to provide the necessary information to all climbers concerning the hazards associated with climbing in Denali National Park.

The NPS is promulgating this interim rule under the ''good cause'' exception of the Administrative Procedure Act (5 U.S.C. 553(b)(B) from general notice and comment rulemaking. As discussed above, the NPS believes that this exception is warranted because of the time constraints involved. Based upon this discussion, the NPS finds pursuant to 5 U.S.C. 533(b)(B) that it would be contrary to the public interest to publish a notice of proposed rulemaking. The NPS is, however, soliciting comments and will review comments and consider making changes to the rule based upon an analysis of comments.

In accordance with the Administrative Procedure Act (5 U.S.C. 531 *et seq.*), the NPS has further determined that publishing this interim rule 30 days prior to the rule becoming effective could further delay the dissemination of safety and resource related information to climbers. This also would be contrary to the public interest and the intended purpose of the rule. Therefore, under the ''good cause'' exception of the Administrative Procedure Act (5 U.S.C. 553(d)(3)), and as discussed above, the NPS has been determined that this interim rulemaking is excepted from the 30-day delay of effective date, and shall therefore become effective upon the date published in the **Federal Register**.

Because the NPS is soliciting comments as discussed above, the NPS plans to analyze comments received and prepare further rulemaking, as appropriate.

Public Participation

The policy of the National Park Service is, whenever practicable, to afford the public an opportunity to participate in the rulemaking process. However, in accordance with the above discussion, the urgent need to disseminate the information concerning the 60-day pre-registration notice and to ensure the safety of the mountain climbers, it has been determined that it is contrary to the public interest to delay the effective date of this interim rule pending public comment.

Nevertheless, interested persons are invited to submit written comments or suggestions regarding the proposed regulations to the address noted at the beginning of this rulemaking. Comments must be received on or before May 30, 1995. The NPS will review comments and consider making changes to the rule based upon an analysis of comments.

Drafting Information

The primary authors of this rule are Dennis Burnett, Washington Office of Ranger Activities and Brenda Bussard of Denali National Park and Preserve, National Park Service.

Paperwork Reduction Act

This rule does not contain collections of information which require approval by the Office of Management and Budget under 44 U.S.C. 3501 *et seq.*

Compliance With Other Laws

In accordance with the Regulatory Flexibility Act, 5 U.S.C. 601 *et seq.*, the NPS has determined that this interim rule will not have a significant economic effect on a substantial number of small entities, nor does it require a preparation of a regulatory analysis.

This rule was not subject to Office of Management and Budget (OMB) review under Executive Order 12866.

The NPS has determined that this proposed rulemaking will not have a significant effect on the quality of the human environment, health and safety because it is not expected to:

(a) Increase public use to the extent of compromising the nature and character of the area or causing physical damage to it;
(b) Introduce non-compatible uses which compromise the nature and characteristics of the area, or cause physical damage to it;
(c) Conflict with adjacent ownerships or land uses; or
(d) Cause a nuisance to adjacent owners or occupants.

Based on this determination, this interim rule is categorically excluded from the procedural requirements of the National Environmental Policy Act (NEPA) by Departmental regulations in 516 DM 6 (49 FR 21438). As such, neither an Environmental Assessment nor an Environmental Impact Statement has been prepared.

List of Subjects in 36 CFR Part 13

Alaska, National Parks; Reporting and recordkeeping requirements.

In consideration of the foregoing, 36 CFR part 13 is amended as follows:

PART 13—NATIONAL PARK SYSTEM UNITS IN ALASKA

Subpart C—Special Regulations—Specific Park areas in Alaska

1. The authority citation for part 13 continues to read as follows:

Authority: 16 U.S.C. 1, 3, 462(k), 3101 *et seq.*; § 13.65(b) also issued under 16 U.S.C. 1361, 1531.

§ 13.63 [Amended]

2. Section 13.63 is amended by revising paragraph (f) to read as follows:

* * * * *

(f) *Mountain climbing.* Climbing on Mount McKinley or Mount Foraker without registering, on a form provided by the Superintendent, at least 60 days in advance of the climb is prohibited.

