DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

[I.D. 102798D]

Mid-Atlantic Fishery Management Council; Meetings

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Notice of public meeting.

SUMMARY: The Mid-Atlantic Fishery Management Council's (Council) Summer Flounder Monitoring Committee, Scup Monitoring Committee, and Black Sea Bass Monitoring Committee will hold a public meeting.

DATES: The meeting will be held on Thursday, November 19, 1998, beginning at 9:00 a.m. with the Summer Flounder Monitoring Committee, followed by the Black Sea Bass Monitoring Committee and the Scup Monitoring Committee.

ADDRESSES: The meeting will be held at the Comfort Inn - Airport Complex, 6921 Baltimore Annapolis Blvd., Baltimore, MD, telephone: 410–789–9100.

Council address: Mid-Atlantic Fishery Management Council, 300 S. New Street, Dover, DE 19904, telephone: 302–674–2331.

FOR FURTHER INFORMATION CONTACT: Christopher M. Moore, Ph.D., Acting Executive Director, Mid-Atlantic Fishery Management Council, telephone: 302–674–2331, ext. 16.

SUPPLEMENTARY INFORMATION: The purpose of these meetings is to recommend the 1999 recreational management measures for summer flounder, black sea bass, and scup.

Although other issues not contained in this agenda may come before the Council for discussion, in accordance with the Magnuson-Stevens Fishery Conservation and Management Act, those issues may not be the subject of formal action during this meeting. Action will be restricted to those issues specifically identified in the agenda listed in this notice.

Special Accommodations

This meeting is physically accessible to people with disabilities. Requests for sign language interpretation or other auxiliary aids should be directed to Joanna Davis at the Council (see **ADDRESSES**) at least 5 days prior to the meeting date.

Dated: October 28, 1998.

Bruce C. Morehead,

Acting Director, Office of Sustainable Fisheries, National Marine Fisheries Service.

[FR Doc. 98–29428 Filed 11–2–98; 8:45 am]

BILLING CODE 3510–22–F

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

[I.D. 102798C]

Mid-Atlantic Fishery Management Council (MAFMC); Meeting

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Notice of public meeting.

SUMMARY: The Mid-Atlantic Fishery Management Council's Squid, Mackerel, and Butterfish Committee, together with the Industry Advisors, will hold a public meeting.

DATES: The meeting will be held on Tuesday, November 17, 1998 from 10:00 a.m. until 5:00 p.m., and Wednesday, November 18, 1998 from 8:00 a.m. until 5:00 p.m.

ADDRESSES: The meeting will be held at the Ramada Inn, 76 Industrial Highway, Essington, PA; telephone: 610–521–9600.

Council address: Mid-Atlantic Fishery Management Council, 300 S. New Street, Dover, DE 19904; telephone: 302–674–2331.

FOR FURTHER INFORMATION CONTACT: Christopher M. Moore, Ph.D., Acting Executive Director, Mid-Atlantic Fishery Management Council; telephone: 302–674–2331, ext. 16.

SUPPLEMENTARY INFORMATION: The purpose of this meeting is to discuss and make recommendations on: Limits on the size of mackerel processing vessels, exemptions from the vessel size limit for mackerel harvesting vessels, upgrades on mackerel vessel size, overfishing definitions for squids, and in season adjustment of annual specifications for squid, mackerel, and butterfish.

Although other issues not contained in this agenda may come before the Committee for discussion, in accordance with the Magnuson-Stevens Fishery Conservation and Management Act, those issues may not be the subject of formal action during this meeting. Action will be restricted to those issues specifically identified in this notice.

Special Accommodations

This meeting is physically accessible to people with disabilities. Requests for sign language interpretation or other auxiliary aids should be directed to Joanna Davis at the Council (see **ADDRESSES**) at least 5 days prior to the meeting date.

Dated: October 28, 1998.

Bruce C. Morehead,

Acting Director, Office of Sustainable Fisheries, National Marine Fisheries Service.

[FR Doc. 98–29430 Filed 11–2–98; 8:45 am]

BILLING CODE 3510–22–F

DEPARTMENT OF DEFENSE

Office of the Secretary

Medical and Dental Services Fiscal Year 1999

ACTION: Notice.

