professional nurses, licensed practical nurses, and other nursing personnel are adequate to formulate and carry out the nursing components of the individual treatment plan for each patient. The factors explaining the standard are as follows:

(1) The registered professional nurse supervising the nursing program has a master's degree in psychiatric or mental health nursing or its equivalent from a school of nursing accredited by the National League for Nursing, or is qualified by education, experience in the care of the mentally ill, and demonstrated competence to participate in interdisciplinary formulation of individual treatment plans; to give skilled nursing care and therapy; and to direct, supervise and train others who assist in implementing and carrying out the nursing components of each patient's treatment plan.

(2) The staffing pattern insures the availability of a registered professional nurse 24 hours each day for direct care; for supervising care performed by other nursing personnel; and for assigning nursing care activities not requiring the services of a professional nurse to other nursing service personnel according to the patient's needs and the preparation and competence of the nursing staff available.

(3) The number of registered professional nurses, including nurse consultants, is adequate to formulate in writing and assure that a nursing care plan for each patient is carried out.

(4) Registered professional nurses and other nursing personnel are prepared by continuing in-service and staff development programs for active participation in interdisciplinary meetings affecting the planning or implementation of nursing care plans for patients including diagnostic conferences, treatment planning sessions, and meetings held to consider alternative facilities and community resources.

(e) *Standard; psychological services.* The psychological services are under the supervision of a qualified psychologist and the psychology staff, including consultants, is adequate in numbers and by qualifications to plan and carry out assigned responsibilities. The factors explaining the standard are as follows:

(1) The psychology department or service is under the supervision of a psychologist with a doctoral degree in psychology from an American Psychological Association approved program in clinical psychology or its adjudged equivalent. Where a psychologist who does not hold the doctoral degree directs the program, he has attained recognition of competency through the American Board of Examiners for Professional Psychology, State certification or licensing, or through endorsement by his State psychological association.

(2) Psychologists, consultants and supporting personnel are adequate in number and by qualifications to assist in essential diagnostic formulations, and to participate in program development and evaluation of program effectiveness, in training and research activities, in therapeutic interventions such as milieu, individual or group therapy, and in interdisciplinary conferences and meetings held to establish diagnoses, goals, and treatment programs.

(f) *Standard; social work services and staff.* Social work services are under the supervision of a qualified social worker, and the social work staff is adequate in numbers and by qualifications to fulfill responsibilities related to the specific needs of individual patients and their families, the development of community resources, and consultation to other staff and community agencies. The factors explaining the standard are as follows:

(1) The director of the social work department or service has a master's degree from an accredited school of social work and meets the experience requirements for certification by the Academy of Certified Social Workers.

(2) Social work staff, including other social workers, consultants and other assistants or case aides, is qualified and numerically adequate to conduct prehospitalization studies; to provide psychosocial data for diagnosis and treatment planning, direct therapeutic services to patients, patient groups or families, to develop community resources, including family or foster care programs; to conduct appropriate social work research and training activities; and to participate in interdisciplinary conferences and meetings concerning diagnostic formulation and treatment planning, including identification and utilization of other facilities and alternative forms of care and treatment.

(g) *Standard; qualified therapists, consultants, volunteers, assistants, aides.* Qualified therapists, consultants, volunteers, assistants or aides are sufficient in number to provide comprehensive therapeutic activities, including at least occupational, recreational and physical therapy, as needed, to assure that appropriate treatment is rendered for each patient, and to establish and maintain a therapeutic milieu. The factors explaining the standard are as follows:

(1) Occupational therapy services are preferably under the supervision of a graduate of an occupational therapy program approved by the Council on Education of the American Medical Association who has passed or is eligible for the National Registration Examination of the American Occupational Therapy Association. In the absence of a full-time, fully qualified occupational therapist, an occupational therapy assistant who is certified by the American Occupational Therapy Association may function as the director of the activities program with consultation from a fully qualified occupational therapist.

(2) When physical therapy services are offered, the services are given by or under the supervision of a qualified physical therapist who is a graduate of a physical therapy program approved by the Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association or its equivalent. In the absence of a full-time, fully qualified physical therapist, physical therapy services are available by arrangement with a certified local hospital or by consultation or part-time services furnished by a fully qualified physical therapist.

(3) Recreational or activity therapy services are available under the direct supervision of a member of the staff who has demonstrated competence in therapeutic recreation programs.

(4) Other occupational therapy, recreational therapy, activity therapy and physical therapy assistants or aides are directly responsible to qualified supervisors and are provided special on-the-job training to fulfill assigned functions.

(5) The total number of rehabilitation personnel, including consultants, is sufficient to permit adequate representation and participation in interdisciplinary conferences and meetings affecting the planning and implementation of activity and rehabilitation programs, including diagnostic conferences; and to maintain all daily scheduled and prescribed activities including maintenance of appropriate progress records for individual patients.

(6) Voluntary service workers are under the direction of a paid professional supervisor of volunteers, are provided appropriate orientation and training, and are available daily in sufficient numbers to be of assistance to patients and their families in support of therapeutic activities.

§ 405.1039 Condition of participation—Special medical record requirements for tuberculosis hospitals.

The medical records maintained by a tuberculosis hospital permit determina-

tion of the degree and intensity of the treatment provided to individuals who are furnished services in the institution.

(a) *Standard; reports on laboratory procedures.* The record contains reports on laboratory procedures undertaken to identify and characterize organisms, identify their drug susceptibility, protect the patient against potential drug toxicity, and measure pulmonary function.

(b) *Standard; records of case review conferences.* The record contains summaries of all scheduled case review conferences performed by the hospital staff, including as a minimum, summaries of case reviews performed upon initiation of therapy, within 8 weeks after initiation of therapy, at least 3 months thereafter, and prior to discharge. The factors explaining the standard are as follows:

(1) A case review conference is a meeting of the medical staff of the hospital at which major medical decisions are made concerning the program of treatment for each patient. Other professional staff involved in the care of the patient participate in the review.

(2) The summary of the case review conference includes: current diagnosis according to the National Tuberculosis Association's Diagnostic Standards and Classification of Tuberculosis, treatment, response to treatment, reference to X-ray and bacteriological findings, any special consultations, recommended schedule of future therapy, and prognosis.

(3) The discharge summary contains a recapitulation of the significant findings and events of the patient's hospitalization including a listing of all drugs used and the reason for discontinuing each, the current diagnoses and medical status of the patient on discharge, and recommendations for follow-up including the kind and duration of posthospitalization chemotherapy.

(c) *Standard; progress notes.* Adequate progress notes contained in the record indicate response to therapy. The factors explaining the standard are as follows:

(1) There is a note on the patient's condition, signed by a physician, at least once monthly.

(2) Any change in treatment plan is indiciated in the progress notes.

§ 405.1040 Condition of participation—Special staff requirements for tuberculosis hospitals.

The hospital has staff adequate in number and qualifications to carry out an active program of treatment for individuals who are furnished services in the institution.

(a) *Standard; medical director.* There is a full-time medical director (or his equivalent) who has at least 3 years experience in chest diseases or is Board eligible or Board certified in internal medicine, and who is well versed in the various aspects of tuberculosis. The factors explaining the standard are as follows:

(1) The medical director is responsible for the medical affairs in the hospital. If he is also responsible for the nonmedical affairs of the hospital, he has an administrator or business manager to administer these affairs.

(2) If the medical director carries a patient load in addition to supervising the conduct of medical affairs in the hospital, this additional responsibility does not interfere with his duties as director.

(b) *Standard; staff physicians.* There is a sufficient number of qualified physicians on the medical staff to provide medical supervision and active treatment for each tuberculosis patient. The factors explaining the standard are as follows:

(1) Physicians are legally qualified and have the professional skills necessary to care for tuberculosis patients.

(2) Active treatment includes:

(i) Initial evaluation at a staff case review conference;

(ii) A planned regimen of specific antituberculous measures, including chemotherapy, designed to render the disease noncommunicable and to improve the patient's condition so that he may safely return to his community for continued supervision and treatment; and

(iii) Periodic assessment of progress at case review conferences.

(3) It is preferable that staff physicians be full-time. If full-time staff cannot be obtained, the services of regularly scheduled part-time physicians may be used in order to provide needed services. This does not preclude the hospital from continuing efforts to obtain sufficient full-time staff.

(4) One or more physicians are on duty at all times.

(c) *Standard; thoracic surgeon.* The services of a thoracic surgeon, as a member of the medical team responsible for treating the tuberculosis patient, are available on a regularly scheduled basis and for emergencies. The factors explaining the standard are as follows:

(1) The thoracic surgeon is either Board certified or eligible for Board certification in thoracic surgery.

(2) In addition to his regular visits to the hospital for examination of selected patients, he attends case review conferences as a member of the medical team responsible for the care of the tuberculous patient.

(3) He is either on the full-time hospital staff or is available under arrangements with the hospital to provide specified consultative and surgical services. Necessary surgical procedures may be performed in another hospital.

(d) *Standard; consultative services.* Consultative services in other medical and surgical specialties are available to meet the total medical needs of the patients. The factors explaining the standard are as follows:

(1) Specialists in areas such as urology and orthopedic surgery are available to assist the staff through consultation and, if necessary, direct service in handling complications of tuberculosis.

(2) Specialists in other fields are available to assist as necessary in the treatment of additional medical disorders of the patients.

(e) *Standard; mental health.* Qualified personnel are available to provide mental health consultation and guidance to the staff, and such direct patient service as is appropriate to give in the tuberculosis hospital. The factors explaining the standard are as follows:

(1) If mental health services are not available from hospital staff, arrangements are made for these services with outside agencies or institutions.

(2) Mental health consultation and guidance, including guidance with respect to the alcoholic patient, are provided to the staff by qualified mental health personnel such as psychiatrist and/or psychologists.

(3) Patients with severe mental disturbances have ready access to the services of a qualified psychiatrist.

(f) *Standard; social needs.* A staff person is responsible for direction and supervision of activities related to the social needs of all patients, and to the mobilization and use of community resources to meet these needs. The number of professional personnel and nonprofessional social work assistants is sufficient to meet the institution's requirements. The factors explaining the standard are as follows:

(1) Preferably, social work direction and supervision are by a qualified social worker with a master's degree from an accredited school of social work and related professional experience.

(2) If the hospital does not have a qualified social worker on the staff, arrangements are made with another agency for overall direction and continuing supervision of hospital social services by a qualified social worker.

(3) The director of the service assigns responsibilities related to the specific needs of individual patients to professional social workers or to nonprofessional social work assistants according to their ability or training. Nonprofessional social work assistants receive in-service training to enable them to perform assigned functions.

(4) A social worker familiar with the patient's social needs participates in the case review conference.

(5) The social service staff effectively uses available community resources to assist in providing needed services to the patient and his family, and is responsible for proper community referrals upon discharge from the hospital.

(g) *Standard; diversionary and recreational services.* A staff person is responsible for arranging for patients appropriate diversionary and recreational activities as an important adjunct to the active treatment program. The factors explaining the standard are as follows:

(1) Preferably, these activities are under the direction of an occupational therapist who is registered by the American Occupational Therapy Association.

(2) Assistants, aides, or volunteers providing these services are directly responsible to a qualified person on the

staff and are provided on-the-job-training.

(h) *Standard; liaison.* There is a person with major responsibility for liaison between the hospital and, in the community in which the patient is to be supervised and treated upon discharge, the official health agency responsible for tuberculosis control and any other agencies or individuals who will be involved in the patient's treatment and follow-up. The factors explaining the standard are as follows:

(1) This person may be an employee of the hospital or an employee of an outside health agency assigned to the hospital for this purpose.

(2) This person is responsible for the administration of a written policy establishing effective lines of communication between the hospital and the official health agency responsible for tuberculosis control in the community and other agencies or individuals who will be involved in the patient's treatment and follow-up.

(3) The policy includes procedures for:

(i) Informing the official health agency of the admission of the patient to the hospital and of the anticipated return of the patient to the community either on discharge or leave from the hospital.

(ii) Assisting the local health agency in obtaining information from the patient on sources of infection and contacts that may have public health significance.

