4. Program for Delegation of Section 112 Standards as Promulgated

Requirements for approval, specified in 40 CFR 70.4(b), encompass section 112(l)(5) requirements for approval of a program for delegation of section 112 standards as promulgated by EPA as they apply to part 70 sources. Section 112(l)(5) requires that the State's program contain adequate authorities, adequate resources for implementation, and an expeditious compliance schedule, which are also requirements under part 70. Therefore, EPA is also proposing to grant approval under section 112(l)(5) and 40 CFR 63.91 of Santa Barbara's program for receiving delegation of section 112 standards that are unchanged from federal standards as promulgated. California Health and Safety Code section 39658 provides for automatic adoption by CARB of section 112 standards upon promulgation by EPA. Section 39666 of the Health and Safety Code requires that districts then implement and enforce these standards. Thus, when section 112 standards are automatically adopted pursuant to section 39658, Santa Barbara will have the authority necessary to accept delegation of these standards without further regulatory action by the District. The details of this mechanism and the means for finalizing delegation of standards will be set forth in a Memorandum of Agreement between Santa Barbara and EPA, expected to be completed prior to approval of Santa Barbara's section 112(l) program for delegation of unchanged federal standards. This program applies to both existing and future standards but is limited to sources covered by the part 70 program.

III. Administrative Requirements

A. Request for Public Comments

The EPA is requesting comments on all aspects of this proposed interim approval. Copies of the District's submittal and other information relied upon for the proposed interim approval are contained in a docket maintained at the EPA Regional Office. The docket is an organized and complete file of all the information submitted to, or otherwise considered by, EPA in the development of this proposed interim approval. The principal purposes of the docket are:

(1) To allow interested parties a means to identify and locate documents so that they can effectively participate in the approval process, and

(2) To serve as the record in case of judicial review. The EPA will consider any comments received by August 9, 1995.

B. Executive Order 12866

The Office of Management and Budget has exempted this action from Executive Order 12866 review.

C. Regulatory Flexibility Act

The EPA's actions under section 502 of the Act do not create any new requirements, but simply address operating permits programs submitted to satisfy the requirements of 40 CFR part 70. Because this action does not impose any new requirements, it does not have a significant impact on a substantial number of small entities.

D. Unfunded Mandates Act

Under Section 202 of the Unfunded Mandates Reform Act of 1995 (''Unfunded Mandates Act''), signed into law on March 22, 1995, EPA must prepare a budgetary impact statement to accompany any proposed or final rule that includes a federal mandate that may result in estimated costs to State, local, or tribal governments in the aggregate; or to the private sector, of $100 million or more. Under section 205, EPA must select the most cost-effective and least burdensome alternative that achieves the objectives of the rule and is consistent with statutory requirements. Section 203 requires EPA to establish a plan for informing and advising any small governments that may be significantly or uniquely impacted by the rule.

EPA has determined that the proposed approval action promulgated today does not include a federal mandate that may result in estimated costs of $100 million or more to either State, local, or tribal governments in the aggregate, or to the private sector. This federal action approves pre-existing requirements under State or local law, and imposes no new federal requirements. Accordingly, no additional costs to State, local, or tribal governments, or to the private sector, result from this action.

List of Subjects in 40 CFR Part 70

Environmental protection, Administrative practice and procedure, Air pollution control, Hazardous substances, Intergovernmental relations, Operating permits, Reporting and recordkeeping requirements.

Authority: 42 U.S.C. 7401–7671q.

Dated: June 30, 1995.

Felicia Marcus,

Regional Administrator.

[FR Doc. 95–16827 Filed 7–7–95; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 405

[BPO–121–P]

RIN 0938–AG48

Medicare Program; Telephone and Electronic Requests for Review of Part B Initial Claim Determinations

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule would allow beneficiaries, providers, and physicians (and other suppliers), who are entitled to appeal Medicare Part B initial claim determinations, to request a review of the carrier's initial determination by telephone or electronic transmission. (Currently, a request for review may be made only in writing.) Allowing the use of telephone and electronic requests would expedite the review process by supplementing, *not replacing*, the current review procedures. It would also improve carrier relationships with the provider and beneficiary communities by providing quick and easy access to the appeals process. (This rule would not provide for telephone or electronic requests for review of Part B initial determinations made by Peer Review Organizations and Health Maintenance Organizations.)