SUMMARY: Notice is hereby given that the Deputy Chief Financial Officer in a memorandum dated September 29, 1998 established the following reimbursement rates for inpatient and outpatient medical care to be provided in FY 1999. These rates are effective October 1, 1998.

Medical and Dental Services: Fiscal Year 1999

The FY 1999 Department of Defense (DoD) reimbursement rates for inpatient, outpatient, and other services are provided in accordance with Title 10, United States Code, Section 1095. Due to size, the sections containing the Drug Reimbursement Rates (Section III.E) and the rates for Ancillary Services Requested by Outside Providers (Section III.F) are not included in this package. The Office of the Assistant Secretary of Defense (Health Affairs) will provide these rates upon request (MAJ Rose Layman, OASD(HA)—Response Management/Tri-Care Management Activity, (703) 681–8912 or DSN 761–8912). The medical and dental service rates in this package (including the rates for ancillary services, prescription drugs or other procedures requested by outside providers) are effective October 1, 1998.

I. Inpatient Rates [1 2]

INPATIENT, OUTPATIENT AND OTHER RATES AND CHARGES

Per inpatient day	International military education and training (IMET)	Interagency and other Federal agency sponsored patients	Other (full/third party)
A. Burn Center	$2,538.00	$4,632.00	$4,952.00
B. Surgical Care Services	1,236.00	2,255.00	2,411.00
(Cosmetic Surgery)			
C. All Other Inpatient Services			
(Based on Diagnosis Related Groups (DRG) [3])			

1. FY99 Direct Care Inpatient Reimbursement Rates

Adjusted standard amount	IMET	Interagency	Other (full/third party)
Large Urban	$2,429.00	$4,552.00	$4,825.00
Other Urban/Rural	2,642.00	5,413.00	5,760.00
Overseas	2,989.00	6,823.00	7,234.00

2. Overview

The FY 1999 inpatient rates are based on the cost per Diagnosis Related Groups (DRG), which is the inpatient full reimbursement rate per hospital discharge weighted to reflect the intensity of the principal diagnosis, secondary, diagnoses, procedures, patient age, etc. involved. The average cost per Relative Weighted Product (RWP) for large urban, other urban/rural, and overseas facilities will be published annually as an inpatient Adjusted Standardized Amount (ASA) (see paragraph I.C.1. above). The ASA will be applied to the RWP for each inpatient case, determined from the DRG weights, outlier thresholds, and payment rules published annually for hospital reimbursement rates under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) pursuant to 32 CFR 199.14(a)(1), including adjustments for length of stay (LOS) outliers. The published ASAs will be adjusted for area wage differences and indirect medical education (IME) for the discharging hospital. An example of how to apply DoD costs to a DRG standardized weight to arrive at DoD costs is contained in paragraph I.C.3., below.

3. Example of Adjusted Standardized Amounts for Inpatient Stays

Figure 1 shows examples for a nonteaching hospital in a Large Urban Area.

a. The cost to be recovered is DoD's cost for medical services provided in the nonteaching hospital located in a large urban area. Billings will be at the third party rate.

b. DRG 020: Nervous System Infection Except Viral Meningitis. The RWP for an inlier case is the CHAMPUS weight of 2.9769. (DRG statistics shown are from FY 1997).

c. The DoD adjusted standardized amount to be charged is $4,825 (i.e., the third party rate as shown in the table).

d. DoD cost to be recovered at a nonteaching hospital with area wage index of 1.0 is the RWP factor (2.9769) in 3.b., above, multiplied by the amount ($4,825) in 3.c., above.

e. Cost to be recovered is $14,364.

FIGURE 1.—THIRD PARTY BILLING EXAMPLES

DRG No.	DRG description	DRG weight	Arithmetic mean LOS	Geometric mean LOS	Short stay threshold	Long stay threshold
010	Nervous System Infection Except Viral Meningitis	2.9769	11.2	7.8	1	30

Hospital	Location	Area wage rate index	IME adjustment	Group ASA	Applied ASA
Nonteaching Hospital	Large Urban	1.0	1.0	$4,825.00	4,825.00

Patient	Length of stay	Days above threshold	Relative weighted product			TPC amount***
			Inlier*	Outlier**	Total	
#1	7 days	0	2.9769	0.0000	2.9769	$14,364
#2	21 days	0	2.9769	0.0000	2.9769	14,364
#3	35 days	5	2.9769	0.6297	3.6066	17,402

* DRG Weight.

