action will not have a substantial direct effect on States or tribal governments, on the relationship between the national government and the States or tribal governments, or on the distribution of power and responsibilities among the various levels of government or between the Federal Government and Indian tribes. Thus, the Agency has determined that Executive Order 13132, entitled ''Federalism'' (64 FR 43255, August 10, 1999) and Executive Order 13175, entitled ''Consultation and Coordination with Indian Tribal Governments'' (65 FR 67249, November 9, 2000) do not apply to this final rule. In addition, this final rule does not impose any enforceable duty or contain any unfunded mandate as described under Title II of the Unfunded Mandates Reform Act of 1995 (UMRA) (2 U.S.C. 1501 *et seq.*).

This action does not involve any technical standards that would require Agency consideration of voluntary consensus standards pursuant to section 12(d) of the National Technology Transfer and Advancement Act of 1995 (NTTAA) (15 U.S.C. 272 note).

VII. Congressional Review Act

Pursuant to the Congressional Review Act (5 U.S.C. 801 *et seq.*), EPA will submit a report containing this rule and other required information to the U.S. Senate, the U.S. House of Representatives, and the Comptroller General of the United States prior to publication of the rule in the **Federal Register**. This action is not a ''major rule'' as defined by 5 U.S.C. 804(2).

List of Subjects in 40 CFR Part 180

Environmental protection, Administrative practice and procedure, Agricultural commodities, Pesticides and pests, Reporting and recordkeeping requirements.

Dated: September 21, 2012.

Daniel J. Rosenblatt,

Acting Director, Registration Division, Office of Pesticide Programs.

Therefore, 40 CFR chapter I is amended as follows:

PART 180—[AMENDED]

■ 1. The authority citation for part 180 continues to read as follows:

Authority: 21 U.S.C. 321(q), 346a and 371.

■ 2. Section 180.628 is amended as follows:

■ i. Remove the entries for crambe, seed; grain, aspirated fractions; hare's ear mustard, seed; jojoba, seed; lesquerella, seed; milkweed, seed; mustard, seed; oil, radish, seed; poppy, seed; rapeseed, seed; rose hip, seed; sesame, seed; tallowwood, seed; tea oil plant, seed; vegetable, foliage of legume, except soybean, subgroup 7A, forage; vegetable, foliage of legume, except soybean, subgroup 7A, hay; and vegetable, legume, group 6, except soybeans; from the table in paragraph (a).

■ ii. Revise the tolerances for cattle, fat; cattle, meat; goat, fat; goat, meat; horse, fat; horse, meat; sheep, fat; sheep, meat; in the table in paragraph (a).

■ iii. Add alphabetically entries for cottonseed subgroup 20C, grain, aspirated grain fractions; rapeseed subgroup 20A; sunflower subgroup 20B; vegetable, legume, group 6; vegetable, foliage of legume, group 7, forage; and vegetable, foliage of legume, group 7, hay; to the table in paragraph (a).

■ iv. Remove the entries for soybean, forage, and soybean, hay, from the table in paragraph (d).

The added and revised text read as follows:

§ 180.628 Chlorantraniliprole; tolerances for residues.

Commodity	Parts per million
* * * * *	
Cattle, fat	0.5
Cattle, meat	0.1
* * * * *	
Cottonseed subgroup 20C	0.3
* * * * *	
Goat, fat	0.5
Goat, meat	0.1
* * * * *	
Grain, aspirated grain fractions	640
* * * * *	
Horse, fat	0.5
Horse, meat	0.1
* * * * *	
Rapeseed subgroup 20B	2.0
* * * * *	
Sheep, fat	0.5
Sheep, meat	0.1
* * * * *	
Sunflower subgroup 20C	0.3
* * * * *	
Vegetable, legume, group 6	2.0
Vegetable, foliage of legume, group 7, forage	30
Vegetable, foliage of legume, group 7, hay	90
* * * * *	

* * * * *

[FR Doc. 2012–24152 Filed 10–2–12; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 412, 413, 424, and 476

[CMS–1588–CN2]

RIN 0938–AR12

Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2013 Rates; Hospitals' Resident Caps for Graduate Medical Education Payment Purposes; Quality Reporting Requirements for Specific Providers and for Ambulatory Surgical Centers; Corrections

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

ACTION: Final rule; correction.