Dated: March 23, 1995.

George T. Frampton, Jr.,

Assistant Secretary for Fish and Wildlife and Parks.

[FR Doc. 95–7906 Filed 3–30–95; 8:45 am]

BILLING CODE 4310–70–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General

42 CFR Part 1003

RIN 0991–AA65

Civil Money Penalties for Referrals to Entities and for Prohibited Arrangements and Schemes

AGENCY: Office of Inspector General (OIG), HHS.

ACTION: Final rule with comment period.

SUMMARY: This final rule implements the civil money penalty (CMP) provisions established through sections 1877(g)(3) and 1877(g)(4) of the Social Security Act. Specifically, in accordance with section 1877(g)(3), these regulations set forth CMPs, assessments and an exclusion against any person who presents, or causes to be presented, a bill or claim the person knows or should know is for a service unlawfully referred under section 1877(a)(1)(A) of the Act, or has not refunded amounts inappropriately collected for a prohibited referral. In addition, in accordance with section 1877(g)(4), these regulations set forth CMPs, assessments and an exclusion in cases where a physician or entity enters into an arrangement or scheme in which the physician or entity knows, or should have known, that the principal purpose is to assure referrals by the physician which, if made directly to a particular entity, would violate the prohibition on referrals described in section 1877(a) of the Act.

DATES: *Effective date:* This final rule with comment period is effective on March 31, 1995.

Comment period: Comments on the applicability of these CMPs for referrals to ''designated health services'' resulting from provisions in the Omnibus Budget Reconciliation Act (OBRA) of 1993 will

be considered if we receive them at the address specified below, no later than 5 p.m. on May 30, 1995. Broadening these CMPs to cover referrals to ''designated health services'' is discussed in sections I.C. and IV. of this preamble. We will not consider comments on provisions that remain unchanged from the October 20, 1993 proposed rule or on provisions that were changed based on public comments.

ADDRESSES: Mail comments to: Office of Inspector General, Department of Health and Human Services, Attention: LRR–30–FC, Room 5246, 330 Independence Avenue SW., Washington, DC 20201.

If you prefer, you may deliver your comments to Room 5551, 330 Independence Avenue, SW., Washington DC 20201. Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code LRR–30–FC. Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of this document, in room 5551, 330 Independence Avenue SW., Washington, DC on Monday through Friday of each week from 8:30 a.m. to 5 p.m., (202) 619–3270.

FOR FURTHER INFORMATION CONTACT: Joel Schaer, Legislation, Regulations and Public Affairs Staff, (202) 619–3270.

SUPPLEMENTARY INFORMATION:

I. Background

A. The Omnibus Budget Reconciliation Acts of 1989 and 1990

In an effort to limit physician referrals involving laboratory services, section 6204 of Pub. L. 101–239, the Omnibus Budget Reconciliation Act (OBRA) of 1989, as amended by section 4207(e) of Pub. L. 101–508 (OBRA of 1990), added a new section 1877—Limitations on Certain Physician Referrals—to the Social Security Act.

As set forth by OBRA 1989 and 1990, section 1877, with certain exceptions, prohibited a physician from making a referral to an entity for the furnishing of clinical laboratory services for which Medicare would otherwise pay, if the physician or a member of the physician's immediate family had a financial relationship with that entity. (See the discussion in section I.C. below regarding expansion of this authority to ''designated health services'' as a result of amendments set forth in OBRA 1993.) This provision further prohibited an entity from presenting, or causing to be presented, a Medicare claim or bill to any individual, third party payer or other entity for laboratory services furnished in accordance with a prohibited referral. The authority for implementing these provisions is a bifurcated responsibility between the Health Care Financing Administration (HCFA) and the OIG. The HCFA has had the responsibility for developing regulations that set forth the specific policies by which such prohibited conduct is defined, while the OIG has maintained responsibility for imposing civil money penalties (CMPs), assessments and program exclusions for violations of this referral ban.