** Outlier calculation = 33 percent of per diem weight × number of outlier days.
= .33 (DRG Weight/Geometric Mean LOS) × (Patient LOS—Long Stay Threshold).
= .33 (2.9769/7.8) × 35 − 30).
= .33 (.38165 × 5 (take out to five decimal places).
= .12594 × 5 (take out to five decimal places).
= .6297 (take out to four decimal places).

*** Applied ASA × Total RWP.

II. Outpatient Rates [1] [2] Per Visit

MEPRS code [4]	Clinical service	International military education and training (IMET)	Interagency and other Federal agency sponsored patients	Other (full/third party)
	A. Medical Care			
BAA	Internal Medicine	$104.00	$186.00	$198.00
BAB	Allergy	48.00	86.00	92.00
BAC	Cardiology	78.00	140.00	149.00
BAE	Diabetic	57.00	102.00	108.00
BAF	Endocrinology (Metabolism)	90.00	162.00	173.00
BAG	Gastroenterology	114.00	205.00	219.00
BAH	Hematology	145.00	260.00	277.00
BAI	Hypertension	89.00	160.00	170.00
BAJ	Nephrology	138.00	245.00	261.00
BAK	Neurology	112.00	200.00	213.00
BAL	Outpatient Nutrition	33.00	59.00	63.00
BAM	Oncology	132.00	236.00	251.00
BAN	Pulmonary Disease	118.00	211.00	225.00
BAO	Rheumatology	84.00	151.00	160.00
BAP	Dermatology	68.00	122.00	130.00
BAQ	Infectious Disease	126.00	225.00	240.00
BAR	Physical Medicine	74.00	133.00	142.00
BAS	Radiation Therapy	91.00	164.00	174.00
	B. Surgical Care			
BBA	General Surgery	164.00	295.00	314.00
BBB	Cardiovascular and Thoracic Surgery	132.00	237.00	252.00
BBC	Neurosurgery	188.00	337.00	359.00
BBD	Ophthalmology	102.00	183.00	194.00
BBE	Organ Transplant	239.00	429.00	457.00
BBF	Otolaryngology	124.00	222.00	237.00
BBG	Plastic Surgery	129.00	231.00	247.00
BBH	Proctology	65.00	117.00	124.00
BBI	Urology	125.00	224.00	239.00
BBJ	Pediatric Surgery	91.00	163.00	174.00
	C. Obstetrical and Gynecological (OB–GYN) Care			
BCA	Family Planning	45.00	81.00	87.00
BCB	Gynecology	101.00	181.00	193.00
BCC	Obstetrics	72.00	129.00	137.00
BCD	Breast Cancer Clinic	171.00	307.00	327.00
	D. Pediatric Care			
BDA	Pediatric	63.00	113.00	120.00
BDB	Adolescent	60.00	108.00	115.00
BDC	Well Baby	40.00	71.00	75.00
	E. Orthopaedic Care			
BEA	Orthopaedic	118.00	212.00	226.00
BEB	Cast	50.00	90.00	96.00
BEC	Hand Surgery	61.00	109.00	116.00
BEE	Orthotic Laboratory	60.00	108.00	115.00
BEF	Podiatry	67.00	119.00	127.00
BEZ	Chiropractic	24.00	42.00	45.00
	F. Psychiatric and/or Mental Health Care			
BFA	Psychiatry	97.00	174.00	186.00
BFB	Psychology	79.00	141.00	150.00
BFC	Child Guidance	52.00	93.00	99.00
BFD	Mental Health	105.00	188.00	201.00
BFE	Social Work	77.00	137.00	146.00
BFF	Substance Abuse	82.00	147.00	156.00
	G. Family Practice/Primary Medical Care			
BGA	Family Practice	74.00	133.00	141.00