SUMMARY: This document corrects technical errors in the final rule that appeared in the August 31, 2012 **Federal Register** entitled ''Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2013 Rates; Hospitals' Resident Caps for Graduate Medical Education Payment Purposes; Quality Reporting Requirements for Specific Providers and for Ambulatory Surgical Centers.''

DATES: *Effective Date:* October 1, 2012.

FOR FURTHER INFORMATION CONTACT: Tzvi Hefter, (410) 786–4487.

SUPPLEMENTARY INFORMATION:

I. Background

In FR Doc. 2012–19079 of August 31, 2012 (77 FR 53258), there were a number of technical errors that are identified and corrected in the Correction of Errors section of this correcting document. The provisions in this correcting document are effective as if they had been included in the final rule appearing in the August 31, 2012 **Federal Register**. Accordingly, the corrections are effective October 1, 2012.

II. Summary of Errors and Corrections Posted on the CMS Web Site

A. Errors in the Preamble

On page 53268, in our summary of the provisions of the Hospital Inpatient Quality Reporting (IQR) Program, we inadvertently referenced hospital-acquired condition (HAC) measure sets

instead of healthcare-associated infection (HAI) measures sets. Also on this page, in our discussion of the cost and benefits of the Hospital Readmission Reduction Program, we made a technical error in the dollar amount by which the Hospital Readmission Reduction Program will reduce payments to hospitals.

On page 53278, we made an inadvertent typographical error in the discussion of prospective adjustments for FY 2010 documentation and coding effect.

On page 53315, in our discussion of International Classification of Disease, Ninth Revisions, Clinical Modification (ICD–9–CM), we inadvertently reference ICD–9–CM coding system instead of ICD–9–CM diagnosis codes.

On pages 53386 and 53392, we made typographical errors in our summation of a public comment regarding the Hospital Readmission Reduction Program.

On page 53387, we are correcting the Web site for obtaining the MedPAR files referenced in our discussion of aggregate payments for excess readmissions and aggregate payments for all discharges under the Hospital Readmission Reduction Program.

On page 53485, in our discussion of long-term care hospital (LTCH) moratorium on the 25-percent payment adjustment threshold policy, we made typographical errors in an example.

On page 53508, we made a grammatical error in our discussion of the Agency for Healthcare Research and Quality (AHRQ) indicators.

On page 53545, in our discussion of validation approaches for the Hospital IQR Program, we made a typographical error.

On page 53557, in our discussion of CDC/NHSN-based HAI measures for the PPS-Exempt Cancer Hospital Quality Reporting Program (PCHQR), we made a grammatical error.

On page 53601, in the table regarding the final performance standards for the FY 2015 Hospital Value-Base Purchasing (HVBP) Program, we inadvertently omitted a clinical process of care measure.

On page 53648, in our discussion of hospital-based inpatient psychiatric service (HBIPS) under the IPFQR Program, we made a typographical error.

On page 53655, in our discussion of the reporting and submission requirements for 2014 IPFQR payment determinations, we inadvertently made technical and typographical errors in a response to a public comment.

On page 53668, in our discussion of the information collection requirements for the LTCH Quality Reporting Program, we made two technical errors in describing the number of hospitals that report data to the National Health Safety Network (NHSN).

On page 53669, in our discussion of the information collection requirements for the LTCH Quality Reporting Program, we made a grammatical error in our response to a comment regarding the cost associated with reported pressure ulcer data.

B. Errors in the Addendum

On page 53706, in the table titled ''Comparison of Factors and Adjustments: FY 2012 Capital Federal Rate and FY 2013 Capital Federal Rate,'' there was a typographical error in the GAF/DRG Adjustment Factor shown for FY 2012.

On page 53731, we made a technical error in the number and hospitals that we estimate will have their base operating payments reduced by readmission reduction program.

C. Summary of Errors in and Corrections to Tables Posted on the CMS Web site

On pages 53717, we list the tables that are tables available only through the Internet. We are correcting the following errors in Tables 9A, 9C, and 15:

In Table 9A.—Hospital Reclassifications and Redesignations—FY 2013, Provider 010164 was inadvertently omitted.