(iii) Transferring to the official health agency and any other agencies or individuals involved in the patient's treatment and follow-up medical and related information as needed to insure continuity and effectiveness of medical care.

[F.R. Doc. 66-11320; Filed, Oct. 17, 1966; 8:47 a.m.]

Title 26—INTERNAL REVENUE

Chapter I—Internal Revenue Service, Department of the Treasury

SUBCHAPTER E—ALCOHOL, TOBACCO, AND OTHER EXCISE TAXES

[T.D. 6897]

PART 177—INTERSTATE TRAFFIC IN FIREARMS AND AMMUNITION

Miscellaneous Amendments

On July 21, 1966, a notice of proposed rule making to amend 26 CFR Part 177 was published in the FEDERAL REGISTER (31 F.R. 9869). In accordance with the notice, interested persons were afforded an opportunity to submit written comments or suggestions pertaining thereto. No comments or suggestions were received within the 30-day period prescribed in the notice, and the amendments as published in the FEDERAL REGISTER are hereby adopted.

This Treasury decision shall become effective upon the date of its publication in the FEDERAL REGISTER.

(Sec. 7 of the Federal Firearms Act; 52 Stat. 1252; 15 U.S.C. 907)

[SEAL] SHELDON S. COHEN,
Commissioner of Internal Revenue.

Approved: October 11, 1966.

STANLEY S. SURREY,
Assistant Secretary of the Treasury.

In order to institute procedures under the Federal Firearms Act Amendment (Public Law 89-184), approved September 15, 1965, and to make appropriate conforming, technical and editorial changes, the regulations in 26 CFR Part 177 are amended as follows:

PARAGRAPH 1. Section 177.10 headed *"Meaning of terms"* is amended by inserting after the undesignated paragraph headed *"Licensed manufacturer"* a new paragraph headed *"Licensee"* to read as follows:

§ 177.10 Meaning of terms.

* * * * *

Licensee. Means a manufacturer, importer or dealer licensed under section 3 of the act (15 U.S.C. 903).

* * * * *

PAR. 2. Section 177.25 is amended to liberalize licensing restrictions in accordance with section 10, 79 Stat. 788; 15 U.S.C. 910, made effective September 15, 1965. As amended, § 177.25 reads as follows:

§ 177.25 Statutory restrictions.

(a) A license shall not be issued to any person who is a fugitive from justice or is under indictment for a crime punishable by imprisonment for a term exceeding one year by or in any court.

(b) A license shall not be issued to any person who has been convicted of a crime punishable by imprisonment for a term exceeding 1 year by or in any court unless such person has, as provided in § 177.31(c), made application for, and been granted, relief from the disabilities under the Federal Firearms Act arising by reason of such conviction.

(Sec. 10, 79 Stat. 788; 15 U.S.C. 910)

PAR. 3. Section 177.27 is amended to clarify the procedure involved. As amended, § 177.27 reads as follows:

§ 177.27 Application for renewal of license.

Prior to the expiration of a license, each licensee will receive a Form 8-A (Firearms). If the licensee intends to engage in the firearms business cited on the previous license during any portion of the ensuing year, he should execute and immediately return the Form 8-A (Firearms), with proper remittance, to the District Director.

PAR. 4. Section 177.29 is amended to clarify the procedures involved and to make certain technical and editorial changes. As amended, § 177.29 reads as follows:

§ 177.29 Procedure by District Director.

(a) Upon receipt of (1) a properly executed application for an original license on Form 7 (Firearms), or (2) a properly executed application for renewal of a license on Form 8-A (Firearms), accompanied by the required license fee, the District Director may make such inquiry as deemed necessary to determine the bona fides of the applicant. Upon determination that the applicant is lawfully entitled to a license, the District Director will issue such applicant a license on Form 8 (Firearms). Each license will bear an individual serial number and such number will be permanently assigned the licensee to whom issued for so long as he maintains continuity of annual renewal.

(b) If an applicant for license renewal is a person conducting business under a previously issued license pursuant to the provisions of § 177.31(b) or § 177.31(c), action regarding the application will be held in abeyance pending final determination of the applicant's criminal case or final action by the Commissioner on an application for relief submitted pursuant to § 177.31(c), as the case may be.

(Sec. 10, 79 Stat. 788; 15 U.S.C. 910, sec. 9, 69 Stat. 242; 5 U.S.C. 1008(b))

PAR. 5. Section 177.31 is amended to liberalize licensing restrictions in accordance with section 10, 79 Stat. 788; 15 U.S.C. 910, and to make certain technical and editorial changes. As amended, § 177.31 reads as follows:

§ 177.31 General.

(a) A license shall not be issued in any case for a period of less than 1 year. A proper license shall entitle the person to whom issued to transport, ship and receive firearms or ammunition in interstate or foreign commerce, within the limitations of the Act (see subpart F of this part), for a period of 1 year from the date of issuance (or until final action on an application for renewal), unless canceled as provided in § 177.30 or revoked as provided in § 177.43.

(b) A licensed manufacturer or licensed dealer who is indicted during the term of his license for a crime punishable by imprisonment for a term exceeding 1 year may continue operations under his license, until a conviction under the indictment becomes final: *Provided,* That if the term of the license expires during the period between the date of the indictment and the date conviction thereunder becomes final, such manufacturer or dealer must file a timely application for the renewal of his license in order to continue operations. Such application shall show that the applicant is under indictment for a crime punishable by imprisonment for a term exceeding 1 year.

(c) A person who has been convicted of a crime punishable by imprisonment for a term exceeding 1 year (other than a crime involving the use of a firearm or other weapon or a violation of the Federal Firearms Act or the National Firearms Act) may make application for relief from the disabilities under the Federal Firearms Act incurred by reason of such conviction and the Commissioner may grant such relief if it is established

to his satisfaction that the circumstances regarding the conviction, and the applicant's record and reputation, are such that the applicant will not be likely to conduct his operations in an unlawful manner, and that the granting of the relief would not be contrary to the public interest.

(1) An application for such relief, addressed to the Commissioner, shall be submitted in triplicate to the Director and shall include such supporting data as the applicant deems appropriate. In the case of a corporation the supporting data should include information as to the absence of culpability in the offense of which the corporation was convicted of any person having the power to direct or control the management of the corporation, if such be the fact.

(2) A licensee who is convicted of a crime punishable by imprisonment for a term exceeding 1 year during the term of a current license or while he has pending a license renewal application, and who qualifies under this paragraph to file an application for removal of disabilities resulting from such conviction, shall not be barred from licensed operations for 30 days after the date upon which his conviction becomes final, and if he files his application for relief with the Commissioner under this paragraph within such 30-day period, he may further continue licensed operations during the pendency of his application. Licensees who do not file an application for relief within 30 days from the date their conviction becomes final, shall not continue licensed operations beyond such 30-day period.

(3) In the event the term of a license of a person qualified to seek relief under this paragraph expires during the 30-day period following the date upon which his conviction becomes final or during the pendency of his application for relief he must file a timely application for renewal of his license in order to continue licensed operations. Such license application shall show that the applicant has been convicted of a crime punishable by imprisonment for a term exceeding 1 year.

(4) The District Director of the District in which the licensed premises are located will be promptly notified of the Commissioner's action on an application for relief and whenever the Commissioner grants relief to any person pursuant to this paragraph, he shall promptly publish in the FEDERAL REGISTER notice of such action, together with the reasons therefor.

(d) The provisions of § 177.83 shall not be construed as prohibiting the shipment of firearms and ammunition in interstate or foreign commerce to a manufacturer or dealer continuing operations under his license pursuant to the provisions of this section.

(Sec. 3, 52 Stat. 1251; 15 U.S.C. 903, sec. 10, 79 Stat. 788; 15 U.S.C. 910, sec. 9, 60 Stat. 242; 5 U.S.C. 1008 (b))

PAR. 6. Section 177.80 is amended in accordance with the provisions contained in section 10, 79 Stat. 788; 15 U.S.C. 910. As amended, § 177.80 reads as follows:

§ 177.80 License to operate.

It shall be unlawful for any manufacturer or dealer, except a manufacturer or dealer having a license issued under the provisions of the Act, to transport, ship, or receive any firearm or ammunition in interstate or foreign commerce. Further, it shall be unlawful for any licensed dealer or licensed manufacturer, who is a fugitive from justice or, except as provided in § 177.31(c), who has been finally convicted of a crime punishable by imprisonment for a term exceeding 1 year in any court, to transport, ship, or receive any firearm or ammunition in interstate or foreign commerce, or to cause any firearm or ammunition to be transported or shipped in interstate or foreign commerce.

(Sec. 2, 52 Stat. 1250 as amended; 15 U.S.C. 902, sec. 10, 79 Stat. 788; 15 U.S.C. 910)

PAR. 7. Section 177.83 is amended in accordance with the provisions contained in section 10, 79 Stat. 788; 15 U.S.C. 910. As amended, § 177.83 reads as follows:

§ 177.83 Interstate deliveries to felons.

It shall be unlawful for any person to ship, transport, or cause to be shipped or transported in interstate or foreign commerce any firearm or ammunition to any person knowing or having reasonable cause to believe that such person is a fugitive from justice or, except as provided by § 177.31(b), is under indictment for or, except as provided by § 177.31(c), has been convicted of, a crime punishable by imprisonment for a term exceeding 1 year by or in any court.

(Sec. 2, 52 Stat. 1250, as amended; 15 U.S.C. 902, sec. 10, 79 Stat. 788; 15 U.S.C. 910)

PAR. 8. Section 177.84 is amended in accordance with the provisions contained in section 10, 79 Stat. 788; 15 U.S.C. 910. As amended, § 177.84 reads as follows:

§ 177.84 Interstate transportation by felons, etc.

It shall be unlawful for any person who is a fugitive from justice or, except as provided by § 177.31(b), is under indictment for or, except as provided by § 177.31(c), has been convicted of, a crime punishable by imprisonment for a term exceeding 1 year by or in any court, to ship, transport, or cause to be shipped or transported in interstate or foreign commerce any firearm or ammunition.

(Sec. 2, 52 Stat. 1250, as amended; 15 U.S.C. 902, sec. 10, 79 Stat. 788; 15 U.S.C. 910)

PAR. 9. Section 177.85 is amended in accordance with the provisions contained in section 10, 79 Stat. 788; 15 U.S.C. 910. As amended, § 177.85 reads as follows:

§ 177.85 Receipt by felons, etc.

It shall be unlawful for any person who is a fugitive from justice or, except as provided by § 177.31(b), who is under indictment for or, except as provided by § 177.31(c), has been convicted of, a crime punishable by imprisonment for a term exceeding 1 year by or in any court, to receive any firearm or ammunition which has been shipped or transported in interstate or foreign commerce.

(Sec. 2, 52 Stat. 1250, as amended; 15 U.S.C. 902, sec. 10, 79 Stat. 788; 15 U.S.C. 910)

PAR. 10. Section 177.102 is amended to make certain technical changes. As amended, § 177.102 reads as follows:

§ 177.102 Disposition after forfeiture.

Any firearm or ammunition forfeited by reason of a violation of the act or any rules or regulations promulgated thereunder, the forfeiture of which firearm or ammunition has not been remitted or mitigated, shall be reported to the Administrator of General Services, General Services Administration, for use or disposition as provided by law (63 Stat. 377).

[F.R. Doc. 66-11232; Filed, Oct. 17, 1966; 8:45 a.m.]

Title 32A—NATIONAL DEFENSE, APPENDIX

Chapter XV—Federal Reserve System

REG. V—LOAN GUARANTEES FOR DEFENSE PRODUCTION

Maximum Rates of Interest

1. Effective September 27, 1966, Regulation V is amended as follows:

a. Section 1 is amended to read as follows:

Section 1. Authority.

This regulation is based upon and issued pursuant to the Defense Production Act of 1950 (referred to in this regulation as the "act"), and Executive Order No. 10480, dated August 14, 1953, as amended (3 CFR 1949–1953 Comp., p. 962) (referred to in this regulation as the "order"), and after consultation with the heads of the guaranteeing agencies designated in the act and the order; namely, the Department of the Army, the Department of the Navy, the Department of the Air Force, the Department of Commerce, the Department of the Interior, the Department of Agriculture, the General Services Administration, the Atomic Energy Commission, the Defense Supply Agency, and the National Aeronautics and Space Administration.

b. Section 5 is amended to read as follows:

Sec. 5. Rates and fees.