MEPRS code [4]	Clinical service	International military education and training (IMET)	Interagency and other Federal agency sponsored patients	Other (full/third party)
BHA	Primary Care	75.00	134.00	143.00
BHB	Medical Examination	66.00	118.00	126.00
BHC	Optometry	48.00	86.00	91.00
BHD	Audiology	27.00	49.00	52.00
BHE	Speech Pathology	69.00	123.00	131.00
BHF	Community Health	48.00	87.00	92.00
BHG	Occupational Health	78.00	141.00	150.00
BHH	TRICARE Outpatient	44.00	79.00	84.00
BHI	Immediate Care	108.00	193.00	206.00
	H. Emergency Medical Care			
BIA	Emergency Medical	114.00	205.00	218.00
	I. Flight Medical Care			
BJA	Flight Medicine	103.00	185.00	197.00
	J. Underseas Medical Care			
BKA	Underseas Medicine	35.00	63.00	67.00
	K. Rehabilitative Services			
BLA	Physical Therapy	34.00	60.00	64.00
BLB	Occupational Therapy	48.00	86.00	91.00

III. Other Rates and Charges [1,2] Per Visit

MEPRS code [4]	Clinical service	International military education and training (IMET)	Interagency and other Federal agency sponsored patients	Other (full/third party)
FBI	A. *Immunization*	$13.00	$22.00	$24.00
DGC	B. *Hyperbaric Chamber* [5]	191.00	343.00	366.00
	C. *Ambulatory Procedure Visit* (*APV*) [6]	926.00	1,657.00	1,765.00
	D. *Family Member Rate* (formerly Military Dependents Rate)	10.45	.....	.....

E. Reimbursement Rates for Drugs Requested By Outside Providers [7]

The FY 1999 drug reimbursement rates for drugs are for prescriptions requested by outside providers and obtained at a Military Treatment Facility. The rates are established based on the cost of the particular drugs provided. Final rule 32 CFR part 200 eliminates the high cost ancillary services' dollar threshold and the associated term ''high cost ancillary service.'' The phrase ''high cost ancillary service'' will be replaced with the phrase ''ancillary services requested by an outside provider'' on publication of final rule 32 CFR Part 220. The list of drug reimbursement rates is too large to include here. These rates are available on request from OASD (Health Affairs)—MAJ Rose Layman, OASD(HA)-Resource Management/Tri-Care Management Activity, (703) 681–8912 or DSN 761–8912.

F. Reimbursement Rates for Ancillary Services Requested By Outside Providers [8]

Final rule 32 CFR part 220 eliminates the high cost ancillary services' dollar threshold and the associated term ''high cost ancillary service.'' The phrase ''high cost ancillary service'' will be replaced with the phrase ''ancillary services requested by an outside provider'' on publication of final rule 32 CFR part 220.

The list of FY 1999 rates for ancillary services requested by outside providers and obtained at a Military Treatment Facility is too large to include here. These rates are available on request from OASD(Health Affairs)—MAJ Rose Layman, OASD(HA)-Resource Management/Tri-Care Management Activity, (703) 681–8912 or DSN 761–8912.

G. Elective Cosmetic Surgery Procedures and Rates

Cosmetic surgery procedure	International classification diseases (ICD–9)	Current procedural terminology (CPT) [9]	FY 1999 charge [10]	Amount of charge
Mammaplasty	85.50 85.32 85.31	19325 19324 19318	Inpatient Surgical Care Per Diem or APV or applicable Outpatient Clinic Rate.	(a b c)
Mastopexy	85.60	19316	Inpatient Surgical Care Per Diem or APV or applicable Outpatient Clinic Rate.	(a b c)