DATES: Comments will be considered if we receive them at the appropriate address, as provided below, no later than 5 p.m. on September 8, 1995.

ADDRESSES: Mail written comments (1 original and 3 copies) to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: BPO–121–P, P.O. Box 26688, Baltimore, MD 21207.

If you prefer, you may deliver your written comments (1 original and 3 copies) to one of the following addresses:

Room 309–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or

Room C5–09–26, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code BPO–121–P. Comments received timely will be available for public inspection as they are received, generally beginning

approximately 3 weeks after publication of a document, in Room 309–G of the Department's offices at 200 Independence Avenue, SW., Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone: (202) 690–7890).

For comments that relate to information collection requirements, mail a copy of comments to: Allison Herron Eydt, HCFA Desk Officer, Office of Information and Regulatory Affairs, Room 10235, New Executive Office Building, Washington, DC 20503.

FOR FURTHER INFORMATION CONTACT: Rosalind Little, (410) 966–6972.

SUPPLEMENTARY INFORMATION:

I. Background

Under current Medicare regulations, if a party indicates dissatisfaction with a Part B initial determination on a claim, either a review is made in accordance with regulations set forth in 42 CFR 405.807 (Review of initial determination) and section 12010 of the Medicare Carriers Manual (effective October 1990) or the request is dismissed if the appellant is not a proper party. (''Party'' is defined at § 405.802 as a person enrolled under Part B of title XVIII, his/her assignee, or other entity having standing in the initial or appellate proceedings.)

Section 405.807 sets forth the review process to be followed by a party who is dissatisfied with an initial determination by a carrier. A party is currently required to file a written request for review of the initial determination with the carrier, the Social Security Administration, or HCFA within 6 months after the date of the notice of the initial determination. The carrier may, upon request by the party, extend the time period to file a request for review if it finds the party had good cause for failing to request a timely review. The review, an independent reexamination of the entire claim, is performed by carrier staff who played no part in making the initial determination.

''Supplier'' is defined at § 400.202 as a physician or other practitioner, or an entity other than a ''provider,'' that furnishes health care services under Medicare. Although ''supplier'' encompasses physicians, for clarity in this document, we refer to both ''physicians'' and ''suppliers''.

''Provider'' is defined at § 400.202 as a hospital, a skilled nursing facility, a comprehensive outpatient rehabilitation facility, a home health agency, or a hospice, that has in effect an agreement to participate in Medicare, or a clinic, a rehabilitation agency, or a public health agency that has a similar agreement but only to furnish outpatient physical therapy or speech pathology services.

Under section 1879(d) of the Social Security Act (the Act), a provider, or a physician or other supplier that accepts assignment to furnish services to Medicare beneficiaries has the same appeal rights as an individual beneficiary under certain limited circumstances if the issue in dispute involves medical necessity or custodial care or home health denials involving the failure to meet homebound or intermittent skilled nursing care requirements. Additionally, regulations at 42 CFR part 405, subpart H (Appeals Under the Medicare Part B Program) provide that a supplier or physician that has taken assignment of a Part B Medicare claim has the same appeal rights as the beneficiary.

II. Proposed Changes to the Procedures for Requesting a Review

We propose to change the Medicare regulations at § 405.807 to allow a party to request a review of a Part B initial claim determination by telephone or by electronic transmission, in addition to the current provisions for a written request. The term ''electronic transmission'' would refer to tape-to-tape, disk-to-disk, or any other HCFA-approved electronic media form for electronic transmission. Fax machine transmissions would not be considered ''electronic transmissions.'' We have included in this section proposed methods for allowing parties to request a review by telephone or electronic transmission.

A. Telephone Requests for Review

The notice accompanying the carrier's initial determination, which explains how to initiate a request for review, would include the telephone number designated by the carrier for making review requests. If an appellant initiates a request for review by telephone, the carrier would assign the request a confirmation number. During the telephone discussion, the appellant would be given the confirmation number and the name of the person who received his or her telephone request. It is important that the confirmation number be kept by the party requesting a review. If it is unclear to the carrier that a request was filed or filed timely, the confirmation number would assist the carrier in locating its records of the telephone request. While providing a confirmation number serves as additional protection for the appellant, loss of the number would not affect access to the appeal process and or appeal records.