Rates of interest, guarantee fees, commitment fees, and other charges which may be made with respect to guaranteed loans and guarantees executed through the agency of any Federal Reserve Bank under this regulation will from time to time be prescribed, either specifically or by maximum limits or otherwise, in section 7 (the Supplement) by the Board of Governors after consultation with the guaranteeing agencies.

c. The folowing new section 7 is added:

Sec. 7. Supplement.

Pursuant to the provisions of the Defense Production Act of 1950 and Executive Order No. 10480, dated August 14, 1953, as amended, the Board of Governors of the Federal Reserve System hereby prescribes the maximum rate of interest, guarantee fees, and commitment fees which may be charged with respect to guaranteed loans executed through the agency of any Federal Reserve Bank:

(a) *Maximum rate of interest.* The maximum interest rate charged a borrower by a financing institution with respect to a guaranteed loan shall not exceed 7½ percent per annum.

(b) *Guarantee fees.* The schedule of fees with respect to guaranteed loans is as follows:

Percent of loan guaranteed	*Guarantee fee (percent of interest payable by borrower on guaranteed portion of loan)*
70 or less	10
75	15
80	20
85	25
90	30
95	35
Over 95	40–50

In any case in which the rate of interest on the loan is in excess of 6 percent, the guarantee fee shall be computed as though the interest rate were 6 percent.

(c) *Commitment fees.* In any case in which a commitment fee is charged a borrower with respect to a guaranteed loan, such fee shall not exceed one-half of 1 percent per annum. In any such case, the financing institution will pay to the guaranteeing agency a percentage of such commitment fee, based on the guaranteed portion of the credit, equal to the same percentage of the interest payable on the loan which is required to be paid by the financing institution to the guarantor as a guarantee fee.

2a. The purposes of these amendments are to bring the regulation up to date and to incorporate into the regulation the currently effective maximum rate of interest, guarantee fees, and commitment fees on defense production loans. The only substantive change relates to the maximum permissible rate of interest, which is increased from 6 to 7½ percent per annum.

b. The requirements of section 553(b) of title 5, United States Code, with respect to notice, public participation, and deferred effective date were not followed in connection with these amendments. Functions exercised under the Defense Production Act are exempt from such requirements (50 App. U.S.C. 2159).

(50 App. U.S.C. 2154; E.O. 10480)

Dated at Washington, D.C., this 11th day of October 1966.

By order of the Board of Governors.

[SEAL] KENNETH A. KENYON,
Assistant Secretary.

[F.R. Doc. 66–11296; Filed, Oct. 17, 1966; 8:45 a.m.]

Title 33—NAVIGATION AND NAVIGABLE WATERS

Chapter II—Corps of Engineers, Department of the Army

PART 204—DANGER ZONE REGULATIONS

Atlantic Ocean, Va.

Pursuant to the provisions of section 7 of the River and Harbor Act of August 8, 1917 (40 Stat. 266; 33 U.S.C. 1), and Chapter XIX of the Army Appropriations Act of July 9, 1918 (40 Stat. 892; 33 U.S.C. 3), § 204.27 is hereby prescribed establishing and governing the use and navigation of a danger zone in the Atlantic Ocean, Va., effective 30 days after publication in the FEDERAL REGISTER as follows:

§ 204.27 Atlantic Ocean off Wallops Island and Chincoteague Inlet, Va.; danger zone.

(a) *The area.* An area immediately offshore from Wallops Island defined by lines drawn as follows: Beginning at latitude 37°51'30" N., longitude 75°27'-30" W.; thence to latitude 37°51'30" N., longitude 75°17'12" W.; thence to latitude 37°43'18" N., longitude 75°29'42" W.; and thence to latitude 37°49'18" N., longitude 75°29'42" W.

(b) *The regulations.* (1) Vessels may enter and operate in the danger zone at all times when warning signals are not displayed.

(2) When warning signals are displayed, all vessels in the danger zone except vessels entering or departing Chincoteague Inlet shall leave the zone promptly by the shortest possible route and shall remain outside the zone until allowed by a patrol boat to enter, or until the danger signal has been discontinued. Vessels entering or departing Chincoteague Inlet shall take the shortest passage possible through the danger zone upon display of the danger signal.

(3) The intent to conduct rocket-launching operations involving the area shall be indicated by a signal consisting of a large orange-colored, "blimp-shaped" balloon by day and a signal rotating alternately red and white beacon by night. The balloon shall be flown at latitude 37°50'38", longitude 75°28'-47" and the beacon shall be displayed about 200 feet above mean high water at latitude 37°50'16", longitude 75°29'-07". The appropriate one of these signals shall be displayed 30 minutes prior to rocket-launching time and shall remain displayed until danger no longer exists.

(4) The regulations in this section shall be enforced by the Director, Wallops Station, National Aeronautics and Space Administration, Wallops Island, Va., or such agencies as he may designate.

[Regs., Sept. 30, 1966, 1507-32 (Atlantic Ocean, Va.)-ENGCW-ON] (Sec. 7, 40 Stat. 266, Chap XIX, 40 Stat. 892; 33 U.S.C. 1, 3)

KENNETH G. WICKHAM,
Major General, U.S. Army,
The Adjutant General.

[F.R. Doc. 66–11289; Filed, Oct. 17, 1966; 8:45 a.m.]

Title 42—PUBLIC HEALTH

Chapter I—Public Health Service, Department of Health, Education, and Welfare

SUBCHAPTER D—GRANTS

PART 52—GRANTS FOR RESEARCH PROJECTS

Subpart E—Grantee Accountability

ACCOUNTING FOR GRANT AWARD PAYMENTS

The purpose of the amendment set forth below is to provide, to the extent indicated, for the accountability of funds granted to educational and other institutions for indirect costs on the basis of a predetermined percentage of allowable direct costs.

Effective on publication in the FEDERAL REGISTER, § 52.41 is revised to read as follows:

§ 52.41 Accounting for grant award payments.

With respect to each approved project the grantee shall account for the sum total of all amounts paid under § 52.14 (e) by presenting or otherwise making available vouchers or any other evidence satisfactory to the Surgeon General of expenditures for direct and indirect costs meeting the requirements of Subpart D of this part: *Provided, however,* That where in accordance with § 52.32 (b)(2) the amount awarded to an educational institution for indirect cost was based on a predetermined fixed-percentage of estimated direct costs, the amount allowed for indirect costs shall be computed on the basis of such predetermined fixed-percentage rates applied to the total, or a selected element thereof, of the reimbursable direct costs incurred. Such predetermined fixed-percentage rates may also be applied in accounting for awards to noneducational institutions to the extent such application is deemed by the Surgeon General to protect adequately the interests of the Government.

(Sec. 215, 58 Stat. 690; 42 U.S.C. 216)

Dated: September 16, 1966.

[SEAL] WILLIAM H. STEWART,
Surgeon General.

Approved: October 7, 1966.

WILBUR J. COHEN,
Acting Secretary.

[F.R. Doc. 66–11319; Filed, Oct. 17, 1966; 8:47 a.m.]

Title 43—PUBLIC LANDS: INTERIOR

Chapter II—Bureau of Land Management, Department of the Interior

SUBCHAPTER E—FOREST MANAGEMENT (5000)

[Circular 2215]

PART 5430—PRESALE PREPARATION, ADVERTISEMENT AND CONTRACT PREPARATION

Subpart 5433—Bids and Award of Contract

QUALIFICATION OF BIDDERS AND PURCHASERS

On page 10415 of the FEDERAL REGISTER of August 3, 1966, there was published a notice of proposed rule making to amend regulations concerning the qualification of bidders and purchasers of Federal timber. Interested persons were given 30 days in which to submit written comments, suggestions, or objections regarding the proposed amendment to the regulations.

No objections have been received and the proposed amendment to the regulations is hereby adopted wtihout change and is set forth below.

Effective date. This amendment shall be effective as of the date of its publication in the FEDERAL REGISTER.

CHARLES F. LUCE,
Under Secretary of the Interior.

OCTOBER 11, 1966.

Section 5433.1 is amended by additional wording relating to eligibility to qualify to purchase set-aside timber. As amended § 5433.1 will read as follows:

§ 5433.1 Qualification of bidders and purchasers.

A bidder or purchaser for the sale of timber must be (a) an individual who is a citizen of the United States, (b) a partnership composed wholly of such citizens, (c) an unincorporated association composed wholly of such citizens, or (d) a corporation authorized to transact business in the States in which the timber is located. A bidder must also have submitted a deposit in advance, as required by § 5433.2. To qualify for bidding to purchase set-aside timber, the bidder must not have been determined by the Small Business Administration to be ineligible for preferential award of set-aside sales and must accompany his deposit with a self-certification statement that he is qualified as a small business concern as defined by the Small Business Administration (13 CFR Part 121).

[F.R. Doc. 66-11298; Filed, Oct. 17, 1966; 8:45 a.m.]

Title 49—TRANSPORTATION

Chapter I—Interstate Commerce Commission

SUBCHAPTER A—GENERAL RULES AND REGULATIONS

[Ex Parte MC-19]

PART 7—LIST OF FORMS, PART II, INTERSTATE COMMERCE ACT

Practices of Motor Common Carriers of Household Goods

At a session of the Interstate Commerce Commission, Division 1, held at its office in Washington, D.C. on the 15th day of July 1966.

It appearing, that the order of the Commission entered in this proceeding on June 7, 1966, effective, as postponed, on January 1, 1967, wherein certain regulations were prescribed and adopted, includes a requirement appearing in § 176.10(e), of this chapter that every household goods carrier shall file each month a report of all instances during the preceding month where the actual charges for services rendered exceeded the estimates of such charges by 10 percent or more, with an explanation of reasons for the variances;

And it further appearing, that it is necessary and desirable that a form be prescribed for use by motor common carriers of household goods in filing reports of underestimates with the Commission in accordance with the said requirement:

It is ordered, That Form BOC 101, Report of Underestimates, a copy of which is attached hereto [1] and made a part hereof, be, and it is hereby approved, adopted and prescribed for appropriate use as required by § 176.10(e);

It is further ordered, That Part 7 of Subchapter A of this chapter be, and it is hereby, amended by adding § 7.101 *BOC 101* to read as follows:

§ 7.101 BOC 101.

Report of Underestimates, Form BOC 101,[1] to be used by motor carriers of household goods to report to the Commission all instances in which actual charges exceed written estimates by 10 percent or more, pursuant to § 176.10(e) of this chapter.

(Secs. 204, 220, 49 Stat. 546 as amended, 563 as amended; 49 U.S.C. 304, 320)

It is further ordered, That this order shall be effective on January 1, 1967.

And it is further ordered, That notice of this order shall be given to motor carriers, other persons of interest, and the general public by depositing a copy thereof in the office of the Secretary of the Commission, Washington, D.C., and by filing a copy thereof with the Director, Office of the Federal Register.

By the Commission, Division 1.

[SEAL] H. NEIL GARSON,
Secretary.

[1] Form BOC 101 filed as part of original document.

[F.R. Doc. 66-11317; Filed, Oct. 17, 1966; 8:47 a.m.]

Title 38—PENSIONS, BONUSES, AND VETERANS' RELIEF

Chapter I—Veterans Administration

PART 3—ADJUDICATION

Subpart E—Waiver of Overpayments

REFUNDS ON OVERPAYMENTS

1. In § 3.1902(b), subparagraph (9) is amended to read as follows:

§ 3.1902 "Overpayments."

* * * * *

(b) * * *

(9) Amounts equal to amounts which have been recovered by the Veterans Administration prior to the date of receipt of the request for waiver.

2. In § 3.1903, paragraph (b) is amended to read as follows:

§ 3.1903 Waiver.

* * * * *

(b) Request for waiver of an overpayment will be considered only if received within 1 year following the date of notice to the payee; otherwise, an application will be considered only if it is supported by new and material evidence.

