

§ 9301.11 Payment and waiver.

* * * * *

(b) *Waiver.* SIGAR may waive all or part of any fee provided for in §§ 9301.8 through 9301.9 when the FOIA Officer deems that as a matter of administrative discretion or disclosure of the information is in the general public's interest because it is likely to contribute significantly to public understanding of the operations or activities of the Government and is not primarily in the commercial interest of the requester. Requesters may request a waiver in their initial FOIA request letter. Requests for a fee waiver should explain how the information requested contributes to the public's understanding of the operations or activities of the government. In determining whether a fee should be waived, the FOIA Officer may consider whether:

(1) The subject matter specifically concerns identifiable operations or activities of the government;

(2) The information is already in the public domain;

(3) Disclosure of the information would contribute to the understanding of the public-at-large as opposed to a narrow segment of the population;

(4) Disclosure of the information would significantly enhance the public's understanding of the subject matter;

(5) Disclosure of the information would further a commercial interest of the requester; and

(6) The public's interest is greater than any commercial interest of the requester.

Dated: June 21, 2012.

Steven J. Trent,

Acting Inspector General, Special Inspector General for Afghanistan Reconstruction.

[FR Doc. 2012-15665 Filed 6-26-12; 8:45 am]

BILLING CODE 3710-L9-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

21 CFR Part 20

[Docket No. FDA-2012-N-0205]

Agreements and Memoranda of Understanding Between the Food and Drug Administration and Other Departments, Agencies, and Organizations; Withdrawal

AGENCY: Food and Drug Administration, HHS.

ACTION: Direct final rule; withdrawal.

SUMMARY: The Food and Drug Administration (FDA) published in the

Federal Register of March 23, 2012 (77 FR 16923), a direct final rule making technical changes to update a requirement that many of its written agreements and memoranda of understanding with other departments, Agencies, and organizations be published in the **Federal Register**. The comment period closed June 6, 2012. FDA is withdrawing the direct final rule because the Agency received significant adverse comment.

DATES: The direct final rule published at 77 FR 16923, March 23, 2012, is withdrawn, effective June 27, 2012.

FOR FURTHER INFORMATION CONTACT:

Daniel W. Sigelman, Office of the Commissioner, Food and Drug Administration, 10903 New Hampshire Ave., Silver Spring, MD 20993-0002, 301-796-4706, FAX: 301-847-8616, email: daniel.sigelman@fda.hhs.gov.

Authority: Therefore, under the Federal Food, Drug, and Cosmetic Act and under authority delegated to the Commissioner of Food and Drugs, the direct final rule published in the **Federal Register** on March 23, 2012 (77 FR 16923) is withdrawn.

Dated: June 22, 2012.

Leslie Kux,

Assistant Commissioner for Policy.

[FR Doc. 2012-15713 Filed 6-26-12; 8:45 am]

BILLING CODE 4160-01-P

DEPARTMENT OF LABOR

Wage and Hour Division

29 CFR Part 570

Child Labor Regulations, Orders and Statements of Interpretation

CFR Correction

■ In Title 29 of the Code of Federal Regulations, Parts 500 to 899, revised as of July 1, 2011, on page 302, the section heading for § 570.65 is corrected to read as follows:

§ 570.65 [CORRECTED]

§ 570.65 Occupations involving the operation of circular saws, band saws, guillotine shears, chain saws, reciprocating saws, wood chippers, and abrasive cutting discs (Order 14).

[FR Doc. 2012-15868 Filed 6-26-12; 8:45 am]

BILLING CODE 1505-01-D

DEPARTMENT OF DEFENSE

Office of the Secretary

32 CFR Part 199

[DOD-2011-HA-0007]

RIN 0720-AB43

TRICARE Reimbursement Revisions

AGENCY: Office of the Secretary, Department of Defense.

ACTION: Final rule.

SUMMARY: This final rule provides several necessary revisions to the regulation in order for TRICARE to be consistent with Medicare. These revisions affect: Hospice periods of care; reimbursement of physician assistants and assistant-at-surgery claims; and diagnosis-related group values, removing references to specific numeric diagnosis-related group values and replacing them with their narrative description.

DATES: *Effective Date:* This rule is effective July 27, 2012.

FOR FURTHER INFORMATION CONTACT: Ms. Ann N. Fazzini, TRICARE Management Activity, Medical Benefits and Reimbursement Systems, telephone (303) 676-3803.

SUPPLEMENTARY INFORMATION:

Background

I. Hospice

This final rule revises the regulation for hospice periods of care. The Defense Authorization Act for FY 1992-1993, Public Law 102-190, directed TRICARE to provide hospice care in the manner and under the conditions provided in section 1861(dd) of the Social Security Act (42 U.S.C. 1395x(dd)). Congress' intent was for TRICARE to establish a benefit in the same manner as Medicare. TRICARE originally had the same periods of hospice care used by Medicare; however, over time the Medicare benefit changed, but TRICARE's regulation has not. The TRICARE regulation currently provides for an initial period of 90 days, a subsequent period of 90 days, a second subsequent period of 30 days, and a final period of unlimited duration. Rather than maintaining this level of specificity in the regulation and to ensure that TRICARE and Medicare's benefit periods are equal, we are revising the regulation to state that the distinct periods of care available under the hospice benefit shall be the same as those offered under Medicare's hospice program. Currently under Medicare, patients are entitled to two 90-day

election periods, followed by an unlimited number of 60-day periods. The level of specific benefits shall be included in the TRICARE Reimbursement Manual, and may be accessed at www.tricare.mil.