B. Proposed HCFA and OIG Regulations

On March 11, 1992, the HCFA issued proposed regulations (57 FR 8588) setting forth provisions that would—(1) with certain specified exceptions, prohibit a physician from making a referral to an entity for the furnishing of laboratory services for which Medicare would otherwise pay, if the physician or a member of his or her immediate family has a financial relationship with that entity; and (2) prohibit an entity from presenting or causing to be presented a Medicare claim or bill for such services furnished in accordance with that referral. Because the statute was quite detailed in scope, the HCFA proposed rule adhered closely to the statutory language and adopted—with little change—several definitions, such as the definition of prohibited financial relationships and compensation arrangements.

In addition, on October 20, 1993 the OIG issued a proposed rule (58 FR 54096) that was designed to codify the penalty provisions of the statute set forth in sections 1877 (g)(3) and (g)(4) of the Social Security Act. The proposed rule addressed the establishment of CMPs of not more than $15,000 for each violation of the ban on making claims for services resulting from prohibited referrals or failing to make a refund, and CMPs of not more than $100,000 for physicians and entities who engage in a circumvention scheme to avoid detection of prohibited referrals.

C. The Omnibus Budget Reconciliation Act of 1993

The Omnibus Budget Reconciliation Act of 1993 expanded the scope of section 1877 of the Act to extend the prohibition to Medicare *and Medicaid* referrals beyond clinical laboratory service to include various ''designated health services.'' Specifically, OBRA 1993 amended the Medicaid payment provisions by adding a new section 1903(s) to state that no payments are to be made to a State for services furnished by designated health services that violate the referral prohibitions of section 1877. The provision is also applicable to the reporting and penalty provisions under sections 1877(f) and (g)(5) of the Act. The designated health services cover both diagnostic services and therapeutic items and services, including physical and occupational therapy services; radiology services; radiation therapy services and supplies; durable medical equipment (DME) and supplies; parenteral and enteral nutrients, equipment and supplies; prosthetics, orthotics and prosthetic devices and supplies; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services.

These expansions resulting from OBRA 1993—the expansion to Medicaid to be effective beginning on December 31, 1994, and the expansion to other designated health services to be effective for referrals made after December 31, 1994—were not incorporated into either the HCFA or OIG proposed rules summarized above. The HCFA intends to publish new proposed regulations—separate from the final rule addressing physician ownership of, and referrals to, entities that furnish clinical laboratory services—that will (1) cover how the referral prohibition applies to additional services now covered by section 1877 as the result of OBRA 1993, (2) explain various new exceptions added to the statute, and (3) define key terms such as financial relationship, inpatient/outpatient services, diagnostic services and DME.

However, because the penalty provisions set forth in sections 1877 (g)(3) and (g)(4) of the Act remain unchanged by these amendments, we are incorporating by reference the expansion to designated health services into our final rulemaking for sanctioning improper claims and circumvention schemes. Since the statutory changes associated with these penalty provisions are self-implementing, we believe that the regulatory revisions set forth in this rulemaking can be implemented without interpretation and that public comment would not substantially modify these regulations. We believe that affording additional proposed rulemaking under these circumstances is unnecessary and would delay the promulgation of regulations that correspond with the current statute. Therefore, we find good cause to waive proposed rulemaking for incorporating the statutory expansion to designated health services by reference into our final rulemaking. However, we are providing a 60-day comment period for

comments limited to the area of designated health services in order to give parties now covered by these CMP regulations as providers of designated health services an opportunity to make applicable comments. Although these regulations are being issued as a final rule, any additional comments will be considered for possible future amendments to the rulemaking, where appropriate.

II. Provisions of the OIG Proposed Rule

The OIG proposed regulations, published in the **Federal Register** on October 20, 1993, provided for a penalty against any person presenting a bill or claim to be paid by Medicare for services furnished under a ''self-referral'' arrangement prohibited under section 1877(a) of the Act, or any person failing to refund amounts that were inappropriately billed and collected as the result of a prohibited referral. The proposed regulations established—

- A CMP of no more than $15,000 for each service provided in accordance with a prohibited referral, for which a bill or claim was presented, or caused to be presented, or caused to be presented, or which was not properly refunded;
- An assessment of not more than twice the amount claimed for each service that was the basis for the CMP; and
- An exclusion of the individual from Medicare and State health care program participation.