* * * * *

3. In § 3.1906, paragraph (c) is amended to read as follows:

§ 3.1906 Revision of decisions.

* * * * *

(c) Where reversal or amendment of a decision is authorized by Central Office under § 3.105(b) because of a difference of opinion, the effective date of waiver will be governed by the principle contained in § 3.400(h). However, no refund will be made of any moneys recovered prior to the date of receipt of the request for waiver.

(72 Stat. 1114; 38 U.S.C. 210)

These regulations are effective November 1, 1966.

By direction of the Administrator.

Approved: October 12, 1966.

[SEAL] CYRIL F. BRICKFIELD,
Deputy Administrator.

[F.R. Doc. 66-11308; Filed, Oct. 17, 1966; 8:46 a.m.]

Title 50—WILDLIFE AND FISHERIES

Chapter I—Bureau of Sport Fisheries and Wildlife, Fish and Wildlife Service, Department of the Interior

PART 32—HUNTING

Seney National Wildlife Refuge, Mich.

The following special regulation is issued and is effective on date of publication in the FEDERAL REGISTER.

§ 32.32 Special regulations; big game; for individual wildlife refuge areas.

MICHIGAN

SENEY NATIONAL WILDLIFE REFUGE

Public hunting of deer and bear on the Seney National Wildlife Refuge is permitted from 6 a.m. to 7 p.m., e.s.t., each day from November 12, 1966, through November 27, 1966, only on the area designated by signs as open to hunting. This open area, comprising 85,200 acres, is delineated on a map available at the refuge headquarters, Seney, Mich., and from the Regional Director, Bureau of Sport Fisheries and Wildlife, 1006 West Lake Street, Minneapolis, Minn. 55408. Hunting shall be in accordance with all applicable State regulations covering the hunting of deer and bear including the requirement that a current Michigan big game license be in the possession of the hunter and shall be subject to the following special conditions:

(1) Firearms (rifles only) chambering center fire cartridges of .23 caliber bullet diameter or larger.

The provisions of this special regulation supplement the regulations which govern hunting on wildlife refuge areas generally, which are set forth in Title 50, Code of Federal Regulations, Part 32 and are effective through November 27, 1966.

JOHN B. HAKALA,
Refuge Manager, Seney National Wildlife Refuge, Seney, Mich.

OCTOBER 11, 1966.

[F.R. Doc. 66-11313; Filed, Oct. 17, 1966; 8:47 a.m.]

PART 33—SPORT FISHING

Merritt Island National Wildlife Refuge, Fla.; Correction

In F.R. Doc. 65-13420, appearing at page 15469 of the issue for December 16, 1965, subparagraph (1), should read as follows:

(1) The sport fishing season on the refuge extends from January 6, 1966, through November 23, 1966.

WALTER A. GRESH,
Regional Director, Bureau of Sport Fisheries and Wildlife.

[F.R. Doc. 66-11312; Filed, Oct. 17, 1966; 8:47 a.m.]

Notices

DEPARTMENT OF THE TREASURY

Fiscal Service

[Dept. Circ. 570, 1966 Rev., Supp. No. 8]

BOSTON INSURANCE CO. AND BOSTON OLD COLONY INSURANCE CO.

Termination of Authority To Qualify as Surety on Federal Bonds and Change of Name of Company

The Certificate of Authority as an acceptable surety on Federal bonds issued by the Secretary of the Treasury under date of June 1, 1966, to the Boston Insurance Co., Boston, Mass., a Massachusetts corporation, under the Act of Congress approved July 30, 1947 (6 U.S.C. 6–13), is hereby terminated for the following reason.

Pursuant to a Reinsurance and Assumption Agreement, approved by the Commissioner of Insurance of the State of Massachusetts on June 6, 1966, effective 12:01 a.m., e.s.t., January 1, 1966, the Continental Insurance Co., New York, N.Y., a New York corporation, acquired certain assets and assumed all of the insurance liabilities of Boston Insurance Co. which, effective June 6, 1966, withdrew from the insurance business and adopted the name Bimar Corp. A copy of the Reinsurance and Assumption Agreement is on file in the Treasury Department, Bureau of Accounts, Surety Bonds Branch, Washington, D.C. 20226.

The Continental Insurance Co., New York, N.Y., which assumed the insurance business of the Boston Insurance Co., holds a Certificate of Authority as an acceptable surety on Federal bonds issued by the Secretary of the Treasury June 1, 1966, with an underwriting limitation of $118,391,000.

Effective June 6, 1966, the Old Colony Insurance Co., Boston, Mass., a Massachusetts corporation, which was a subsidiary of the Boston Insurance Co., formally changed its name to Boston Old Colony Insurance Co. A copy of a certificate issued by the Secretary of the Commonwealth of Massachusetts certifying to the change of name has been received and filed in the Treasury Department.

A Certificate of Authority as an acceptable surety on Federal bonds dated June 6, 1966, has been issued by the Secretary of the Treasury to the following company under the Act of Congress approved July 30, 1947 (6 U.S.C. 6–13), to replace the certificate issued June 1, 1966 to the company under its former name, Old Colony Insurance Co. The underwriting limitation of $717,000 previously established for the company remains unchanged.

Name of company, location of principal executive office, and State in which incorporated: Boston Old Colony Insurance Company, Boston, Massachusetts; Massachusetts.

In view of the foregoing, no action need be taken by bond-approving officers, by reason of the reinsurance and assumption of the insurance business of the Boston Insurance Co. by Continental Insurance Co., the withdrawal from the insurance business of Boston Insurance Co., or the change of name of Old Colony Insurance Co., with respect to any bond or other obligation in favor of the United States or in which the United States has an interest, direct or indirect, issued on or before June 6, 1966, by Boston Insurance Co. or Old Colony Insurance Co. pursuant to the Certificates of Authority issued to the companies by the Secretary of the Treasury.

Certificates of Authority expire on May 31 each year, unless sooner revoked and new certificates are issued on June 1, so long as the companies remain qualified (31 CFR Part 223). A list of qualified companies is published annually as of June 1, in Department Circular 570, with details as to underwriting limitations, areas in which licensed to transact fidelity and surety business and other information. Copies of the circular, when issued, may be obtained from the Treasury Department, Bureau of Accounts, Surety Bonds Branch, Washington, D.C. 20226.

Dated: October 13, 1966.

[SEAL] JOHN K. CARLOCK,
Fiscal Assistant Secretary.

[F.R. Doc. 66–11304; Filed, Oct. 17, 1966; 8:46 a.m.]

Office of the Secretary

[Antidumping—ATS 643.3–W]

STEEL WELDED WIRE MESH FROM ITALY

Determination of Sales at Not Less Than Fair Value

OCTOBER 12, 1966.

On August 5, 1966, there was published in the FEDERAL REGISTER a "Notice of Intent To Discontinue Investigation and of Tentative Determination That No Sales Exist Below Fair Value" because of price revisions with respect to steel welded wire mesh for concrete reinforcement imported from Italy, and that such fact is considered to be evidence that there are not, and are not likely to be, sales below fair value.

The merchandise under consideration consists of lightweight concrete reinforcement mesh for buildings.

The complainant submitted a written request for an opportunity to present views in person in opposition to the tentative determination. The opportunity was afforded to the complainant, and all interested parties of record were notified and were represented at the hearing.

After consideration of all written and oral argument presented, I hereby determine that because of price revisions, steel welded wire mesh for concrete reinforcement from Italy is not being, nor likely to be, sold at less than fair value within the meaning of section 201(a) of the Antidumping Act, 1921, as amended (19 U.S.C. 160(a)).

This determination and the statement of the reason therefor are published pursuant to section 201(c) of the Antidumping Act, 1921, as amended (19 U.S.C. 160 (c)).

[SEAL] TRUE DAVIS,
Assistant Secretary of the Treasury.

[F.R. Doc. 66–11305; Filed, Oct. 17, 1966; 8:46 a.m.]

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

ALASKA

Notice of Filing of Plats of Survey

1. Plats of survey of the lands described below will be officially filed in the Anchorage Office, Anchorage, Alaska, effective at 10 a.m., November 1, 1966.

SEWARD MERIDIAN

T. 20 N., R. 3 W.,
Sec. 31: Lots 1, 2, 3, 4, 5, 6, 7, NE¼, E½W½, SE¼;
Sec. 32: All;
Sec. 33: All;
Sec. 34: All;
Sec. 35: All;
Sec. 36: Lots 1, 2, 3, N½, SW¼;
Tract A.

Containing 22,778.01 acres.

2. The land is hilly to mountainous, covered with spruce and birch, with cottonwood timber along the banks of Willow Creek. The undergrowth consists of alder, berry brush, and patches of devil's club in the creek bottom. The soil varies from sandy loam, covered with vegetable mold, to black muck in marshy areas. Willow Creek flows westerly through the subdivided portion of the township. Peters Creek joins Willow Creek in the northeast quarter of section 36.

3. The public lands affected by this order are hereby restored to the operation of the public land laws, subject to any valid existing rights, the provisions of existing withdrawals, and the requirements of applicable law, rules, and regulations.

4. The greater part of the land affected by this notice has been selected by the State of Alaska in accordance with and subject to the limitations and requirements of the Alaska Statehood Act of

July 7, 1958 (72 Stat. 339), and the regulations in 43 CFR 2222.9–1(a) and Part 1840.

5. Inquiries concerning the lands should be addressed to the Manager, Anchorage Land Office, 555 Cordova Street, Anchorage, Alaska 99501.

T. G. BINGHAM,
Manager, Anchorage Land Office.

[F.R. Doc. 66–11310; Filed, Oct. 17, 1966; 8:46 a.m.]

IDAHO

Notice of Filing of Protraction Diagrams

OCTOBER 10, 1966.

Notice is hereby given that effective at and after 10 a.m. on November 14, 1966, the following protraction diagrams are officially filed of record in the Idaho Land Office, Room 327, Federal Building, Boise, Idaho 83701. In accordance with Title 43, Code of Federal Regulations, these protractions will become the basic record for describing the lands for all authorized uses. Until this date and time the diagrams have been placed in open files and are available to the public for information only.

IDAHO PROTRACTION DIAGRAMS

Nos. 25, 26, 27, 28, 29, 30, 31, 32 and 36

BOISE MERIDIAN

Approved September 21, 1966

No. 25

Ts. 27 and 28 N., Rs. 13, 14, 15, and 16 E.

No. 26

Ts. 27 and 28 N., Rs. 10, 11, and 12 E.

No. 27

Ts. 27 and 28 N., Rs. 7, 8, and 9 E.

No. 28

Ts. 27 and 28 N., Rs. 4, 5, and 6 E.

No. 29

T. 27 N., Rs. 20, 21, and 22 E.

No. 30

T. 25 N., Rs. 20, 21, 22, and 23 E.
T. 26 N., Rs. 20, 21, and 22 E.

No. 31

T. 25 N., Rs. 18, and 19 E.
T. 26 N., R. 19 E.

No. 32

T. 25 N., Rs. 15, 16, and 17 E.
T. 26 N., Rs. 15, and 16 E.

No. 36

Ts. 25 and 26 N., Rs. 4, 5, and 6 E.

Copies of these diagrams are for sale at one dollar ($1.00) each by the Cadastral Engineering Office, Bureau of Land Management, Post Office Box 2237, Boise, Idaho 83701.

ORVAL G. HADLEY,
Manager,
Land Office, Boise, Idaho.

[F.R. Doc. 66–11311; Filed, Oct. 17, 1966; 8:46 a.m.]