We believe that allowing appellants to initiate a request for review by telephone would facilitate easier access to the appeals process. We recognize, however, that there may be instances in which the appellants may have difficulty in reaching a carrier by telephone. In order to ensure that appellants who encounter difficulties have sufficient time to file a written request for review by the 180-day deadline, we would limit the period to request a review by telephone to a period of 150 days after the date of the notice of the initial determination. This shorter period for initiating a review by telephone would afford an appellant who may be unsuccessful in reaching a carrier by telephone an additional ''window of opportunity'' to make a written request for review before the time to appeal expires.

We believe that providing this window would establish a safeguard for appellants who were unable to reach the carrier by telephone. This safeguard is necessary because of difficulty verifying that the appellant could not reach the carrier by telephone. Therefore, if the appellant telephoned the carrier on the 150th day and could not get through, he or she would still have an additional 30 days to submit a written request for review.

We intend to establish instructions for carriers that would ensure that the right to a review is not compromised. These instructions would include, but may not be limited to, the following:

B. Requests for Review

- The carrier's initial claim notice must specify the telephone number that a party dissatisfied with the initial determination can call to request a review. The initial claim notice must also specify the timeframe for requesting review by telephone (that is, 150 days), as well as the timeframe for filing a written request for review (that is, 180 days).
- The carrier must inform and educate the beneficiaries about its telephone review process through any one of the following:

—Bulletins/newsletters.
—Newspaper articles.
—Senior citizen groups.
—Beneficiary outreach workshops.
—Carrier's customer service/inquiry department.
—Provider relations department.

- The carrier must document all telephone calls at the time a call is received. The carrier must record the date the appellant called and the confirmation number assigned to assure timely filing.

- The carrier must attempt to resolve as many issues as possible during the telephone conversation. Some telephone reviews may not be processed or completed because of the complexity of issues, need for additional documentation, or other factors. At the end of each telephone review, the carrier must advise the appellant of further appeal rights.
- The carrier must give the appellant a written determination advising him or her of the results of the review, regardless of whether a review is requested by telephone, in writing, or via electronic transmission.

C. Electronic Requests for Review

Filing review requests electronically would be easier and faster for parties than submitting a letter or the HCFA–1964 form (Request for Review of Part B Medicare Claim). Electronic requests would shorten the mailing time for submitting review requests and eliminate the paper hassle of hardcopy requests. Currently, not all of the carriers have the capacity to receive electronic requests for review. However, in the future all carriers will have the capability to accept electronic requests for review from entities that submit their claims electronically. We propose to provide for electronic requests for review but to limit this process to those entities that electronically bill their claims to a carrier system that has the capability to receive electronic requests for review. We would instruct carriers to inform their billers whenever they obtain this capability and inform them how the process works.

The following steps show how the electronic process is expected to work:

- Once the biller electronically receives notification of the initial claim determination from the carrier, he or she must enter a ''specified code'' to indicate that the retransmission is a request for review.
- For each line of the claim being submitted for review, the biller must indicate the reason for the review in the ''Notes'' field. This request for review is transmitted to the carrier.
- Any additional documentation the biller wants to submit can be mailed, or with carrier agreement, faxed to the carrier.

An appellant would have a 180-day period to request a review of an initial determination by electronic means, which is the same time allowed to file a written request for review. The appellant submitting an electronic request for review would receive an online acknowledgement at the time of transmission. Therefore, the appellant would have documentation that a request for review was filed and the time of filing. Since the appellant who submitted an electronic request would have more control over initiating the request for review than an appellant who telephoned for a request, we are not limiting electronic requests to 150 days.

The above explanation is being furnished simply to provide an idea of the way the process should work. However, should this proposed rule be finally implemented, the above process is not necessarily the exact process that will be employed.

III. Reasons for the Revisions

Parties to a Part B determination, particularly physicians who take assignment, often contact carriers by telephone to dispute a determination that a service was not covered or to obtain information about why they were paid less than they thought was reasonable. Sometimes, physicians call because they believe the code assigned to the service is incorrect, or they want to correct some other error they believe the carrier made.

Many beneficiaries raise questions about initial determinations if a denial or partial denial of a bill is involved. Beneficiaries often want to know why charges were reduced, especially if they believe the charges were reasonable.