In determining the amount of penalty and assessment for this violation, the proposed rule specified that the OIG would apply the five existing criteria set forth in § 1003.106(a) of the regulations, and proposed a sixth criterion to be applied to consider timeliness and completeness with respect to the appropriate refund(s).

In addition, the proposed regulations provided for a penalty against a physician or entity entering into an agreement or ''circumvention'' scheme to assure referrals which, if they were made directly, would violate the prohibition on referrals set out in section 1877(a) of the Act. One example of such a scheme would be a cross-referral arrangement where the physician owners of two different entities refer to each other. The proposed regulations established—

- A CMP of not more than $100,000 for each arrangement or circumvention scheme entered into by a physician or entity;
- An assessment of not more than twice the amount claimed by the physician or entity for each service billed under the prohibited arrangement; and
- An exclusion of the physician or entity form Medicare and State health care program participation.

In determining the amount of the penalty and assessment for this violation, the proposed rule specified that the OIG would apply the five existing criteria in § 1003.106(a) of the regulations, and proposed an additional criterion that would consider the amount of ownership interests involved.

III. Response to the Public Comments

In response to this proposed rule, the OIG received a total of five timely-filed public comments from associations and individuals. Set forth below is a summary of those comments received and our response to the various concerns they raised.

Definition of ''Timely Basis''

Comment: Proposed § 1003.102(b)(8) stated that the OIG may impose a penalty against any person ''who has not refunded on a *timely basis* amounts collected as a result of billing an individual, third party payer or other entity for a clinical laboratory service that was provided in accordance with a prohibited referral * * *'' (underlining added). The commenter believes that providers should be made aware of any time requirements to which they will be held accountable, and recommends that we define the term ''timely basis.''

Response: We agree with the commenter that this term should be clarified, and are defining ''timely basis'' in § 1003.101 of the regulations as the 60 day period from the time the prohibited amounts are collected. We believe that there is precedent for defining this time period.

Currently, the general government refund policy for *overpayments* is 30 days. For example, section 1815(d) of the Social Security Act—addressing payments to providers under part A of the Medicare program—requires a refund (or offset) of excess payments within 30 days of a final determination that the amount of payment was in excess of the amount due. However, the 30 days begins to run after a *final determination* is made that there was an overpayment, while § 1003.102(b)(8) of our regulations contemplates that the person who collected amounts for a service provided in accordance with a prohibited referral will take the initiative to refund those amounts on a timely basis without first being subject to a ''final determination.''

The HCFA regulations at 42 CFR 411.24(h) seem more analogous to the ''refund'' provision addressed in these penalty provisions than to the overpayment time periods. These HCFA Medicare secondary payer regulations require a beneficiary or other party who receives a third party payment to reimburse Medicare within 60 days. Under 411.24(h), the recipient of the third party payment is expected to take the initiative to refund the program, without first receiving notice, or having a ''determination'' by HCFA that the refund is required. Since the OIG regulations intend for persons who profit from prohibited referrals to initiate making the refund, we believe that a 60 day period is a reasonable time period to establish is defining ''timely basis.''

Clarifying the Scope of the Regulations

Comment: One commenter asked that we clarify the regulations text to specify, as we did in the preamble to the proposed rule, that *physicians*—as well as the laboratory (or designated health service provider)—may be subject to CMPs for causing the submission of claims for services resulting from prohibited referrals.

Response: We believe that the language set forth in § 1003.102 is adequate to cover the scope of these provisions. The word ''person'' as defined in § 1003.101 includes an individual, trust, estate, partnership, corporation, professional association or corporation, or other entity. Physicians, as ''individuals,'' are specifically included under this definition.

Criteria for Circumvention Scheme Sanctions

Comment: The rulemaking proposed adding a new criterion in § 1003.106(a) that would take into account the amount of ownership interests involved when determining penalty amounts or assessments for circumvention schemes. One commenter strongly supported this criterion of requiring providers to disclose the *amount* of ownership interest whenever making an ownership disclosure under section 1877 rather than just the fact of ownership interest in a facility.