[Montana 073207]

MONTANA

Notice of Proposed Classification of Public Lands

Correction

In F.R. Doc. 66–10229, appearing at page 12455 of the issue for Tuesday, September 20, 1966, the penultimate line of the land description should be deleted and the following inserted therefor:

Sec. 25, NW¼;

DEPARTMENT OF AGRICULTURE

Commodity Credit Corporation

[Amdt. 1]

SALES OF CERTAIN COMMODITIES

October Sales List

Pursuant to the policy of the Commodity Credit Corporation issued October 12, 1954 (19 F.R. 6669), and subject to the conditions stated therein, the CCC Monthly Sales List for October 1966 is amended as set forth below:

The Export Section for wheat is amended to read as follows:

All classes of wheat are available for export sale at all U.S. Coasts including the Great Lakes and St. Lawrence ports, however, sales at West Coast ports are subject to the exceptions for the various programs as follows:

A. Announcement GR–345 (Revision III, July 6, 1962, as amended), Wheat Export Program. Hard Red Winter and Hard Red Spring wheat will not be sold at West Coast ports. For Durum wheat offered for sale under this announcement at West Coast ports buyer must show export from West Coast ports and shipment into a dollar market (including shipment under CCC approved credit sale—non PL 480) to a destination west of the 170 meridian, west longitude and east of the 60th meridian, east longitude, and to countries on the West Coast of Central and South America.

B. Announcement GR–346 (Revision I, June 23, 1960, as amended), for export as flour.

C. Announcement GR–261 (Revision II, January 9, 1961, as amended and supplemented) for export as wheat as follows:

(1) All classes will be sold for application to barter contracts except that wheat of the classes Hard Red Winter, Hard Red Spring, and Durum will not be sold for barter at West Coast ports nor will evidence of export at West Coast ports be acceptable under a sale for barter;

(2) All classes will be sold for application to approved CCC credit sales except that (a) in the case of Hard Red Winter and Hard Red Spring wheat sold at West Coast ports, buyers must show export from a West Coast port to a destination within the geographical area described in A above, and (b) Durum wheat will not be sold at West Coast ports for application to credit sales nor will evidence of export from West Coast ports be acceptable under a sale of Durum for application to a credit transaction;

(3) Hard Red Winter and Hard Red Spring wheat will be sold at West Coast ports for export commodity certificates to fill a dollar market sale and buyer must show export from West Coast port to a destination within the geographical area described in A above.

D. Announcement GR–262 (Revision II, January 9, 1961, as amended) for export as flour as follows: All classes will be sold for application to barter and approved CCC credit transactions except that sales for barter will not be made at West Coast ports nor will evidence of export from West Coast ports be acceptable under a sale for barter pursuant to this announcement.

(Sec. 4, 62 Stat. 1070, as amended; 15 U.S.C. 714b. Interpret or apply sec. 407, 63 Stat. 1066; sec. 105, 63 Stat. 1051, as amended by 76 Stat. 612; secs. 303, 306, and 307, 76 Stat. 614–617; 7 U.S.C. 1441 (note))

Signed at Washington, D.C., on October 12, 1966.

H. D. GODFREY,
Executive Vice President,
Commodity Credit Corporation.

[F.R. Doc. 66–11302; Filed, Oct. 17, 1966; 8:46 a.m.]

CIVIL AERONAUTICS BOARD

[Docket No. 15419]

BLOCKED-SPACE AIRFREIGHT TARIFFS

Notice of Prehearing Conference

In the light of the Supreme Court's recent denial of certiorari in connection with the litigation with respect to the Board's blocked-space airfreight policy, it is appropriate that the tariff investigation now go forward. Accordingly, this proceeding is set for prehearing conference at 10 a.m., November 8, 1966, in Room 726, Universal Building, Connecticut and Florida Avenues NW., Washington, D.C., before Examiner Ralph L. Wiser.

Proposed revisions in the statements of issues, revised requests for information, and revisions in the statements of positions of the parties, as well as proposed procedural dates, shall be submitted in writing with copy to the examiner and all parties by October 27, 1966. The parties should make their submissions on the basis of grant by the Board of the requested consolidation of Docket 17594 into this proceeding.

Dated at Washington, D.C., October, 12, 1966.

[SEAL] RALPH L. WISER,
Hearing Examiner.

[F.R. Doc. 66–11314; Filed, Oct. 17, 1966; 8:47 a.m.]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Food and Drug Administration

GEIGY CHEMICAL CORP.

Notice of Filing of Petition Regarding Pesticides

Pursuant to the provisions of the Federal Food, Drug, and Cosmetic Act (sec. 408(d)(1), 68 Stat. 512; 21 U.S.C. 346a (d)(1)), notice is given that a petition

(PP 7F0535) has been filed by Geigy Chemical Corp., Ardsley, N.Y. 10502, proposing the establishment of tolerances for residues of the insecticide *O,O*-diethyl *O*-[2-isopropyl-4-methyl-6-pyrimidinyl] phosphorothioate in or on raw agricultural commodities, as follows:

40 parts per million in or on peanut forage.
10 parts per million in or on peanut hulls and hay.
0.75 part per million in or on brussels sprouts, peanuts, and sugarcane.
0.10 part per million in or on potatoes and sweet potatoes.

The analytical method proposed in the petition for determining residues of the insecticide is a sulfide method which includes the following steps: The residue is extracted with petroleum ether and after suitable cleanup is transferred to hydrobromic acid. The solution is then boiled, converting the sulfur to hydrogen sulfide. The hydrogen sulfide is trapped in zinc acetate solution and determined colorimetrically as methylene blue.

Dated: October 10, 1966.

J. K. KIRK,
Associate Commissioner for Compliance.

[F.R. Doc. 66-11318; Filed, Oct. 17, 1966; 8:47 a.m.]

GENERAL SERVICES ADMINISTRATION

[Federal Procurement Regs.; Temporary Reg. 8]

EQUAL EMPLOYMENT OPPORTUNITY

Standard Government Contract Forms; Extension of Temporary Regulation

To heads of Federal agencies:

1. *Purpose.* This regulation continues in effect the provisions of FPR Temporary Regulation No. 1, October 19, 1965 (30 F.R. 13475), as extended by FPR Temporary Regulation No. 6, April 25, 1966 (31 F.R. 6388).

2. *Background.* FPR Temporary Regulation No. 1, as extended by FPR Temporary Regulation No. 6, prescribed certain revisions to standard Government contract forms in accordance with the requirements of section 404 of Executive Order No. 11246, September 24, 1965 (30 F.R. 12319). Following the issuance by the Secretary of Labor of the revision of the regulations on equal employment opportunity which currently is under consideration, the provisions of Temporary Regulation No. 1 will be codified in the Federal Procurement Regulations.

3. *Effective date.* This regulation is effective on October 25, 1966.

4. *Expiration date.* Unless revised or canceled earlier by a formal FPR amendment, this regulation and the provisions of FPR Temporary Regulation No. 1 expire on April 24, 1967.

Dated: October 3, 1966.

LAWSON B. KNOTT, Jr.,
Administrator of General Services.

[F.R. Doc. 66-11297; Filed, Oct. 17, 1966; 8:45 a.m.]

[Federal Property Management Regulations Temporary Regulation No. E-6]

OFFICE FURNITURE

Use Standards

To: Heads of Federal Agencies.

1. *Purpose.* This regulation establishes revised standards for use of office furniture in consonance with the objectives of the President set forth in his memorandum of September 16, 1966, to heads of departments and agencies on cost reduction in procurement, supply, and property management.

2. *Applicability.* The provisions of this regulation apply to all executive agencies. Other agencies are encouraged to adhere to the revised standards so that maximum benefits can be realized by the Government.

3. *Background.* The President directed that a special sustained Government-wide effort be made so that costs could be further reduced in the procurement and management of property. To that end, a determination has been made that in the interest of economy, use standards for office furniture should be revised.

4. *Use standards for office furniture.* Office furniture, whether new or rehabilitated, shall be used as prescribed by the following standards:

a. The use of executive type wood (traditional or modern) office furniture shall be limited to personnel in Grade GS-18 and above or the equivalent thereto, including military rank. This type of office furniture includes items which are available from Federal Supply Schedules FSC Group 71, Part VI and Part XII and the executive office furniture (Allenwood) available from Federal Prison Industries, Inc.

b. The use of unitized wood office furniture shall be limited to personnel in Grade GS-15 and above or the equivalent thereto, including military rank. This type is included in Federal Supply Schedule FSC Group 71, Part VIII.

5. *Application of revised use standards.* Despite the revised standards, redistribution of furniture merely to comply therewith should not be effected. However, to avoid new procurement where an employee is entitled by reason of grade to other than standard metal furniture, furniture to which he is entitled shall be provided by transfer of furniture owned by the agency.

6. *Review of purchase actions.* Agencies shall review immediately all outstanding requisitions, purchase orders, or contracts to assure that office furniture, when acquired and placed in use, will conform to the standards prescribed by this regulation. Where conformance will not result, action shall be taken to cancel such portions as will assure conformance if this can be done without incurring penalty charges. In the event penalty charges will be incurred, the Chief, Furniture and Furnishings Branch, Procurement Operations Division, Federal Supply Service, telephone: Area Code 202, 343-8211 or Government Dial Code 183, extension 38211, shall be contacted for determination as to whether the quanities involved can be diverted to GSA stock for other utilization. GSA will monitor all orders for wood or executive type furniture placed with Federal Supply Schedule contractors.

7. *Other issuances affected.* The use standards for office furniture included in FPMR 101-25.302-1 are replaced by this regulation.

8. *Effective date.* This regulation is effective October 14, 1966.

9. *Expiration date.* This regulation expires June 30, 1967, unless sooner rescinded or revised, and as appropriate will be incorporated in the permanent Federal Property Management Regulation, Title 41, CFR.

Dated: October 14, 1966.

LAWSON B. KNOTT, Jr.,
Administrator of General Services.

[F.R. Doc. 66-11357; Filed, Oct. 17, 1966; 8:48 a.m.]

OFFICE OF EMERGENCY PLANNING

NEBRASKA

Notice of Major Disaster

Notice of Major Disaster for the State of Nebraska, dated September 1, 1966, and published September 8, 1966 (31 F.R. 11783), is hereby amended to include the following county among those counties determined to have been adversely affected by the catastrophe declared a major disaster by the President in his declaration of August 31, 1966:

Sherman County.

Dated: October 11, 1966.

FARRIS BRYANT,
Director,
Office of Emergency Planning.

[F.R. Doc. 66-11290; Filed, Oct. 17, 1966; 8:45 a.m.]

INTERSTATE COMMERCE COMMISSION

[Notice 1427]

MOTOR CARRIER TRANSFER PROCEEDINGS

OCTOBER 13, 1966.

Synopses of orders entered pursuant to section 212(b) of the Interstate Commerce Act, and rules and regulations prescribed thereunder (49 CFR Part 179), appear below:

As provided in the Commission's special rules of practice any interested person may file a petition seeking reconsideration of the following numbered proceedings within 20 days from the date of publication of this notice. Pursuant to section 17(8) of the Interstate Commerce Act, the filing of such a petition will postpone the effective date of the order in that proceeding pending its disposition. The matters relied upon by

petitioners must be specified in their petitions with particularity.

No. MC–FC–68605. By order of October 10, 1966, the Transfer Board approved the transfer to Hoag Trucking, Inc., Philip, S. Dak., of the operating rights in certificate No. MC–124755 (Sub-No. 3), issued September 21, 1964, to Homer Hoag, doing business as Hoag Trucking Co., Post Office Box 307, Philip, S. Dak., authorizing the transportation of feed, over irregular routes, from Sioux City, Iowa, to Wall, S. Dak., and points other than incorporated cities or towns, within 50 miles of Wall, S. Dak., and in permits Nos. MC–116751 and MC–116751 (Sub-No. 4), issued September 21, 1964, and July 20, 1965, respectively, to Homer Hoag, the former authorizing the transportation of lumber, over irregular routes, from points in Montana, Wyoming, North Dakota, Utah, Colorado, Nebraska, Minnesota, Iowa, Michigan, Illinois, Arkansas, Washington, Oregon, and Idaho, to Philip, S. Dak., and the latter the transportation of lumber and lumber products, over irregular routes, from points in Idaho, Montana, Orgeon, and Washington to points in South Dakota. Dual operations were authorized.