As a result of these calls, carriers frequently make corrections by telephone, calling the process a reopening, informal review, or other name. This action requires administrative funds, even though the party has not actually used the administrative review process. The carrier, in effect, may do two reviews in place of one for each instance in which the informal action does not satisfy the party.

A party that calls to inquire about the initial determination, we believe, would be pleased to know he or she has the option of writing or calling to request a review. Whenever possible, the carrier would attempt to resolve issues during a call and provide a review determination at the conclusion of the call. At the end of each telephone review, the carrier would advise the party of further appeal rights.

The current review process that requires a party to write to request a review takes time and effort, especially for beneficiaries. At times, the party requesting a review in writing may have to wait approximately 45 days to receive a review determination. Our intention in encouraging telephone requests for reviews is to foster quick communication between the review staff and the parties. The proposed additional means of requesting a review by telephone or electronic transmission would improve customer service in the following ways:

- Making access to the appeals process easier.
- Saving time.
- Providing a more prompt response.
- Reducing paperwork. (Currently a party must write a letter or complete HCFA Form 1964 (Request for Review) or submit a completed EOMB to request a review.)
- Ensuring prompt payments.
- Improving our relationship with the beneficiary and physician/supplier communities.

IV. Exclusions From Telephone and Electronic Reviews

We do not intend to provide for telephone requests for review on Part B determinations made by Peer Review Organizations (PROs) because of the types of issues PROs handle. The issues are usually medically focused and highly technical. We also believe this process would not be administratively efficient and reasonable, if, in most cases, adjudication cannot occur at the time of the call. The process could actually result in delays and/or duplication of effort. We believe the issues and documentation needed to process PRO appeals are sufficiently different from other Part B reviews and the telephone request process would be cumbersome for these appeals.

Similarly, we do not intend to provide for telephone requests for review on Part B initial determinations made by Health Maintenance Organizations (HMOs). Requests for reconsideration of initial determinations made by HMOs are governed exclusively by 42 CFR part 417, subpart Q. Unlike part 473, subpart B (PRO reconsiderations and appeals process), there is no cross-reference to part 405, subpart H in part 417, subpart Q.

Electronic requests for review would be available to those billers that bill their claims to a carrier system that has the capability to receive electronic requests for review. Although PROs may make the review determination, it is the carrier or fiscal intermediary's responsibility to process any adjustments to the claim, as a result of the review determination. Since the PROs are not involved in the billing process, the PROs would not need to have the capability to receive claims and/or electronic requests for reviews.

V. Provisions of the Proposed Regulation

Under sections 205(a), 1102(a), 1871(a)(1) and 1872 of the Act, the

Secretary has the authority to prescribe regulations as may be necessary to administer the Medicare program. It is under these statutory authorities that we propose to change the Medicare regulations to allow a party to request a review of a Part B initial claim determination by telephone or by electronic transmission.

We propose to revise § 405.807 (Review of Initial Determination) as follows:

- Redesignate existing paragraph (d) as new paragraph (b) and remove the words ''in writing'' from newly redesignated paragraph (b).
- Redesignate existing paragraph (b) as paragraph (c) and revise it to allow the additional methods of telephone and electronic transmission for a party (other than a PRO) to request a review of an initial determination by a carrier.
- Redesignate existing paragraph (c) as paragraph (d) and revise it to allow for a period of 150 days after the date of the notice of the initial determination for a party to telephone the carrier and request a review.
- Add new paragraph (e) to clarify that a beneficiary, provider, or attending practitioner who is dissatisfied with a PRO initial determination may request a review of an initial determination only in writing.

VI. Collection of Information Requirements

Section 405.807 of this document contains information collection and recordkeeping requirements that are subject to review by the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1980 (44 U.S.C. 3501 et seq.). These reporting and recordkeeping requirements are not effective until a notice of OMB's approval is published in the **Federal Register**. This proposed rule would impose minimal recordkeeping requirements. We would require carriers to assign a confirmation number to a party that initiates a request for review by telephone. The party would be given the confirmation number by the person who received his or her telephone request. We anticipate that the confirmation number would be the same number the carrier uses as its internal control number/documentation number (usually a 13-digit number). If this can be done, there would not be any additional recordkeeping on the carrier's part. The carrier is already assigning this number and recording it.