Cosmetic surgery procedure	International classification diseases (ICD–9)	Current procedural terminology (CPT) [9]	FY 1999 charge [10]	Amount of charge
Facial Rhytidectomy	86.82 86.22	15824	Inpatient Surgical Care Per Diem or APV or applicable Outpatient Clinic Rate.	(a b c)
Blepharoplasty	08.70 08.44	15820 15821 15822 15823	Inpatient Surgical Care Per Diem or APV or applicable Outpatient Clinic Rate.	(a b c)
Mentoplasty (Augmentation/Reduction).	76.68 76.67	21208 21209	Inpatient Surgical Care Per Diem or APV or applicable Outpatient Clinic Rate.	(a b c)
Abdominoplasty	86.83	15831	Inpatient Surgical Care Per Diem or APV or applicable Outpatient Clinic Rate.	(a b c)
Lipectomy suction per region [11]	86.83	15876 15877 15878 15879	Inpatient Surgical Care Per Diem or APV or applicable Outpatient Clinic Rate.	(a b c)
Rhinoplasty	21.87 21.86	30400 30410	Inpatient Surgical Care Per Diem or APV or applicable Outpatient Clinic Rate.	(a b c)
Scar Revisions beyond CHAMPUS.	86.84	1578__	Inpatient Surgical Care Per Diem or APV or applicable Outpatient Clinic Rate.	(a b c)
Mandibular or Maxillary Repositioning.	76.41	21194	Inpatient Surgical Care Per Diem or APV or applicable Outpatient Clinic Rate.	(a b c)
Minor Skin Lesions [12]	86.30	1578__	Inpatient Surgical Care Per Diem or APV or applicable Outpatient Clinic Rate.	(a b c)
Dermabrasion	86.25	15780	Inpatient Surgical Care Per Diem or APV or applicable Outpatient Clinic Rate.	(a b c)
Hair Restoration	86.64	15775	Inpatient Surgical Care Per Diem or APV or applicable Outpatient Clinic Rate.	(a b c)
Removing Tattoos	86.25	15780	Inpatient Surgical Care Per Diem or APV or applicable Outpatient Clinic Rate.	(a b c)
Chemical Peel	86.24	15790	Inpatient Surgical Care Per Diem or APV or applicable Outpatient Clinic Rate.	(a b c)
Arm/Thigh Dermolipectomy	86.83	1583__	Inpatient Surgical Care Per Diem or APV or applicable Outpatient Clinic Rate.	(a b c)
Brow Lift	86.3	15839	Inpatient Surgical Care Per Diem or APV or applicable Outpatient Clinic Rate.	(a b c)

H. Dental Rate [13] Per Procedure

MEPRS code [4]	Clinical service	International military education and training (IMET)	Interagency and other Federal agency sponsored patients	Other (full/third party)
	Dental Services ADA Code and DoD established weight	$56.00	$101.00	$108.00

I. Ambulance Rage [14] Per Visit

MEPRS code [4]	Clinical service	International military education and training (IMET)	Interagency and other Federal agency sponsored patients	Other (full/third party)
FEA	Ambulance	$56.00	$101.00	$107.00

J. Ancillary Services Requested by an Outside Provider [8] Per Procedure

MEPRS code [4]	Clinical service	International military education and training (IMET)	Interagency and other Federal agency sponsored patients	Other (full/third party)
	Laboratory procedures requested by an outside provider CPT '98 Weight Multiplier.	$10.00	$17.00	$18.00
	Radiology procedures requested by an outside provider CPT '98 Weight Multiplier.	25.00	45.00	48.00
	Cardiology procedures requested by an outside provider CPT '98 Weight Multiplier.	17.00	31.00	33.00

K. AirEvac Rate [15] Per visit

MEPRS code [4]	Clinical service	International military education and training (IMET)	Interagency and other Federal agency sponsored patients	Other (full/third party)
	AirEvac Services—Ambulatory	$90.00	$161.00	$172.00
	AirEvac Services—Litter	256.00	459.00	489.00

L. Observation Rate [16] Per hour

MEPRS code [4]	Clinical service	International military education and training (IMET)	Interagency and other Federal agency sponsored patients	Other (full/third party)
	Observation Services—Hour	$14.50	$25.83	$27.50

Notes on Cosmetic Surgery Charges

[a] Per diem charges for inpatient surgical care services are listed in Section I.B. (See notes 9 through 11, below, for further details on reimbursable rates.)

[b] Charges for ambulatory procedure visits (formerly same day surgery) are listed in Section III.C. (See notes 9 through 11, below, for further details on reimbursable rates.) The ambulatory procedure visit (APV) rate is used if the elective cosmetic surgery is performed in an ambulatory procedure unit (APU).

[c] Charges for outpatient clinic visits are listed in Sections II.A–K. The outpatient clinic rate is not used for services provided in an APU. The APV rate should be used in these cases.

Notes on Reimbursable Rates

[1] Percentages can be applied when preparing bills for both inpatient and outpatient services. Pursuant to the provisions of 10 U.S.C. 1095, the inpatient Diagnosis Related Groups and inpatient per diem percentages are 96 percent hospital and 4 percent professional charges. The outpatient per visit percentages are 89 percent outpatient services and 11 percent professional charges.

[2] DoD civilian employees located in overseas areas shall be rendered a bill when services are performed. Payment is due 60 days from the date of the bill.

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

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

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

[5] Hyperbaric services charges shall be based on hours of service in 15 minute increments. The rates listed in Section III.B. are for 60 minutes or 1 hour of service. Providers shall calculate the charges based on the number of hours (and/or fractions of an hour) of service. Fractions of an hour shall be rounded to the next 15 minute increment (e.g., 31 minutes shall be charged as 45 minutes).

[6] Ambulatory procedure visit is defined in DOD Instruction 6025.8, ''Ambulatory Procedure Visit (APV),'' dated September 23, 1996, as immediate (day of procedure) pre-procedure and immediate post-procedure care requiring an unusual degree of intensity and provided in an ambulatory procedure unit (APU). Care is required in the facility for less than 24 hours. This rate is also used for elective cosmetic surgery performed in an APU.

[7] Prescription services requested by outside providers (e.g., physicians or dentists) are relevant to the Third Party Collection Program. Third party payers (such as insurance companies) shall be billed for prescription services when beneficiaries who have medical insurance obtain medications from a Military Treatment Facility (MTF) that are prescribed by providers external to the MTF. Eligible beneficiaries (family members or retirees with medical insurance) are not personally liable for this cost and shall not be billed by the MTF. Medical Service Account (MSA) patients, who are not beneficiaries as defined in 10 U.S.C. 1074 and 1076, are charged at the ''Other'' rate if they are seen by an outside provider and only come to the MTF for prescription services. The standard cost of medications ordered by an outside provider includes the cost of the drugs plus a dispensing fee per prescription. The prescription cost is calculated by multiplying the number of units (e.g., tablets or capsules) by the unit cost and adding a $5.00 dispensing fee per prescription. Final rule 32 CFR part 220 eliminates the high cost ancillary services' dollar threshold and the associated term ''high cost ancillary service.'' The phrase ''high cost ancillary service'' will be replaced with the phrase ''ancillary services requested by an outside provider'' on publication of final rule 32 CFR part 220. The elimination of the threshold also eliminates the need to bundle costs whereby a patient is billed if the total cost of ancillary services in a day (defined as 0001 hours to 2400 hours) exceeded $25.00. The elimination of the threshold is effective as per date stated in final rule 32 CFR part 220.

[8] Charges for ancillary services requested by an outside provider (physicians, dentists, etc.) are relevant to the Third Party Collection Program. Third party payers (such as insurance companies) shall be billed for ancillary services when beneficiaries who have medical

insurance obtain services from the MTF that are prescribed by providers external to the MTF. Laboratory and Radiology procedure costs are calculated by multiplying the DoD established weight for the Physicians' Current Procedural Terminology (CPT) '98) code by either the cardiology, laboratory or radiology multiplier (Section III.J). Eligible beneficiaries (family members or retirees with medical insurance) are not personally liable for this cost an shall not be billed by the MTF. MSA patients, who are not beneficiaries as defined by 10 U.S.C. 1074 and 1076, are charged at the ''Other'' rate if they are seen by an outside provider and only come to the MTF for ancillary services. Final rule 32 CFR part 220 eliminates the high cost ancillary services' dollar threshold and the associated term ''high cost ancillary service.'' The phrase ''high cost ancillary service'' will be replaced with the phrase ''ancillary services requested by an outside provider'' on publication of final rule 32 CFR part 220. The elimination of the threshold also eliminates the need to bundle costs whereby a patient is billed if the total cost of ancillary services in a day (defined as 0001 hours to 2400 hours) exceeded $25.00. The elimination of the threshold is effective as per date stated in final rule 32 CFR part 220.

[9] The attending physician is to complete the CPT '98 code to indicate the appropriate procedure followed during cosmetic surgery. The appropriate rate will be applied depending on the treatment modality of the patient: ambulatory procedure visit, outpatient clinic visit or inpatient surgical care services.

[10] Family members of active duty personnel, retirees and their family members, and survivors shall be charged elective cosmetic surgery rates. Elective cosmetic surgery procedure information is contained in Section III.G. The patient shall be charged the rate as specified in the FY 1999 reimbursable rates for an episode of care. The charges for elective cosmetic surgery are at the full reimbursement rate (designated as the ''Other'' rate) for inpatient per diem surgical care services in Section I.B., ambulatory procedure visits as contained in Section III.C, or the appropriate outpatient clinic rate in Sections II.A–K. The patient is responsible for the cost of the implant(s) and the prescribed cosmetic surgery rate. (Note: The implants and procedures used for the augmentation mammaplasty are in compliance with Federal Drug Administration guidelines.)

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

[12] These procedures are inclusive in the minor skin lesions. However, CHAMPUS separates them as noted here. All charges shall be for the entire treatment, regardless of the number of visits required.

[13] Dental service rates are based on a dental rate multiplier times the American Dental Association (ADA) code and the DoD established weight for that code.

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

[15] Air in-flight medical care reimbursement charges are determined by the status of the patient (ambulatory or litter) and are per patient. The appropriate charges are billed only by the Air Force Global Patient Movement Requirement Center (GPMRC).

[16] Observation Services are billed at either the hourly or daily charge. Begin counting when the patient is placed in the observation bed, and round to the nearest hour. The daily rate for full/third party, for example, would be $660 based on 24 hours of service. If a patient status changes to inpatient, the charges for observation services are added to the DRG assigned to the case and not billed separately. If a patient is released from Observation status and is sent to an APV, the charges for Observation services are not billed separately, but are added to the APV rate in order to recover all expenses.

Dated: October 27, 1998.

L.M. Bynum,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 98–29314 Filed 11–2–98; 8:45 am]

BILLING CODE 5000–04–M

DEPARTMENT OF DEFENSE

Office of the Secretary

TRICARE/CHAMPUS; FY99 DRG Updates

AGENCY: Office of the Secretary, DOD.

ACTION: Notice of DRG revised rates.

SUMMARY: This notice describes the changes made to the TRICARE/CHAMPUS DRG-based payment system in order to conform to changes made to the Medicare Prospective Payment System (PPS). It also provides the updated fixed loss cost outlier threshold, cost-to-charge ratios and the Internet address for accessing the updated adjusted standardized amounts, DRG relative weights, and beneficiary cost-share per diem rates to be used for FY 1999 under the TRICARE/CHAMPUS DRG-based payment system.

EFFECTIVE DATES: The rates, weights and Medicare PPS changes which affect the TRICARE/CHAMPUS DRG-based payment system contained in this notice are effective for admissions occurring on or after October 1, 1998.

ADDRESSES: TRICARE Management Activity (TMA), Medical Benefits and Reimbursement Systems, 16401 East Centretech Parkway, Aurora, CO 80011–9403.

For copies of the **Federal Register** containing this notice, contact the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402, (202) 783–3238. The charge for the **Federal Register** is $1.50 for each issue payable by check or money order to the Superintendent of Documents.

FOR FURTHER INFORMATION CONTACT: Marty Maxey, Medical Benefits and Reimbursement Systems, TMA, telephone (303) 676–3627. To obtain copies of this document, see the **ADDRESSES** section above. Questions regarding payment of specific claims under the TRICARE/CHAMPUS DRG-based payment system should be addressed to the appropriate contractor.

SUPPLEMENTARY INFORMATION: The final rule published on September 1, 1987 (52 FR 32992) set forth the basic procedures used under the CHAMPUS DRG-based payment system. This was subsequently amended by final rules published August 31, 1988 (53 FR 33461), October 21, 1988 (53 FR 41331), December 16, 1988 (53 FR 50515), May 30, 1990 (55 FR 21863), October 22, 1990 (55 FR 42560), and September 10, 1998 (63 FR 48439).

An explicit tenet of these final rules, and one based on the statute authorizing the use of DRGs by TRICARE/CHAMPUS, is that the TRICARE/CHAMPUS DRG-based payment system is modeled on the Medicare PPS, and that, whenever practicable, the TRICARE/CHAMPUS system will follow the same rules that apply to the Medicare PPS. HCFA publishes these changes annually in the **Federal Register** and discusses in detail the impact of the changes.

In addition, this notice updates the rates and weights in accordance with our previous final rules. The actual changes we are making, along with a description of their relationship to the Medicare PPS, are detailed below.