No. MC–FC–69083. By order of October 10, 1966, the Transfer Board approved the transfer to Edward F. Milovicz, doing business as Mexico Motor Express, Mexico, N.Y., of certificate No. MC–80714, issued August 14, 1957, to Horace B. Schellenberg, doing business as Pulaski Motor Express, Pulaski, N.Y., authorizing the transportation of general commodities, with usual exceptions, over regular routes, between Syracuse and Lacona, N.Y., and between Syracuse and Hastings, N.Y., serving certain intermediate and off-routes points. Robert S. Amdursky, 26 East Oneida Street, Oswega, N.Y., attorney for applicants.

No. MC–FC–69084. By order of October 10, 1966, the Transfer Board approved the transfer to Jackson Trucking, Inc., of permit No. MC–71883, issued January 4, 1954, to A. G. Jackson, Jamestown, N.Y., authorizing the transportation over regular routes, of: Packinghouse products, from Buffalo, N.Y., to specified points in New York and Pennsylvania, and from Jamestown, N.Y., to specified points in New York and Pennsylvania; and, over irregular routes, commodities classified in 46 M.C.C. 23 as (a) meat, meat products and meat byproducts; (b) dairy products, and (c) articles distributed by meat packinghouses from Jamestown, N.Y., to points in Allegany County, N.Y., and those in Potter, Elk, Cameron and Forest Counties, Pa., packinghouse products and dairy products, fresh fruits and vegetables, from Buffalo, N.Y., to points in Erie County, Pa.; and packinghouse products, restricted to transportation in conjunction with pool-car shipments, from Jamestown, N.Y., to points in Erie County, Pa., on and east of Pennsylvania Highway 8, those in Cattaraugus and Chatauqua Counties, N.Y., and those in Warren and McKean Counties, Pa. William J. Hirsch, 43 Niagara Street, Buffalo, N.Y. 14202, attorney for applicants.

No. MC–FC–69091. By order of October 10, 1966, the Transfer Board approved the transfer to James D. Zelka and Richard Strucky, doing business as James Zelka Trucking, 120 North Custer Avenue, Hardin, Mont. 59034, of certificate of registration No. MC–120931 (Sub-No. 1) evidencing a right to engage in the transportation in interstate or foreign commerce of express and freight, between points in Montana, issued August 13, 1964, to Ben Feller, Hardin, Mont., and acquired by James Zelka, doing business as James Zelka Trucking, pursuant to consummation of No. MC–FC–68623 on May 29, 1966.

No. MC–FC–69092. By order of October 10, 1966, the Transfer Board approved the transfer to E. Edna Mulholland, doing business as James Mulholland Moving & Storage, Upper Darby, Pa., of the operating rights in certificate No. MC–74576, issued March 8, 1941, to James Mulholland, Upper Darby, Pa., authorizing the transportation of: Household goods, over irregular routes, between points and places in the Philadelphia, Pa., commercial zone, as defined by the Commission in 17 M.C.C. 533, on the one hand, and, on the other, points and places in Pennsylvania, New Jersey, Maryland, New York, and Delaware. John J. Robinson, 7100 West Chester Pike, Upper Darby, Pa., attorney for applicants.

No. MC–FC–69097. By order of October 10, 1966, the Transfer Board approved the transfer to Blaine L. White, doing business as Blaine White & Son, R.F.D. No. 2, Rexburg, Idaho, of the operating rights in certificate No. MC–125142, issued November 15, 1963, to White Enterprises, Inc., R.F.D. No. 2, Rexburg, Idaho, authorizing the transportation, over regular routes, of animal and poultry feed between Ogden, Utah, and Ashton, Idaho, serving certain intermediate and off-route points.

No. MC–FC–69112. By order of October 12, 1966, the Transfer Board approved the transfer to Mid Continent Freight Lines, Inc., a Minnesota corporation, Minneapolis, Minn., of the operating rights in certificate Nos. MC–103158 (Sub-No. 29), MC–108158 (Sub-No. 50), MC–108158 (Sub-No. 51), and MC–108158 (Sub-No. 52), issued June 22, 1962, February 23, 1962, June 28, 1961, and November 16, 1962, respectively, to Mid Continent Freight Lines, Inc., an Oklahoma corporation, Minneapolis, Minn., authorizing the transportation of: General commodities, with the usual exceptions, between specified points and areas in Oklahoma, Missouri, Kansas, Illinois, Minnesota, Wisconsin, Indiana, and Texas. Donald A. Morken, 1000 First National Bank Building, Minneapolis, Minn. 55402, attorney for applicants.

[SEAL] H. NEIL GARSON,
Secretary.

[F.R. Doc. 66–11315; Filed, Oct. 17, 1966; 8:47 a.m.]

[Notice 271]

MOTOR CARRIER TEMPORARY AUTHORITY APPLICATIONS

OCTOBER 13, 1966.

The following are notices of filing of applications for temporary authority under section 210a(a) of the Interstate Commerce Act provided for under the new rules in Ex Parte No. MC 67 (49 CFR Part 240), published in the FEDERAL REGISTER, issue of April 27, 1965, effective July 1, 1965. These rules provide that protests to the granting of an application must be filed with the field official named in the FEDERAL REGISTER publication, within 15 calendar days after the date notice of the filing of the application is published in the FEDERAL REGISTER. One copy of such protest must be served on the applicant, or its authorized representative, if any, and the protest must certify that such service has been made. The protest must be specific as to the service which such protestant can and will offer, and must consist of a signed original and six copies.

A copy of the application is on file, and can be examined, at the Office of the Secretary, Interstate Commerce Commission, Washington, D.C., and also in the field office to which protests are to be transmitted.

MOTOR CARRIERS OF PROPERTY

No. MC 844 (Sub-No. 4 TA), filed October 11, 1966. Applicant: C. O. HAY, doing business as HAY TRUCKING CO., 954 Barton Street, Post Office Box 6367, McKellar Station, Memphis, Tenn. 38106. Applicant's representative: R. Connor Wiggins, Jr., Suite 909, 100 North Main Building, Memphis, Tenn. 38103. Authority sought to operate as a *common carrier*, by motor vehicle, over regular routes, transporting: *General commodities* (except those of unusual value, and except livestock, commodities in bulk, commodities requiring special equipment, and those injurious or contaminating to other lading), from Brinkley, Ark., to Lonoke, Ark., over U.S. Highway 70, and return over the same route, serving the intermediate point of Carlisle, Ark., for 180 days. Supporting shippers: J. D. Wood, Inc., Lonoke, Ark., Woody's Hardware Co., Lonoke, Ark., Robinson & Lilly Service Co., Inc., Lonoke, Ark., Joe Royal Chevrolet Co., Lonoke, Ark., G. P. Cazer Equipment Co., Carlisle, Ark., Bailey's Auto and Tractor Parts, Carlisle, Ark., Baldwin Oil Co., Inc., Carlisle, Ark., Carlisle Motors, Inc., Carlisle, Ark. Send protests to: William W. Garland, District Supervisor, Interstate Commerce Commission, Bureau of Operations and Compliance, 390 Federal Office Building, 167 North Main Street, Memphis, Tenn. 38103.

No. MC 30844 (Sub-No. 225 TA), filed October 11, 1966. Applicant: KROBLIN REFRIGERATED XPRESS, INC., Post Office Box 5000, 2125 Commercial Street, Waterloo, Iowa 50704. Applicant's representative: James F. Sexton (same address as applicant). Authority sought

to operate as a *common carrier*, by motor vehicle, over irregular routes, transporting: *Frozen foods*, from the plantsite of the Kitchens of Sara Lee at Deerfield, Ill., and warehouse facilities utilized by the Kitchens of Sara Lee at Chicago, Ill., to points in Connecticut, Delaware, Maryland, Massachusetts, New Jersey, New York, Pennsylvania, Rhode Island, and the District of Columbia, for 150 days. Supporting shipper: Kitchens of Sara Lee, 500 Waukegan Road, Deerfield, Ill. 60015. Send protests to: Charles C. Biggers, District Supervisor, Interstate Commerce Commission, Bureau of Operations and Compliance, 235 Federal Building, Fourth and Perry Streets, Davenport, Iowa 52801.

No. MC 110144 (Sub-No. 8 TA), filed October 11, 1966. Applicant: JACK C. ROBINSON, doing business as ROBINSON FREIGHT LINES, Post Office Box 4126, 3600 Paper Mill Road, Knoxville, Tenn. 37921. Applicant's representative: Jack C. Robinson, Post Office Box 4126, Knoxville, Tenn. 37921. Authority sought to operate as a *common carrier*, by motor vehicle, over regular routes, transporting: *General commodities*, except classes A and B explosives, household goods as defined by the Commission, commodities in bulk, and those requiring special equipment, between Memphis, Tenn., and West Monroe, La.: From Memphis over U.S. Highway 61 to junction U.S. Highway 82, thence over U.S. Highway 82 to Montrose, Ark.; thence over U.S. Highway 165 to West Monroe, La., and return over the same route, serving the intermediate points of Bastrop and Monroe, La., and the off-route point of Sterlington, La., for 180 days. Supporting shippers: The application is supported by statements of 28 shippers which may be examined here at the Interstate Commerce Commission, Washington, D.C. Send protests to: J. E. Gamble, District Supervisor, Bureau of Operations and Compliance, Interstate Commerce Commission, 706 U.S. Courthouse, Nashville, Tenn. 37203.

MOTOR CARRIER OF PASSENGERS

No. MC 128637 TA, filed October 11, 1966. Applicant: JELCO BUSES, INC., doing business as, HALVORSON BUS LINES, Route 4, Box 440, Sparta, Wis. 54656. Authority sought to operate as a *contract carrier*, by motor vehicle, over irregular routes, transporting: *Passengers and their baggages*, in charter movements, (1) between Chicago, Ill., and Minneapolis, Minn., on the one hand, and, on the other, Camp McCoy, Wis., and (2) beginning and ending at Camp McCoy, Wis., and extending to points in Illinois, Minnesota, Iowa, and Missouri, for 180 days. Supporting shipper: Office of Economic Opportunity, McCoy Job Corps Center, Post Office Box 255, Sparta, Wis. 54656. Send protests to: C. W. Buckner, District Supervisor, Interstate Commerce Commission, Bureau of Operations and Compliance, 214 North Hamilton Street, Madison, Wis. 53703.

By the Commission.

[SEAL] H. NEIL GARSON, *Secretary*.

[F.R. Doc. 66-11316; Filed, Oct. 17, 1966; 8:47 a.m.]

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PART II

Department of Health, Education, and Welfare

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Social Security Administration

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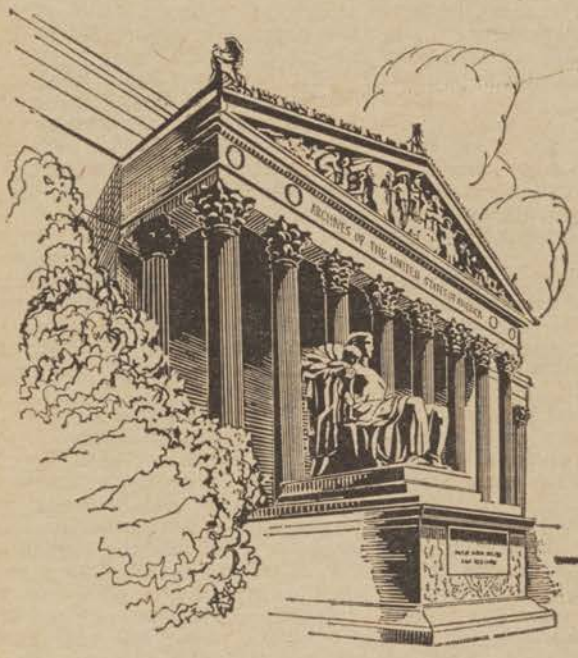
Federal Health Insurance for the Aged



Principles of Reimbursement for Provider Costs and for Services by Hospital-based Physicians

Title 20—EMPLOYEES' BENEFITS

Chapter III—Social Security Administration, Department of Health, Education, and Welfare

[Reg. No. 5]

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED (1965 _____)

Subpart D—Principles of Reimbursement for Provider Costs and for Services by Hospital-Based Physicians

On June 28, 1966, there was published in the FEDERAL REGISTER (31 F.R. 8940) a notice of proposed rule making relating to the principles of reimbursement to be followed in identifying the source and amount of benefit payments under title XVIII of the Social Security Act (20 CFR Part 405) for services performed by hospital-based physicians. Interested persons were given the opportunity to submit written comments within 30 days after publication.