The party who would be given the confirmation number would have to record the number. This number would confirm that the party timely filed a request should that become an issue later. The confirmation number would assist the carrier in locating its record of the telephone request. It would take less than one minute for the carrier to assign and record the confirmation number and the same for the party to record the confirmation number. While providing a confirmation number serves as additional protection for the party, loss of the number would not affect access to the appeal process and/or appeal records. Organizations and individuals desiring to submit comments on the information collection and recordkeeping requirements should direct them to the OMB official whose name appears in the **ADDRESSES** section of this preamble.

VII. Response to Comments

Because of the large number of items of correspondence we normally receive on Federal Register documents published for comments, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the ''DATES'' section of this preamble, and, if we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

VIII. Regulatory Impact Statement

We generally prepare a regulatory flexibility analysis that is consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612), unless we certify that a rule would not have a significant economic impact on a substantial number of small entities. For purposes of the RFA, carriers and beneficiaries are not considered to be small entities. We consider all providers, physicians, and other suppliers to be small entities. Under this proposed rule, beneficiaries, providers, and physicians and other suppliers may request a review of an initial claim determination by telephone or through electronic transmission. This review is the first level of appeal for Part B claims and is performed by carrier staff who had no part in making the initial determination. This review, without the presence of oral testimony by the appellant party, is considered to be less costly to all parties and is a more expeditious way of handling complaints than a hearing.

Section 1102(b) of the Act requires us to prepare a regulatory impact statement if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 50 beds.

We are not preparing a regulatory impact statement since we have determined, and we certify, that this rule would not have a significant economic impact on the operations of a substantial number of small rural hospitals.

In accordance with the provisions of Executive Order 12866, this proposed rule was not reviewed by the Office of Management and Budget.

List of Subjects in 42 CFR Part 405

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 405 would be amended as follows:

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

1. The authority citation for part 405, subpart H is revised to read as follows:

Authority: Secs. 205(a), 1102, 1842(b)(3)(C), 1869(b), and 1871, and 1872 of the Social Security Act, as amended. (42 U.S.C. 405(a), 1302, 1395u(b)(3)(C), 1395ff(b), 1395hh and 1395ii.)

Subpart H—Appeals Under the Medicare Part B Program

2. Section 405.807 is revised to read as follows:

§ 405.807 Review of initial determination.

(a) *General.* A party to an initial determination by a carrier, who is dissatisfied with the initial determination, may request that the carrier review the determination. If a review is requested, the request for review does not constitute a waiver of the right to a hearing (under § 405.815) subsequent to the review.

(b) *Definition. Request for review* is a clear expression by a party to an initial determination that indicates he or she is dissatisfied with the initial determination and wants to appeal the matter.

(c) *Place and method of filing a request.* Except for the limitation on PRO requests set forth in paragraph (e) of this section, a request by a party for a carrier to review the initial determination may be made only in one of the following ways:

(1) In writing and filed at an office of the carrier or at an office of SSA or HCFA.

(2) By telephone to the telephone number designated by the carrier as the

appropriate number for its receipt of requests for review.

(3) By electronic transmission to the carrier.

(d) *Time of filing request.* (1) For telephone requests, a party to the initial determination may request a review of the initial determination within 150 days after the date of the notice of the initial determination.

(2) For requests made in writing or by electronic transmission, a party to the initial determination may request a review of the determination within 180 days after the date of the notice of the initial determination.

(3) The carrier may, upon request by the party affected, extend the period for requesting the review.

(4) For telephone requests, a party to the initial determination is not precluded from later making a written or electronic request if unable to contact the carrier within the 150 day timeframe. The party has an additional 30 days to submit a written or electronic request for review.

(e) *Exception to telephone and electronic review requests.* A party that submits a request for review of a Medicare Part B initial determination on a claim by a PRO must follow the submittal requirements described in paragraph (c)(1) of this section.

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

Dated: June 28, 1995.

Bruce C. Vladeck,

Administrator, Health Care Financing Administration.

[FR Doc. 95–16807 Filed 7–7–95; 8:45 am]

BILLING CODE 4120–01–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Parts 32 and 36

[DA 95–1409]

Proposed Reporting Requirements on Video Dialtone Costs and Jurisdictional Separations for Local Exchange Carriers Offering Video Dialtone Service

AGENCY: Federal Communications Commission.