Response: We appreciate the commenter's support of this additional criterion, and believe that requiring the provider to disclose the amount of ownership will act as a further deterrent to providers referring patients to facilities in which they have financial interests.

Comment: In referencing both § 1003.102(b)(9) of the proposed regulations and existing § 1003.102(c), one commenter raised concerns regarding the ability of outside third parties to effectively counsel

practitioners if such counseling activities were considered subject to penalties as part of a ''circumvention'' scheme. The commenter expressed concern that the regulation would discourage lawyers, accountants and other professionals from advising physicians on how to set up practices for fear that the advising professional would be ''adding and abetting'' a violation.

Response: This regulation is directed specifically at *physicians* and *entities* that enter into a ''cross-referral arrangement'' or a scheme which the physician or entity knows or should know is designed to circumvent the prohibitions of this provision. It should in no way discourage physicians from seeking professional advice in good faith, or discourage attorneys and accountants from giving such advice in good faith.

Resource Issues

Comment: One commenter took issue with the regulatory impact statement that states the rulemaking will have no direct effect on the economy or on Federal or State expenditures. The commenter believes that there will be a considerable increase in the workload of Medicare auditors and fraud units in their efforts to detect fraud and abuse, and believes that the impact statement should reflect these increased activities.

In addition, based on information a second commenter is currently receiving on physician ownership of other entities when individuals are requesting provider numbers, the commenter indicated that they would need to establish specific flags or edits to be adequately apprised of situations involving potential violations.

Response: We do not believe that these penalty provisions will result in significantly increased expenditures for detection efforts in this area, and believe that these concerns do not warrant altering the existing regulatory impact statement. While we do not anticipate funding levels to significantly increase as a result of this additional authority, we remain acutely aware of the issue and need for resources in general, and will continue to invite and rely on active participation from within the health care industry to aid in efforts to accurately and effectively identify and police self-referral violations.

Delaying Issuance of the Final OIG Regulations

Comment: One commenter asked that issuance of the OIG final penalty provisions be delayed until HCFA has promulgated both sets of final implementing regulations addressing prohibited referrals and prohibited arrangements and schemes under section 1877 of the Act.

Response: As indicated above, HCFA plans two separate rulemaking initiatives—one addressing clinical laboratory services and a second for designated health services—to address the prohibitions set forth in section 1877 of the Act. The OIG has always maintained, however, that its statutory CMP authorities are independent authorities under which it may bring enforcement actions before regulations are published. For that reason, we do not believe that it is necessary for the OIG to wait upon finalization of HCFA's regulations to publish in final form our CMP regulations addressing the penalty and enforcement provisions of sections 1877 (g)(3) and (g)(4).

IV. Technical Changes

As discussed above, we are incorporating into this final rule the expansion of section 1877 resulting from OBRA 1993 to include Medicare payments for much of the health care industry, i.e., for clinical laboratory services and the additional ten ''designated health services'' effective for referrals made after December 31, 1994.

V. Cross-References to the HCFA Regulations

Sections 1003.100(b)(1) (ix)–(xi), 1003.102(a)(5) and 1003.102 (b)(9) and (b)(10) cross-reference HCFA regulations' §§ 411.351 and 411.353 that will not be codified until the HCFA Physician Referral rules are published in final form. We note that these citations to the HCFA regulations are tentative and will be amended, if necessary, when those provisions are finalized.

VI. Regulatory Impact Statement

The Office of Management and Budget has reviewed this final rule with comment period in accordance with the provisions of Executive Order 12866. As discussed above, the provisions contained in this rulemaking set forth new authorities to the OIG for levying CMPs against persons or entities that file claims for services furnished on the basis of prohibited referrals or who engaged in prohibited circumvention schemes proscribed by statute. These provisions are a result of statutory changes and serve to clarify departmental policy with respect to the imposition of CMPs against persons and entities who violate the statute. We believe that the great majority of providers and practitioners do not engage in such prohibited activities and practices discussed in these regulations. As a result, we believe that the aggregate economic impact of these provisions will be minimal, affecting only those who have engaged in prohibited behavior in violation of the statute. As such, this final rule should have no effect on the economy or on Federal or State expenditures.