Written submissions were received and considered. Certain changes were made in the proposed regulations pursuant to these comments. The following changes are considered to be the most important:

(1) Section 405.480(f) has been revised to make the regulations responsive to situations where a physician is compensated by a medical school or other organization for services he furnishes to hospital patients.

(2) Section 405.483(c) has been changed to make the optional, uniform percentage method available in certain cases for the recordation and billing for services other than pathology and radiology services.

(3) A new paragraph (c) has been added to § 405.485 to make the regulations responsive to situations where the charges for hospital-based physicians' services are billed by a hospital as part of its fixed, all-inclusive rate.

Other changes of a clarifying and editorial nature have been made.

Chapter III, Title 20 is amended by adding thereto §§ 405.480 through 405.488, to read as set forth below. The addition of §§ 405.480 through 405.488 to Title 20 shall be effective upon publication in the FEDERAL REGISTER.

Dated: October 4, 1966.

[SEAL] ROBERT M. BALL,
Commissioner of Social Security.

Approved: October 11, 1966.

JOHN W. GARDNER,
Secretary of Health, Education, and Welfare.

Subpart D—Principles of Reimbursement for Provider Costs and for Services by Hospital-Based Physicians

Sec.

AUTHORITY: The provisions of this Subpart D issued under secs. 1102, 1814(b), 1833(a), 1861(v), and 1871, 49 Stat. 647, as amended, 79 Stat. 296, 79 Stat. 302, 79 Stat. 322, 79 Stat. 331; 42 U.S.C. 1302, 1395 et seq.

§ 405.480 Determining reimbursement for services performed by hospital-based physicians.

(a) *General.* The Health Insurance for the Aged Act establishes two separate health insurance programs for the elderly. One provides hospital insurance protection to nearly all the aged financed largely through social security taxes (see Subpart A of this part). The other provides supplementary medical insurance to aged people who enroll and agree to pay monthly premiums, that are matched with amounts from Federal general revenues (see Subpart B of this part).

(b) *Sources of benefit payments.* Under the law, benefit payments for the services of physicians (except for services of residents and interns under professionally-approved training programs) furnished to individual patients are under the supplementary medical insurance program (see Subpart B of this part). However, some of the services which hospital-based physicians perform are clearly not furnished to an individual patient. To the extent that the cost of such services is borne by the hospital, reimbursement will be made to the hospital under the hospital insurance program or, in certain cases, as a hospital cost under the supplementary medical insurance program.

(c) *Applicability of principles of reimbursement.* The principles set forth in §§ 405.480–405.488 deal principally with the identification of the source and amount of benefit payments under the program for services performed by physicians (other than interns and residents) in a hospital setting under circumstances where physicians typically are salaried or receive compensation from or through the hospital under arrangements such that the physician is paid an agreed amount or the hospital remits to him an agreed portion of the collections from patients and the hospital collects the funds from patients either in its own right or as agent for the physician. These principles establish criteria for distinguishing between those services of physicians who are so compensated which are reimbursable to hospitals and such physicians' services to patients reimbursed under the supplementary medical insurance program. The principles also establish a basis for determining the reasonable charges for physicians' services to patients in situations where, under existing arrangements between hospitals and physicians, billings to patients have not separately identified charges for physicians' services and charges for hospital services. (Where charges for physicians' services to patients have been identified separately from charges for hospital services, the customary charges for physicians' services thus will have been established and a basis afforded for determining the reasonable charges for such services. Where, for example, as is sometimes the case in the arrangements between hospital-based physicians and hospitals, especially, but not exclusively, in the arrangements between teaching hospitals and surgeons, among others, the charges for the physicians' services to the patient are separately identified, the determination of the reasonable charges for such services will take into account customary charges of such physicians so established.) Finally, the principles establish a basis for ascertaining the customary charges for a physician's services to patients in situations where, under the previously existing arrangement between the hospital and the physician, charges to patients had not been separately identified but where under a modification of the previously existing arrangement the hospital and the physician agree to bill patients separately for their respective services.

(d) *Arrangements for services of hospital-based physicians.* (1) Hospitals in the United States have in force a wide variety of arrangements for the compensation of hospital-based physicians. The Health Insurance for the Aged program does not required change in the substance of these arrangements, whether the arrangements call for compensation by way of salary, or a percentage, or in any other manner, or whether payments are received by the hospital (either in its own right or as agent for the physician) or are received directly by the physician.

(2) In many cases, a physician contracts with a hospital to provide only his own professional services, the hospital assuming the cost of supporting personnel (who, in this case, are hospital employees) and bearing the expense of furnishing space, supplies, and the like. Sometimes, however, the physician assumes some or all of these costs. In some instances, the arrangement may constitute a concession or lease, the physician employing the supporting personnel and bearing all other expenses, including a payment to the hospital for the use of space.

(e) *Types of services rendered.* Many hospitals retain physicians on a full-time basis as, for example, in the fields of pathology, physiatry, anesthesiology, and radiology, and in many instances (especially in teaching hospitals) in other fields of medical specialization as well. The functions of these physicians vary widely. In some cases they devote full time to education or administration. Conversely, some are exclusively concerned with patient care. Any one of these physicians may be engaged in a

variety of activities including teaching, research, administration, supervision of professional or technical personnel, service on hospital committees, and other hospital-wide activities, as well as direct personal health services to individual patients. Sometimes the hospital's arrangement is made with a group of physicians who assume joint responsibility for discharging agreed-upon duties.

(f) *Provisions for remuneration.* The compensation to the physician generally is either on a salary basis, a percent of the gross income received from the patients for the particular services (usually a group of related services—all those performed in a radiology department, for example), or a percent of the net income (gross income less related expenses) received from patients, or some modification or combination of these (such as percentage with a guaranteed minimum). Generally the hospital collects the charges for the services of these physicians and their supporting personnel, acting in some cases in its own right, in some as agent for the physician. Where the arrangement between the hospital and the physician is that the compensation to the physician is on a salary or percentage of income basis, and the parties to the arrangement have thus agreed between themselves on the amount or the measure of compensation to be received by the physician for his services, the sum of the payments, with respect to the physician's services, under both the hospital insurance program and the supplementary medical insurance program (including deductible and coinsurance amounts payable by beneficiaries) should approximate that portion of the agreed upon compensation which is attributable to covered services. Some hospitals, moreover, have arrangements with medical schools or other organizations under which physicians receive compensation from such organizations for services the physicians provide to hospital patients. The remuneration of physicians from such sources may be included in determining reasonable charges for physicians' services in accordance with § 405.485(a).

(g) *Identification of types of services for purposes of program payments.* However the billing is handled and whatever the method of distributing the proceeds between the hospital and the physician, it has been the almost universal practice to make a single charge to the patient for each of these services. In order to make payments under title XVIII of the Act, however, it is necessary, where billing is by or through the hospital, to distinguish between the medical and surgical services rendered by a physician to a patient, on the one hand, and the hospital services (including physicians' services for the hospital), on the other. This is required because the payments will come from different trust funds, the payments will usually be handled by different intermediaries, and the methods of determining the two payments will differ materially. Thus, there are two sources of payment under the health insurance program for services furnished to beneficiaries covered under title XVIII of the Act. The hospital and the physician may, however, if they wish, pool the two payments where received by the hospital in its own right or as agent for the physician and may distribute the proceeds in accordance with their preexisting arrangement, or in any other way on which they may agree.

§ 405.481 Noninterference by Federal Government.

It is not the function of the health insurance programs established under title XVIII of the Act to determine the arrangement which a hospital and a hospital-based physician may enter into for the compensation of the physician. The Secretary will not specify or influence the provisions of the contract or arrangement between hospitals and hospital-based physicians. The hospital and physician can continue to negotiate all aspects of their arrangement to their mutual satisfaction. The principles in this Subpart D are designed to give recognition to the arrangement entered into by a hospital and a physician by establishing criteria for determining, within the framework of the arrangement, amounts payable under the hospital insurance program and amounts payable under the supplementary medical insurance program to the end that the total payments with respect to the physicians' services to the hospital and for the patient are related as closely as is possible to the level of compensation the parties have agreed upon.

§ 405.482 Program payments for physicians' services to hospitals and to individual patients.

(a) *Principle.* Whatever the arrangement may be between hospital and physician, the law requires that medical and surgical services rendered to a covered individual by a hospital-based physician be reimbursed only under the supplementary medical insurance program—Part B of title XVIII of the Act. The costs to a hospital for services furnished in a hospital by a physician which are not professional services to a patient are included in the reasonable cost reimbursement to the hospital.

(b) *Physicians' services to patients.* Title XVIII of the Act specifically excludes from hospital cost reimbursement under Part A the cost of medical or surgical services provided by a physician, resident, or intern except for those services rendered by interns or residents in approved teaching programs. Therefore, compensation paid by the hospital to the hospital-based physician cannot be included in hospital reimbursable cost to the extent that it represents compensation for physicians' services described in § 405.483. Phyicians' services, as defined in section 1861(q) of the Act, means "professional services performed by physicians, including surgery, consultation, and home, office and institutional calls * * *."

§ 405.483 Physician service under Part B.

(a) *Principle.* A professional service rendered by a physician to a hospital patient that can be reimbursed only under the supplementary medical insurance program (Part B of title XVIII of the Act), as distinguished from his professional services which are of benefit to patients generally, means an identifiable service requiring performance by a physician in person, which contributes to the diganosis of the condition of the patient with respect to whom the charge under the supplementary medical insurance program is to be recognized, or contributes to the treatment of such patient.

(b) *Recordation and billing of charges on item-by-item basis.* The component of the hospital-based physician's services for which reimbursement must be made under Part B of title XVIII of the Act, the supplementary medical insurance program, is only that part of his professional services with respect to which he is personally involved in the provision of services to individual patients as distinct from other professional services he may render in the hospital setting, such as teaching, research, performance of autopsies, committee work, quality control activities and administration. Compliance with this principle for various types of services rendered by hospital-based physicians normally will require (1) determination with respect to each separate service or type of service rendered, of what part may properly be charged under the supplementary medical insurance program, (2) compilation of the results of these determinations in the form of a schedule either of amounts or percentages applicable to separate services or types of services, and (3) recordation of such charges on an item-by-item basis for each service rendered to a patient.

(c) *Optional method of recordation and billing on a uniform-percentage basis.* (1) Application of the item-by-item method may present special problems in the case of a particular hospital department. This is illustrated by pathology laboratory services and radiology services, which involve a high volume of individual procedures, variation in the extent of involvement in services on the part of technicians and others and on the part of the physician, and difficulty in distinguishing between professional activities which are of general benefit to all patients and those performed directly for an identifiable patient. Where the physician participates personally in some procedures and not in others by virtue of quality control activities or because his professional concern is directed to the result in a given case, it may be difficult to ascertain the presence or absence of a specific quantum of professional activity in an individual case. Moreover, the assigning of the appropriate amount of "professional component" to a particular procedure or test for a particular patient receiving the benefit of the physician's service, as defined in paragraph (a) of this section, may not only result in inequality of charges among patients but also may present an undue task of recordation. Administratively costly and impractical requirements could ensue in collecting

the data needed for presentation of bills involving minimal charges on an item-by-item basis to individual patients. Under these conditions, it may not be administratively practical for the physician, the hospital and the Part B carrier to keep track of appropriate professional charges on an item-by-item and patient-by-patient basis.

(2) With respect to pathology services, for example, an individual entitled to Part B benefits under title XVIII of the Social Security Act (in connection with a hospital stay, or in connection with a series of outpatient diagnostic tests) will, on the average, have multiple laboratory procedures which in the aggregate permit the assumption that at some point with respect to at least some of the laboratory services there has been "an identifiable service requiring performance by a physician in person."

