the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). This is not considered a major rule because it has an effect on the Medicare program of less than $100 million in 1 year.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $6 million to $29 million in any 1 year. For purposes of the RFA, all ambulance providers/suppliers are considered to be small entities. Individuals and States are not included in the definition of a small entity.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 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 100 beds. This notice does not apply to small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. This notice does not result in an expenditure in any 1 year by State, local, or tribal governments of $110 million.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. This rule will not have a substantial effect on State or local governments.

This notice provides an update for inflation as mandated by statute. We estimate that the total expenditure for CY 2003 for ambulance services covered by the Medicare program is approximately $3 billion. Inflation of 1.1 percent will result in an additional total expenditure of approximately $30 million.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

Authority: Section 1834(l) of the Social Security Act (42 U.S.C. 1395m(l)).

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

Dated: October 4, 2002.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

Approved: November 1, 2002.

Tommy G. Thompson,

Secretary.

[FR Doc. 02–29850 Filed 11–20–02; 10:28 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare and Medicaid Services

Notice of Proposed Settlement and Fairness Hearing

The Centers for Medicare and Medicaid Services gives notice that if you are a medicare beneficiary you may be a member of a class action lawsuit involving local coverage policies. This case challenges, among other things, the notice given when claims are denied by Medicare based on local coverage policies. The United States District Court for the District of Arizona has certified a nationwide class action in this case, *Erringer* v. *Thompson,* No. CV 01–112 TUC BPV (D. Ariz.), and the parties have submitted a proposed Settlement Agreement to the Court for its approval. You have the right to receive a copy of, and comment on, the proposed settlement Agreement. To receive a copy of the Agreement, please write or email class counsel at one of the addresses listed below. A copy of the proposed Agreement is also available on the Web at: *http://www.acdl.com/legalnews.html.* If you want to comment on the proposed Agreement, you must submit written comments to the Court.

Summary of Agreement

The proposed Agreement settles all claims relating to the initial notice provided to Medicare beneficiaries, whose claims for payment are denied in whole or in part based on application of a Local Medical Review Policy (LMRP) or a Local Coverage Determination (LCD), regarding: (i) the use of such policies in the determination of a beneficiary's claim for benefits, and (ii) the beneficiary's opportunity to provide additional evidence or information in support of his/her claim for benefits. In exchange for Plaintiffs releasing all such claims, Defendant agrees to provide beneficiaries whose claims are denied based on an LMRP or LCD notice that: (1) An LMRP or LCD was used in making the decision to deny their claim; (2) an LMRP or LCD provides a guide to assist in determining whether a particular item or service is covered by Medicare; (3) a copy of the LMRP or LCD is available from the local intermediary or carrier by calling the toll free telephone number listed on the beneficiary's Medicare Summary Notice; (4) the beneficiary can compare the facts in his/her case to the guidelines set out in the LMRP or LCD to see whether additional information from his/her physician might change Medicare's decision; and (5) the beneficiary may also send any additional information regarding any appeal. The Agreement also provides for a way that beneficiaries may receive a copy of the LMRP or LCD used in their case, provides for monitoring of Medicare contractors' compliance with the proposed Agreement's provisions, and provides for a payment of $23,061 in attorney's fees and costs to Plaintiffs' counsel.

Fairness Hearing

The Court will conduct a fairness hearing before Magistrate Judge Bernardo P. Velasco, at the United States District Court, Evo A. DeConcini U.S. Courthouse, 405 W. Congress Street, Tucson, Arizona 85701, on February 3, 2003, at 9 a.m., to determine whether to approve the proposed Agreement as fair, adequate and reasonable. Objections to the proposed Agreement will be considered by the Court if such objections are filed in writing with the Clerk of Court at the above address, on or before December 31, 2002. Attendance at the hearing is not necessary to have an objection considered; however, class members wishing to be heard orally in opposition to the proposed Agreement should indicate in their written objection their intention to appear at the hearing.

Class Counsel

The attorneys representing the plaintiffs and the class as class counsel are:

Sally Hart, Arizona Center for Disability Law and Center for Medicare Advocacy, Inc., 100 N. Stone Ave., Suite 305, Tucson, AZ 85701. (520) 327–9547. *shart@acdl.com.*

Dina Lesperance, Arizona Center for Disability Law, 3839 N. Third St., Suite 209, Tucson, AZ 85012–2069.

Gill Deford, Center for Medicare Advocacy, Inc., PO Box 350, Willimantic, CT 06266. (860) 456–7790.

Counsel for Defendant

Counsel for Defendant is:

Ori Lev, United States Department of Justice, PO Box 883, Washington, DC 20044.

Dated: November 5, 2002.

John P. Burke III,

Paperwork Reduction Act Team Leader, CMS Reports Clearance Officer, Office of Strategic Operations and Strategic Affairs, Division of Regulations Development and Issuances.

[FR Doc. 02–28873 Filed 11–21–02; 8:45 am]

BILLING CODE 4120–03–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare and Medicaid Services

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Dina Lesperance, Arizona Center for Disability Law, 3839 N. Third St., Suite 209, Tucson, AZ 85012–2069.

Gill Deford, Center for Medicare Advocacy, Inc., P.O. Box 350, Willimantic, CT 06266, (860) 456–7790.

Counsel for Defendant

Counsel for Defendant is: Ori Lev, United States Department of Justice, P.O. Box 883, Washington, DC 20044.

Dated: November 6, 2002.

John P. Burke, III,

Paperwork Reduction Act Team Leader, CMS Reports Clearance Officer, Office of Strategic Operations and Strategic Affairs, Division of Regulations Development and Issuances.

[FR Doc. 02–29128 Filed 11–21–02; 8:45 am]

BILLING CODE 4120–03–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1217–N]

Medicare Program; December 16, 2002, Meeting of the Practicing Physicians Advisory Council

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Notice.

SUMMARY: In accordance with section 10(a) of the Federal Advisory Committee Act, this notice announces a meeting of the Practicing Physicians Advisory Council. The Council will be meeting to discuss certain proposed changes in regulations and carrier manual instructions related to physicians' services, as identified by the Secretary of the Department of Health and Human Services. This meeting is open to the public.

Meeting Registration: Persons wishing to attend this meeting must contact the meeting coordinator Diana Motsiopoulos at *dmotsiopoulos@cms.hhs.gov* or (410)–786–3379 at least 72 hours in advance to register. Persons who are not registered in advance will not be permitted into the CMS Headquarters and thus will not be able to attend the