In Table 9C.—Hospitals Redesignated as Rural under Section 1886(d)(8)(E) of the Act—FY 2013, Provider 040118 was mistakenly listed as a section 401 provider and will be removed. Provider 290009 was inadvertently omitted and will be listed as a rural reclassification from CBSA 39900 to CBSA 29.

In addition, we note that the correction of errors for Tables 9A and 9C require us to make conforming changes to Tables 2, 4A, 4B, 4C, and 4J, respectively.

In Table 15.—FY 2013 Final Readmissions Adjustment Factors, we inadvertently included Medicare inpatient claims from the FY 2008 MedPAR file with discharge dates occurring prior to July 1, 2008 in determining the base operating DRG payment amounts in the calculation of aggregate payments for excess readmissions and aggregate payments for all discharges that were used to calculate the readmissions adjustment factors published for the FY 2013 IPPS/LTCH final rule. Under the policy we adopted in that final rule, for FY 2013, aggregate payments for excess readmissions and aggregate payments for all discharges are calculated using data from Medicare inpatient MedPAR claims with discharge dates occurring on or after July 1, 2008, and no later than June 30, 2011.

III. Waiver of Proposed Rulemaking and Delay in the Effective Date

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** to provide a period for public comment before the provisions of a rule take effect in accordance with section 553(b) of the Administrative Procedure Act (APA) (5 U.S.C. 553(b)). However, we can waive this notice and comment procedure if the Secretary finds, for good cause, that the notice and comment process is impracticable, unnecessary, or contrary to the public interest, and incorporates a statement of the finding and the reasons therefore in the notice.

Section 553(d) of the APA ordinarily requires a 30-day delay in effective date of final rules after the date of their publication in the **Federal Register**. This 30-day delay in effective date can be waived, however, if an agency finds for good cause that the delay is impracticable, unnecessary, or contrary to the public interest, and the agency incorporates a statement of the findings and its reasons in the rule issued.

In our view, this correcting document does not constitute a rule that would be subject to the APA notice and comment or delayed effective date requirements. This correcting document corrects technical errors and typographical errors in the preamble, regulations text, tables included in the Addendum of the FY 2013 IPPS/LTCH PPS final rule, and tables posted on the CMS Web site but does not make substantive changes to the policies or payment methodologies that were adopted in the final rule. As a result, this correcting document is intended to ensure that the preamble, regulations text, tables included in the Addendum of the FY 2013 IPPS/LTCH PPS final rule, and tables posted on the CMS Web site accurately reflect the policies adopted in that final rule.

In addition, even if this were a rule to which the notice and comment and delayed effective date requirements applied, we find that there is good cause to waive such requirements. Undertaking further notice and comment procedures to incorporate the corrections in this document into the final rule or delaying the effective date would be contrary to the public interest. Furthermore, such procedures would be unnecessary, as we are not altering the policies that were already subject to comment and finalized in our final rule. Therefore, we believe we have good cause to waive the notice and comment and effective date requirements.

IV. Correction of Errors

In FR Doc. 2012–19079 of August 31, 2012 (77 FR 53258), make the following corrections:

A. Corrections of Errors in the Preamble

1. On page 53268,

a. First column, first partial paragraph, line 10, the phrase ''HAC measures sets'' is corrected to read ''HAI measures sets''.

b. Third column, last paragraph, second line from the bottom, the figure ''$280'' is corrected to read ''$290''.

2. On page 53278, third column, first partial paragraph, line 32, the phrase ''in FY 2010.'' is correct to read ''in FY 2013.''.

3. On page 53315, third column, last paragraph, line 4, the phrase ''the ICD–9–CM coding system'' is corrected to read ''the ICD–9–CM diagnosis codes''.

4. On page 53386, third column, third paragraph, line 7, the phrase ''for applicable conditions.'' is deleted.

5. On page 53387, third column, second paragraph, lines 37 and 38, the Web site ''*http://www.cms.hhs.gov/LimitedDataSets/*'' is corrected to read ''*http://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/LimitedDataSets/index.html*''.

6. On page 53392, lower half of the page, first column, first paragraph—

a. Line 10, the phrase ''all discharges for applicable conditions'' is corrected to read ''all discharges''.

b. Lines 12 and 13, the phrase ''all discharges for applicable conditions.'' is corrected to read ''all discharges.''.