(3) In order to facilitate administration, provide a better cost control, and to assure a practical basis for handling charges to individual patients, an optional method of recordation and billing may be elected upon agreement by the physician and the hospital in appropriate cases. Under this optional method, the component of the physician's services to patients would be determined for all medicare patients through application of a uniform percentage to the total charges for such services in a particular department, with the percentage used being designed to produce in the aggregate a measurement of the professional component attributable to patient services which would not be significantly different in amount from that produced by the method of itemization of detailed measurement of such components reflecting variation in the factor of personal participation of the physician in each individual procedure for each individual patient. The percentage factor will be considered reasonable if it can be shown that it does not result from attributing as medical services to patients the costs of teaching, research, administration, and other services that are clearly reimbursable under the hospital insurance program.

(4) Election to use the optional method does not alter the applicability of the principles as the basic criterion for distinguishing professional services chargeable under the supplementary medical insurance program from those to be included in the hospital's reimbursable costs. The optional method is not available where it would result in a charge to medicare patients for services which are not ordinarily furnished by the physicians of the department of the hospital to hospital patients utilizing the services of that department.

§ 405.484 Hospital-physician agreements for physician compensation.

(a) *Principle.* For purposes of reimbursement, intermediaries and carriers will respect, within reasonable limits, an agreement between a hospital and a physician concerning the portion of the physician's compensation which, if he is engaged in the care of individual patients, is to be attributed to such care, and the portion which is to be attributed to service to the institution. The procedure hospitals and physicians are to follow in obtaining review of their agreement by intermediaries is described in § 405.487. The amount attributed to the care of patients will, to the extent of services rendered to supplementary medical insurance beneficiaries (identified in accordance with § 405.483), be recognized as proper charges to such patients, reimbursable under the supplementary medical insurance program. The amount attributed to service to the institution will be recognized as a cost which is reimbursable to the hospital.

(b) *Scope and effect of agreement.* Typically, contracts between hospital-based physicians and hospitals provide for the payment of an aggregate amount (in the form of a salary, a percentage arrangement, or on some other basis) to the physician for all of his services within the institution without a service-by-service itemization. Where the physician is on salary and normally spends full time in administation of departmental affairs, the full salary may be considered a reimbursable hospital cost item and medicare will bear its proportionate share of such cost. Where a salaried physician devotes only part of his time to institutional affairs and also renders an appreciable volume of personal patient care, only part of his salary may be attributed to hospital costs since the law requires that "medical or surgical services" must be excluded in determining a hospital's reimbursable costs.

(c) *Allocation of compensation by parties.* An agreement by the parties that a certain portion of the physician's compensation will be excluded from hospital costs and will be charged to those patients who are identified in accordance with § 405.483 will be respected unless, because of the small portion of time the physician devotes to the personal care of patients, such an agreement could lead to unreasonable charges to such patients.

§ 405.485 Schedules of charges for Part B physician's services.

(a) *Principle.* Once the portion of a physician's compensation attributable to professional services to supplementary medical insurance beneficiaries has been determined, a schedule of charges can be developed. To be deemed reasonable the charges should be designed to yield in the aggregate, as nearly as may be possible, an amount equal to such portion of his compensation. As among the patients to be charged (identified in accordance with § 405.483), the allocation of charges may be based on a schedule of relative values, on a uniform percentage of the charges made by the hospital or the physician to other patients for both professional and supporting components of the services, or on another method approved by the carrier as equitable.

(b) *Development of schedules.* Since the present almost universal practice does not separate the profesional services to individual patients from the other components of hospital-based physicians' services for purposes of determining the manner or amount of his compensation, it is necessary to devise a method for making this separation. The approach set forth in this section starts with the assumption that the present level of compensation of hospital-based physicians is reasonable. The assumption, of course, is open to challenge in any given case, and the carriers must deal with such challenges on the basis of prevailing rates of compensation in comparable institutions. Over a period of time the schedules of charges will be subject to revision in the light of changes in the prevailing levels of compensation.

(c) *Development of charges on per diem basis.* Some relatively few hospitals in which the hospital-based physicians are compensated by salary or other fixed amount of remuneration do not charge on a fee-for-service basis for each service provided a patient, but charge a fixed, all-inclusive rate, computed on a daily or other time basis or a per-visit basis, applicable uniformly to each patient without regard to the quantum of service required by the patient and without distinction between hospital services and physicians' services. Psychiatric hospitals, tuberculosis hospitals, and some governmental general hospitals commonly follow such a charge practice. Other hospitals use the fixed charge method for all services or only in connection with the services of certain of their departments while charging on a fee-for-service basis for the various services actually furnished to the patients in other departments. Where the billing by the hospital is on a per diem or other time period basis or on a per-visit basis, charges for the professional services of hospital-based physicians to patients may be computed on such a basis for program purposes. Under this method, after the apportionment of the physicians'compensation has been made in accordance with § 405.484, a per diem, per visit, or other unit charge can be developed, designed to yield in the aggregate, as nearly as may be possible, an amount equal to the physicians' compensation attributable to professional services to patients.

§ 405.486 Effect of physician's assumption of operating costs.

(a) *Principle.* Where a hospital-based physician himself bears some or all of the costs of operation of a hospital department and bills his patients directly rather than through the hospital, the reasonable charges for his services recognized under the supplementary medical insurance program will reflect the costs so borne by him. Where all the costs are to be borne by the physician, charges heretofore established for such services by agreement between the physician and the hospital may be acceptable as reasonable charges for purposes of the supplementary medical insurance program, but they will require adjustment either upward or downward if the hospital has been bearing a cost significantly greater or less than its share of the proceeds of such charges.

(b) *Billing for physician services.* (1) The objective in determining reasonable charges where the physician bills patients directly is the same as that expressed in § 405.485(a); to bring about as little change as possible (in the normal case) in the compensation the physician receives for his services in the hospital. Where the physician bills the patient directly, costs of operating the hospital department which are borne by the physican will be reflected in his reasonable charges which are compensable under the supplementary medical insurance program; the hospital will receive reimbursement through the hospital insurance program for those costs, if any, which it incurs. Where, however, a hospital initially pays some or all of the operating expenses of a hospital department (e.g., pays the salaries of nonprofessional personnel and purchases supplies and equipment), even though subsequently those items and services for which it pays the operating expenses are furnished for the use of the physician in return for an agreed upon payment by the physician to the hospital, such operating costs are reimbursable under the hospital insurance program as hospital costs, and are not to be reflected in the reasonable charges of the physician. Any payments received by the hospital under such an arrangement shall be treated as a reduction of allowable costs of the hospital reimbursable through the hospital insurance program.

(2) Where a hospital has been receiving, as its portion of the receipts for such services, significantly more or less than the costs the hospital has incurred in the provision of the services, this excess or shortage should not be transferred from the hospital to the physician merely because he decides to bill his patients directly. Since payment to the hospital is made on the basis of its reasonable costs for all hospital services, the transfer of such excess or shortage to the physician necessarily would alter the total cost of patient hospital and medical care—a result which the legislation was not intended to bring about. The reasonable charges of a physician who enters into a lease or similar arrangement with a hospital under which the physician assumes the costs of operating the department and bills the patients directly would be based upon the remuneration he received for his services immediately prior to the leasing arrangement plus his reasonable costs of operation, taking into account the hospital's cost experience in providing such services. Reasonable charges, so determined, would be subject to appropriate future adjustment to take into account changing economic factors. Reference back to the remuneration formerly received by the physician from the hospital as a factor in determining his reasonable charges under the lease or similar arrangement is required to give effect to the provisions of the statute which direct that consideration be given, in determining reasonable charges, to the customary charges generally made by the physician for similar services. Where no pattern of customary charges has been established for the physician's professional services to patients other than the compensation he received from the hospital for his services, such compensation would serve as the basis for establishing the customary charge.

(3) Since prevailing charges of physicians in the locality for similar services also are to be considered in determining reasonable charges of a physician, the charges of nonhospital laboratories, clinics, and the like for similar services would be taken into account in determining whether or not the customary charges, established in accordance with §§ 405.480 through 405.488, are within the range of prevailing charges. The situations, however, are frequently not comparable because of the large volume, and consequent low unit cost, of a laboratory that performs all of the services required in a hospital. Although charges prevailing in nonhospital laboratories are to be taken into account, they will not be guides for determining reasonable charges in situations where they would produce an unreasonable result.

(4) Although the law excludes physicians' services from the definition of hospital services, it further provides that services of nonphysicians aiding physicians are not deemed to be the services of a physician and are covered under the hospital insurance plan whether they are furnished by the hospital or by a physician under an arrangement with the hospital which calls for billing for such services to be by or through the hospital exclusively. Where, therefore, billing for services of a hospital department, including the services of the physician in such department, is by or through the hospital, the charges for the physician's services to the patient and for the nonphysician components of the services furnished by the physician under his arrangement with the hospital shall be determined as provided in subparagraph (1) of this paragraph, and may be included in a single bill which identifies separately the amounts billed for the respective components of the services. The amount of the physician's charge attributable to the nonphysician components of the service represents a cost to the hospital which is reimbursable to the hospital. The amount attributable to the physician's services to the patient is the physician's charge compensable under the supplementary medical insurance program.

(5) Also, tangentially related to the issue of billing for services of hospital-based physicians is the question of billing for diagnostic or therapeutic items or services not furnished in a hospital department, but under arrangements made by the hospital with outside laboratories for such items or services. Many hospitals, especially smaller hospitals, do not maintain full laboratory facilities. Such institutions frequently enter into arrangements with independent outside laboratories for the performance of diagnostic procedures, as, for example, in the field of pathology. In such instances, typically, the laboratory bills the hospital for the services performed, and the hospital, under present practices, bills the patient. Services performed under such an arrangement would be included as inpatient hospital services, and the cost thereof—that is, the cost the hospital incurs in paying the laboratory's charges for the services—would, if reasonable, be reimbursable to the hospital.

§ 405.487 Maintenance of records and review of reasonable costs and charges.

(a) *Principle.* Hospitals and hospital-based physicians will be required to keep records and furnish information to substantiate the agreements they enter into with respect to the allocation of the compensation of the physicians.

(b) *Rationale to support agreements for allocation of compensation.* (1) Where the agreement between the hospital and the physician reasonably allocates the physician's compensation between services covered as costs to be reimbursed to the hospital and those covered under the supplementary medical insurance program on a charges basis, it will generally be accepted if the parties concerned furnish an acceptable rationale for the allocation.

(2) Such allocation (made in accordance with § 405.484) should be capable of substantiation by the hospital and the physician. The parties' determination and supporting information should be reviewed by the hospital insurance intermediary and the carrier. The intermediary will be responsible for the approval of the portion of the physician's compensation which has been determined by the parties to be a cost which is reimbursable to the hospital and the carrier will be responsible for the approval or disapproval of the parties' reasonable charge determination.

(3) If the parties do not come to an agreement, or if either the hospital insurance intermediary or the carrier believes that the rationale does not justify the parties' allocation between reimbursable hospital costs and medical insurance charges, it will notify the other so that coordinated action, if necessary, can be undertaken. The fiscal intermediary responsible for hospital cost reimbursement and the carrier responsible for payments under the supplementary medical insurance program will resolve the issue by negotiation if possible, otherwise by time studies or other suitable methods.

(4) Under these principles, it is recognized that a physician who serves two or more hospitals may under his agreements have significantly different allocations and consequently significantly different charges for the same service in the different hospitals served by him.

§ 405.488 Effect of principles.

(a) Nothing in the foregoing principles restricts the right of the physician (in the absence of his acceptance of an assignment by the patient) to determine the amount of his charge to the patient for his services, or restricts the hospital and the physician in providing for such disposition of the payments received from the health insurance programs and the beneficiaries under the programs as they may agree upon.

(b) The total costs of hospital and medical services to inpatients and outpatients prior to the inauguration of this program should not be increased solely by reason of the requirement for division of payments for the services of hospital-based physicians between the hospital insurance program and the supplementary medical insurance program.

(c) The foregoing principles will, to the extent they are applicable, also govern reimbursement in cases where physicians have a financial arrangement of the kind referred to in § 405.480(c) with an extended care facility or home health agency and where a hospital-based physician provides services to the hospital's outpatients.

[F.R. Doc. 66-11271; Filed, Oct. 14, 1966; 8:48 a.m.]