In addition, we generally prepare a regulatory flexibility analysis consistent with the Regulatory Flexibility Act (5 U.S.C. 601 through 612) unless the Secretary certifies that a regulation will not have a significant economic impact on a substantial number of small business entities. While some sanctions and penalties may have an impact on small entities, we do not anticipate that a substantial number of these small entities will be significantly affected by this rulemaking. Therefore, we have concluded, and the Secretary certifies, that a regulatory flexibility analysis is not required for this final rule.

List of Subjects in 42 CFR Part 1003

Administrative practice and procedure, Fraud, Grant programs—health, Health facilities, Health professions, Maternal and child health, Medicaid, Medicare, Penalties.

42 CFR part 1003 is amended as set forth below:

PART 1003—CIVIL MONEY PENALTIES, ASSESSMENTS AND EXCLUSIONS

1. The authority citation for part 1003 is revised to read as follows:

Authority: 42 U.S.C. 1302, 1320–7, 1320a–7a, 1320b–10, 1395u(j), 1395u(k), 1395dd(d)(1), 1395mm, 1395nn(g), 1395ss(d), 1396b(m), 11131(c) and 11137(b)(2).

2. Section 1003.100 is amended by revising paragraph (a); by republishing paragraph (b)(1) introductory text; by revising paragraphs (b)(1)(vi) and (b)(1)(vii); and by adding new paragraphs (b)(1)(viii)–(xi) to read as follows:

§ 1003.100 Basis and purpose.

(a) *Basis.* This part implements sections 1128(c), 1128A, 1140, 1842(j), 1842(k), 1876(i)(6), 1877(g), 1882(d) and 1903(m)(5) of the Social Security Act, and sections 421(c) and 427(b)(2) of Pub. L. 99–660 (42 U.S.C. 1320a–7, 1320a–7a, 1320a–7(c), 1320b(10), 1395mm, 1395ss(d), 1395u(j), 1395u(k), 1396b(m), 11131(c) and 11137(b)(2)).

(b) *Purpose.* * * *

(1) Providers for the imposition of civil money penalties and, as applicable, assessments against persons who—

* * * * *

(vi) Violate a requirement of section 1867 of the Act or § 489.24 of this title;

(vii) Substantially fail to provide an enrollee with required medically necessary items and services, or engage in certain marketing, enrollment, reporting, claims payment, employment or contracting abuses; or

(viii) Have submitted certain prohibited claims under the Medicare program;

(ix) Present or cause to be presented a bill or claim for designated health service (as defined in § 411.351 of this title) that they know, or should know, were furnished in accordance with a referral prohibited under § 411.353 of this title;

(x) Have collected amounts that they know or should know were billed in violation of § 411.353 of this title and have not refunded the amounts collected on a timely basis; or

(xi) Are physicians or entities that enter into an arrangement or scheme that they know or should know has as a principal purpose the assuring of referrals by the physician to a particular entity which, if made directly, would violate the provisions of § 411.353 of this title.

* * * * *

3. Section 1003.101 is amended by adding a definition for the term *timely basis* to read as follows:

§ 1003.101 Definitions

* * * * *

Timely basis means, in accordance with § 1003.102(b)(9) of this part, the 60-day period from the time the prohibited amounts are collected by the individual or the entity.

* * * * *

4. Section 1003.102 is amended by revising paragraphs (a)(3), (a)(4) introductory test, and (a)(4)(iii); and by adding paragraphs (a)(5), (b)(9) and (b)(10) to read as follows:

§ 1003.102 Basis for civil money penalties and assessments.