ACTION: Proposed rule.

SUMMARY: On June 23, 1995, the Bureau issued an Order Inviting Comments that solicits comments on proposed reports for local exchange carriers offering video dialtone service. The proposed reports would enable the Commission to monitor video dialtone's impact on LECs cost, local telephone rates, and the assignment of costs between federal and state jurisdictions. The Bureau acted under authority delegated to it in the *Video Dialtone Reconsideration Order,* (FCC 94–269. 10 FCC Rcd 244, 326(1994)) which set forth accounting and reporting requirements for LECs that offer video dialtone service.

DATES: Comments are due July 26, 1995. Reply comments are due August 14, 1995.

ADDRESSES: The Federal Communications Commission, 1919 M Street, NW., Washington, DC 20554.

FOR FURTHER INFORMATION CONTACT: Kenneth Ackerman, Common Carrier Bureau, Accounting and Audits Division, (202) 418–0810.

SUPPLEMENTARY INFORMATION: On November 7, 1994 the Commission issued the *Video Dialtone Reconsideration Order,* requiring LECs to establish two sets of subsidiary accounting records to capture the shared and wholly dedicated video dialtone investment, revenue and expense. The Commission also required the summaries of these records be filed on a quarterly basis in order to enhance the Commission's ability to identify and evaluate video dialtone costs for the tariff review process and for future monitoring efforts. The Commission delegated to the Common Carrier Bureau the authority to determine the content and format of the subsidiary records and the quarterly reports. In addition, the Commission directed the Bureau to develop a data collection program to track the impact of video dialtone on local telephone rates and the assignment of costs between federal and state jurisdictions. The Bureau Order asks parties to comment on its proposal to establish a quarterly report and an annual report in which they would collect and summarize video dialtone investment, expense and revenue data disaggregated by regulated and nonregulated classification and also by jurisdictional categories. The Order also requests that parties identify the circumstances under which the Bureau could streamline or lift these proposed reporting requirements and the changes it should make in response to those circumstances.

Complete text of this Order Inviting Comments is available for inspection and copying in the Accounting and Audits Division public reference room, 2000 L Street, NW., Suite 812, Washington DC. Copies are also available from International Transcription Service, Inc., at 2100 M Street, NW., Suite 140, Washington, DC 20037, or call (202) 857–3800.

Federal Communications Commission.

William F. Caton,

Acting Secretary.

[FR Doc. 95–16844 Filed 7–7–95; 8:45 am]

BILLING CODE 6712–01–M

47 CFR Part 73

[MM Docket No. 95–103, RM–8659]

Radio Broadcasting Services; Wyeville, WI

AGENCY: Federal Communications Commission.

ACTION: Proposed rule.

SUMMARY: This document requests comments on a petition filed by Josephine Miracle requesting the allotment of Channel 267A to Wyeville, Wisconsin, as that community's first local service. The coordinates for Channel 267A are 44–01–39 and 90–16–35. There is a site restriction 8.7 kilometers (5.4 miles) east of the community.

DATES: Comments must be filed on or before August 21, 1995, and reply comments on or before September 5, 1995.

ADDRESSES: Federal Communications Commission, Washington, DC 20554. In addition to filing comments with the FCC, interested parties should serve the petitioner, as follows: Josephine Miracle, 206 East 19th Street, Lockport, Illinois 60441.

FOR FURTHER INFORMATION CONTACT: Kathleen Scheuerle, Mass Media Bureau, (202) 418–2180.

SUPPLEMENTARY INFORMATION: This is a summary of the Commission's *Notice of Proposed Rule Making,* MM Docket No. 95–103, adopted June 23, 1995, and released June 30, 1995. The full text of this Commission decision is available for inspection and copying during normal business hours in the Commission's Reference Center (Room 239), 1919 M Street, NW., Washington, DC. The complete text of this decision may also be purchased from the Commission's copy contractors, International Transcription Services, Inc., 2100 M Street, NW., Suite 140, Washington, DC 20037, (202) 857–3800.

Provisions of the Regulatory Flexibility Act of l980 do not apply to this proceeding.

Members of the public should note that from the time a Notice of Proposed Rule Making is issued until the matter is no longer subject to Commission consideration or court review, all *ex parte* contacts are prohibited in Commission proceedings, such as this one, which involve channel allotments.