7. On page 53485, second column, first partial paragraph—

a. Line 26, the phrase ''IPPS Hospital A'' is corrected to read ''IPPS Hospital B''.

b. Line 29, the phrase ''LTCH B'' is corrected to read ''LTCH A''.

c. Line 31, the phrase ''§ 412.536(a)(3)(1)'' is corrected to read ''§ 412.536(a)(3)(i)''.

8. On page 53508, second column, last paragraph, line 1, the phrase ''We wish to clarify'' is corrected to read ''We are clarifying''.

9. On page 53545, second column, first partial paragraph, line 5, the bracketed phrase ''[or catheter?]'' is corrected to read ''or catheter''.

10. On page 53557, second column, first full paragraph, line 2, the phrase ''with other our'' is corrected to read ''with our other''.

11. On page 53601, bottom of the page, the table entitled ''FINAL PERFORMANCE STANDARDS FOR THE FY 2015 HOSPITAL VBP PROGRAM CLINICAL PROCESS OF CARE, OUTCOME, AND EFFICIENCY DOMAINS,'' the listed entry is added after Measure ID AMI–8a to read as follows:

CLINICAL PROCESS OF CARE MEASURES

Measure ID	Description	Achievement threshold	Benchmark
HF–1	Discharge Instructions	0.94118	1.00000

12. On page 53648, first column, first full paragraph, lines 9 and 10, the phrase ''physical restraint (HBIPS–2) use'' is corrected to ''physical restraint use''

13. On page 53655, third column, second paragraph, lines 6 and 7, the phrase ''behavioral services in the IPF settings'' is corrected to read ''behavioral health services in the IPF setting.''

14. On page 53668,

a. Second column, second full paragraph, line 9, the phrase ''over 200'' is corrected to read ''upwards of 300''.

b. Third column, first partial paragraph, lines 17 and 18, the phrase ''321 LTCHs'' is corrected to read ''upwards of 300 LTCHs''.

15. On page 53669, third column, first full paragraph, lines 9 through 11, the phrase ''to comply with the reporting pressure ulcer data.'' is corrected to read ''to report pressure ulcer data.''.

B. Corrections of Errors in the Addendum

1. On page 53706, middle of the page, the table entitled, ''COMPARISON OF FACTORS AND ADJUSTMENTS: FY 2012 CAPITAL FEDERAL RATE AND FY 2013 CAPITAL FEDERAL RATE,'' listed entry is corrected to read as follows:

	FY 2012	FY 2013	Change	Percent change
GAF/DRG Adjustment Factor [1]	1.0004	0.9998	0.9998	−0.02

[1] The update factor and the GAF/DRG budget neutrality adjustment factors are built permanently into the capital Federal rates. Thus, for example, the incremental change from FY 2012 to FY 2013 resulting from the application of the 0.9998 GAF/DRG budget neutrality adjustment factor for FY 2013 is a net change of 0.9998 (or −0.02 percent).

2. On page 53731, first column, first paragraph, line 28, the figure ''2,206'' is corrected to read ''2,217''.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: September 27, 2012.

Oliver Potts,

Deputy Executive Secretary to the Department, Department of Health and Human Services.

[FR Doc. 2012–24307 Filed 9–28–12; 4:15 pm]

BILLING CODE 4120–01–P

DEPARTMENT OF TRANSPORTATION

Office of the Secretary

49 CFR Part 40

[Docket DOT–OST–2010–0026]

RIN 2105–AE14

Procedures for Transportation Workplace Drug and Alcohol Testing Programs: 6-acetylmorphine (6-AM) Testing

AGENCY: Office of the Secretary, U.S. Department of Transportation (DOT).

ACTION: Final rule.

SUMMARY: This rule adopts as final, without change, a May 4, 2012, interim final rule (IFR) which no longer requires laboratories and Medical Review Officers (MRO) to consult with one another regarding the testing for the presence of morphine when the laboratory confirms the presence of 6-acetylmorphine (6-AM). Also, laboratories and MROs will no longer need to report 6-AM results to the Office of Drug and Alcohol Policy and Compliance (ODAPC). This rule also responds to comments on the IFR.