II. Physician Assistants and Assistant-at-Surgery

The current regulatory language references specific reimbursement percentages for assistant-at-surgery reimbursement. Rather than including these specific percentage amounts, which would require a regulatory change any time the percentage amounts change, we are making a general statement referring to the current percentages used by Medicare. Our authority for this is 10 U.S.C. 1079(h) which states: Except as provided in paragraphs (2) and (3), payment for a charge for services by an individual health care professional (or other noninstitutional health care provider) for which a claim is submitted under a plan contracted for under subsection (a) shall be equal to an amount determined to be appropriate, to the extent practicable, in accordance with the same reimbursement rules as apply to payments for similar services under title XVIII of the Social Security Act (42 U.S.C. 1395 *et seq.*). The Secretary of Defense shall determine the appropriate payment amount under this paragraph in consultation with the other administering Secretaries. The specific percentages are more appropriately included in the TRICARE Reimbursement Manual, and may be accessed at www.tricare.mil.

III. DRG

10 U.S.C. 1079(j)(2) provides that the amount to be paid to a provider of services for services provided under a plan covered by this section shall be determined under joint regulations to be prescribed by the administering Secretaries which provide that the amount of such payments shall be determined to the extent practicable in accordance with the same reimbursement rules as apply to payments to providers of services of the same type under title XVIII of the Social Security Act (42 U.S.C. 1395 *et seq.*).

In accordance with the above statute, the TRICARE/CHAMPUS DRG-based payment system transitioned to adopting the Medicare Severity-DRG based payment system on October 1, 2008. When TRICARE transitioned to the severity-based system, it was necessary to renumber the existing DRGs, and to assign different narrative descriptions to the DRG numbers. As a result, the existing regulatory reference

to specific DRG numbers and descriptions became obsolete, so we are removing the numeric references in the regulation and utilizing only the descriptive terminology.

Public Comments

A proposed rule was published on January 13, 2011 (76 FR 2291). Two sets of comments were received on the proposed rule. One commenter supported the proposed rule and urged the DoD to make it final. The other commenter concurred with the reimbursement changes in the proposed rule, but expressed concern that current TRICARE policy does not cover mental and behavioral services when delivered by a physician assistant (PA). They stated that PAs are qualified health care professionals who are authorized by state law to provide a wide range of behavioral health services to patients in all settings.

We appreciate the commenter's interest in TRICARE's behavioral health care services. TRICARE offers a robust behavioral health care program and allows care by qualified mental health providers, as listed in 32 CFR 199.4 as follows: Psychiatrists or other physicians; clinical psychologists, certified psychiatric nurse specialists, clinical social workers, and certified marriage and family therapists; and pastoral and mental health counselors under a physician's supervision. TRICARE views these professionals as qualified behavioral health services providers with the specialized training to ensure quality of care to our beneficiaries. Consequently, we have no plans to expand coverage to allow behavioral health services by PAs.

Regulatory Procedures

Executive Order 12866, "Regulatory Planning and Review" and Executive Order 13563, "Improving Regulation and Regulatory Review"

Section 801 of title 5, United States Code, and Executive Orders (E.O.) 12866 and 13563 require certain regulatory assessments and procedures for any major rule or significant regulatory action, defined as one that would result in an annual effect of \$100 million or more on the national economy or which would have other substantial impacts. It has been certified that this rule is not economically significant. It has been reviewed by the Office of Management and Budget as required under the provisions of E.O. 12866 and 13563.

Public Law 104-4, Section 202, "Unfunded Mandates Reform Act"

Section 202 of Public Law 104-4, "Unfunded Mandates Reform Act," requires that an analysis be performed to determine whether any federal mandate may result in the expenditure by State, local and tribal governments, in the aggregate, or by the private sector of \$100 million in any one year. It has been certified that this rule does not result in the expenditure by State, local and tribal governments, in aggregate, or by the private sector, of \$100 million or more in any one year, and thus this final rule is not subject to this requirement.

Public Law 96-354, "Regulatory Flexibility Act" (RFA) (5 U.S.C. 601)

Public Law 96-354, "Regulatory Flexibility Act" (RFA) (5 U.S.C. 601), requires that each Federal agency prepare a regulatory flexibility analysis when the agency issues a regulation which would have a significant impact on a substantial number of small entities. This final rule is not an economically significant regulatory action, and it has been certified that it will not have a significant impact on a substantial number of small entities. Therefore, this final rule is not subject to the requirements of the RFA.

Public Law 96-511, "Paperwork Reduction Act" (44 U.S.C. Chapters 35)

This final rule does not contain a "collection of information" requirement, and will not impose additional information collection requirements on the public under Public Law 96-511, "Paperwork Reduction Act" (44 U.S.C. Chapter 35).

Executive Order 13132, "Federalism"

E.O. 13132, "Federalism," requires that an impact analysis be performed to determine whether the rule has federalism implications that would have substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government. It has been certified that this final rule does not have federalism implications, as set forth in E.O. 13132.

List of Subjects in 32 CFR part 199

Claims, Dental health, Health care, