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.

I. Medicare PPS Changes Which Affect the TRICARE/CHAMPUS DRG-Based Payment System

Following is a discussion of the changes the Health Care Financing Administration (HCFA) has made to the Medicare PPS that affect the TRICARE/CHAMPUS DRG-based payment system.

A. DRG Classifications

Under both the Medicare PPS and the TRICARE/CHAMPUS DRG-based payment system, cases are classified into the appropriate DRG by a Grouper program. The Grouper classifies each case into a DRG on the basis of the diagnosis and procedure codes and demographic information (that is, sex, age, and discharge status). The Grouper used for the TRICARE/CHAMPUS DRG-based payment system is the same as the current Medicare Grouper with two modifications. The TRICARE/CHAMPUS system has replaced Medicare DRG 435 with two age-based DRGs (900 and 901), and we have implemented thirty-four (34) neonatal DRGs in place of Medicare DRGs 385 through 390. For admissions occurring on or after October 1, 1995, the CHAMPUS grouper hierarchy logic was changed so the age split (age <29 days) and assignments to MDC 15 occur before assignment of the PreMDC DRGs. This resulted in all neonate tracheostomies and organ transplants to be grouped to MDC 15 DRGs and not to DRGs 480–483 or 495. For admissions occurring on or after October 1, 1998, the CHAMPUS grouper hierarchy logic was changed to move DRG 103 to the PreMDC DRGs and to assign patients to PreMDC DRGs 480, 103 and 495 before assignment to MDC 15 DRGs and the neonatal DRGs. Grouping for all other DRGs under the TRICARE/CHAMPUS system is identical to the Medicare PPS.

For FY 1999, HCFA will implement a number of classification changes, including surgical hierarchy changes, revisions to the Major Problem Diagnosis List, and refinements to the Complications and Comorbidities (CC) List. The CHAMPUS Grouper will incorporate all changes made to the Medicare Grouper.

B. Wage Index and Medicare Geographic Classification Review Board Guidelines

TRICARE/CHAMPUS will continue to use the same wage index amounts used for the Medicare PPS. In addition, TRICARE/CHAMPUS will duplicate all changes with regard to the wage index for specific hospitals that are redesignated by the Medicare Geographic Classification Review Board.

C. Hospital Market Basket

TRICARE/CHAMPUS will update the adjusted standardized amounts according to the final updated hospital market basket used for the Medicare PPS according to HCFA's July 31, 1998, final rule.

D. Outlier Payments

Since TRICARE/CHAMPUS does not include capital payments in our DRG-based payments, we will use the fixed loss cost outlier threshold calculated by HCFA for paying cost outliers in the absence of capital prospective payments. For FY99, the fixed loss cost outlier threshold is based on the sum of the applicable DRG-based payment rate plus any amounts payable for IDME plus a fixed dollar amount. Thus, for FY99, in order for a case to qualify for cost outlier payments, the costs must exceed the TRICARE/CHAMPUS DRG base payment rate for the DRG plus the IDME payment plus $10,129 (wage adjusted). The marginal cost factor for cost outliers continues to be 80 percent.

E. Graduate Medical Education

TRICARE/CHAMPUS will adopt Medicare's PPS changes as they pertain to the counting and reporting of residents on the Medicare cost reports for purposes of reimbursing hospitals for the TRICARE/CHAMPUS share of graduate medical education costs.

F. Transfers

TRICARE/CHAMPUS will adopt Medicare's PPS changes as they pertain to the expanded transfer definition. We will publish an interim final rule to reflect these changes in 32 CFR Part 199(a)(1).

G. Blood Clotting Factor

TRICARE/CHAMPUS will adopt the two new HCPCS billing codes and payment rates for purified Factor IX products, as outlined in HCFA's May 12, 1998, final rule. These new codes and payment rates are effective for admissions on or after June 11, 1998. In addition, we will adopt the changes to the payment rates for blood clotting factor for hemophilia patients as outlined in HCFA's July 31, 1998, final rule, effective for admissions on or after October 1, 1998.

H. Bad Debt Increase

TRICARE/CHAMPUS will adopt Medicare's PPS changes to gradually reduce the payment for bad debt for hospitals over the next several years.

II. Cost to Charge Ratio

For FY 1999, the cost-to-charge ratio used for the TRICARE/CHAMPUS DRG-based payment system will be 0.5487, which is increased to 0.5562 to account for bad debts. This shall be used to calculate the adjusted standardized amounts and to calculate cost outlier payments, except for children's hospitals. For children's hospital cost outliers, the cost-to-charge ratio used is 0.6085.

III. Updated Rates and Weights

The updated rates and weights are accessible through the Internet at *http://www.tso.osd.mil* under the heading Provider Reimbursement Rates. Table 1 provides the ASA rates and Table 2 provides the DRG weights to be used under the TRICARE/CHAMPUS DRG-based payment system during FY 1999 and which is a result of the changes described above. The implementing regulations for the TRICARE/CHAMPUS DRG-based payment system are in 32 CFR Part 199.

Dated: October 27, 1998.

L.M. Bynum,

Alternate Federal Register Liaison Officer, Department of Defense.

[FR Doc. 98–29315 Filed 11–2–98; 8:45 am]

BILLING CODE 5000–04–M

DEPARTMENT OF DEFENSE

Department of the Navy

Notice of Termination of Environmental Impact Statements on Three Navy Actions

AGENCY: Department of the Navy, DOD.

ACTION: Notice.

SUMMARY: The Department of the Navy had previously announced its intent to prepare Environmental Impact Statements for three actions, however, after beginning the NEPA process, Navy determined that the actions would not result in significant impacts to the human environment. Navy's intent to prepare Environmental Impact Statements is hereby withdrawn for the following actions: disposal and privatization of Naval Air Warfare Center Indianapolis, Indiana; disposal and reuse of Naval Surface Warfare Center Louisville, Kentucky, and; disposal and reuse of Naval Radio Transmitter Facility Driver, Virginia.

FOR FURTHER INFORMATION CONTACT: Mr. Matthew Hess, Office of Chief of Naval Operations (Code N456F) at telephone (703) 604–5421, fax (703) 602–4642, or e-mail to hessm@n4.opnav.navy.mil.

SUPPLEMENTARY INFORMATION: Pursuant to Section 102(2)(C) of the National Environmental Policy Act (NEPA) of