DATES: The rule is effective October 3, 2012.

FOR FURTHER INFORMATION CONTACT: Bohdan Baczara, U.S. Department of Transportation, Office of Drug and Alcohol Policy and Compliance, 1200 New Jersey Avenue SE., Washington, DC 20590; 202–366–3784 (voice), 202–366–3897 (fax), or *bohdan.baczara@dot.gov* (email).

SUPPLEMENTARY INFORMATION:

Background and Purpose

On August 16, 2010, [75 FR 49850] the Department published its final rule to harmonize with many aspects of the revised Department of Health and Human Services (HHS) Mandatory Guidelines [73 FR 71858]. One item with which the DOT harmonized was the laboratory testing for 6-acetylmorphine (6-AM) without a morphine marker. 6-AM is a unique metabolite produced when a person uses the illicit drug heroin. Prior to the October 1, 2010, rulemaking, both the HHS and Department of Transportation (DOT) regulations required the laboratory to first test for morphine, and if it detected morphine at the HHS/DOT cutoff of 2000ng/mL, the lab would then test for 6-AM.

For the reasons discussed in the DOT final rule [75 FR 49850], we decided that, until more experience was gained with the new testing procedures for 6-AM, we would place additional requirements on laboratories and MROs. Specifically, when there was a 6-AM positive result and morphine was not detected by a laboratory at the 2000ng/mL cutoff, we added a requirement for the laboratory and MRO to determine whether morphine was detected at the laboratory's level of detection (LOD). If morphine was not detected at the laboratory's LOD, the laboratory and MRO were to report that result to DOT's Office of Drug and Alcohol Policy and Compliance (ODAPC). After consulting with ODAPC, the MRO would make a verified result determination, keeping in mind that there is no legitimate explanation for 6-AM in the employee's specimen [see § 40.151(g)]. The Department would track these results and discuss them with HHS.

On May 4, 2012, the Department issued an IFR [77 FR 26471] and effective July 3, 2012, related to 6-AM testing. For reasons stated in that IFR, we removed the requirement for laboratories and MROs to consult with one another regarding the testing for the presence of 6-AM. The IFR also streamlined the laboratory analysis and MRO reporting of 6-AM results by not having either the laboratory or MRO report the 6-AM information to ODAPC. The IFR also sought comments to the IFR which were to be submitted by June 4, 2012. There were two such comments.

Discussion of Comments to the Docket

There were two comments to the docket representing three organizations. One comment was submitted by a large organization which represents physicians who are MROs. The other comment was submitted by a large medical review officer service and consortium which provide drug and alcohol testing services primarily to the pipeline industry.

Each of the commentors fully supported the Department's position on amending the requirements for testing and reporting 6-AM test results. Their support of the IFR further reinforces that there are no legitimate medical explanations for the confirmation of 6-AM on a DOT drug test and that the MRO must make positive results determinations in these cases.

One commenter asked whether we had noted a spike followed by a decline in the 6-AM results during the first year of testing, as they did. They wondered whether our commissioned study was designed to shed light on their observation.

We would note that over time, the Department has indeed seen an increase of laboratory-reported 6-AM test results. However, we found that the largest semi-annual period rise of 6-AM results, by number and percentage increase, came even before the October 2010 effective date of the new rules. This larger rise was noted when we compared the July–December 2009 period with the January–June 2010 period. Also, it is important to note that the number of total drug tests reported by laboratories has risen during each 6-month period, starting with the July–December 2009 period, and the number of 6-AM positive results has steadily risen each period since July–December 2008.

The following table displays the laboratory data for 6-AM before, during transition, and after full implementation of the new testing protocols:

Semi-Annual period	2008 July–Dec	2009 Jan–June	2009 July–Dec	2010 Jan–June	2010 * July–Dec	2011 Jan–June	2011 July–Dec
Total Laboratory Test Results.	2.85 million ...	2.59 million ...	2.57 million ...	2.69 million ...	2.77 million ...	2.82 million ...	2.87 million
6-AM Laboratory Positives ..	121	158	173	281	298	371	429

* The new requirement for 6-AM testing was in effect for the last 3 months of the period.