(a) * * *

(3) An item or service furnished during a period in which the person was excluded from participation in the program to which the claim was made in accordance with a determination made under sections 1128 (42 U.S.C. 1320a–7), 1128A (42 U.S.C. 1320a–7a), 1156 (42 U.S.C. 1320c–5), 1160(b) as in effect on September 2, 1982 (42 U.S.C. 1320c–9(b)), 1842(j)(2) (42 U.S.C. 1395u(j)), 1862(d) as in effect on August 18, 1987 (42 U.S.C. 1395y(d)), or 1866(b) (42 U.S.C. 1395cc(b));

(4) A physician's services (or an item or service) for which the person knew, or should have known, that the individual who furnished (or supervised the furnishing of) the service—

* * * * *

(iii) Represented to the patient at the time the service was furnished that the physician was certified in a medical specialty board when he or she was not so certified; or

(5) A payment that such person knows, or should know, may not be made under § 411.353 of this title.

(b) * * *

(9) Has not refunded on a timely basis, as defined in § 1003.101 of this part, amounts collected as the result of billing an individual, third party payer or other entity for a designated health service that was provided in accordance with a prohibited referral as described in § 411.353 of this title;

(10) Is a physician or entity that enters into—

(i) A cross referral arrangement, for example, whereby the physician owners of entity ''X'' refer to entity ''Y,'' and the physician owners of entity ''Y'' refer to entity ''X'' in violation of § 411.353 of this title, or

(ii) Any other arrangement or scheme that the physician or entity knows, or should know, has a principal purpose of circumventing the prohibitions of § 411.353 of this title.

* * * * *

5. Section 1003.103 is amended by revising paragraphs (a) and (b) to read as follows:

§ 1003.103 Amount of penalty.

(a) Except as provided in paragraphs (b), (c) and (d) of this section, the OIG may impose a penalty of not more than $2,000 for each item or service that is subject to a determination under § 1003.102.

(b) The OIG may impose a penalty of not more than $15,000 for each person with respect to whom a determination was made that false or misleading information was given under § 1003.102(b)(4), or for each item and service that is subject to a determination under § 1003.102(a)(5) or § 1003.102(b)(9) of this part. The OIG may impose a penalty of not more than $100,000 for each arrangement or scheme that is subject to a determination under § 1003.102(b)(10) of this part.

* * * * *

6. Section 1003.106 is amended by revising paragraph (a)(1) introductory text and paragraph (a)(1)(iv); by redesignating paragraph (a)(1)(v) as paragraph (a)(1)(vii); and by adding new paragraphs (a)(1)(v) and (a)(1)(vi) to read as follows:

§ 1003.106 Determination regarding the amount of the penalty and assessment.

(a) *Amount of penalty.* (1) In determining the amount of any penalty or assessment in accordance with § 1003.102 (a), (b)(1), (b)(4), (b)(9), and (b)(10), the Department will take into account—

* * * * *

(iv) The financial condition of the person presenting the claim or request for payment, or giving the information;

(v) The completeness and timeliness of the refund with respect to § 1003.102(b)(9);

(vi) The amount of financial interest involved with respect to § 1003.102(b)(10); and

* * * * *

Dated: October 4, 1994.

June Gibbs Brown,

Inspector General.

Approved: December 30, 1994.

Donna E. Shalala,

Secretary.

[FR Doc. 95–7845 Filed 3–30–95; 8:45 am]

BILLING CODE 4150–04–M

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

43 CFR Public Land Order 7129

[WY–930–1430–01; WYW–92953–01]

Revocation of Executive Order No. 3410, Dated February 22, 1921; Wyoming

AGENCY: Bureau of Land Management, Interior.

ACTION: Public Land Order.

SUMMARY: This order revokes an Executive order that involves 2,844.17 acres of National Forest System land withdrawn for powersite purposes in the Shoshone National Forest. The land is no longer needed for powersite purposes. This action will open 2,336.22 acres to such forms of disposition as may by law be made of National Forest System land, including exchange under the General Exchange Act of 1922. The 2,336.22 acres has been open to mining under the provisions of the Mining Claims Rights Restoration Act of 1955, and these provisions are no longer required. There are 427.95 acres that would remain closed to disposal by an overlapping withdrawal. The remaining 80 acres have been conveyed into private ownership with revocation being a record clearing action as it pertains to that land. The entire acreage, with the exception of the 80 acres,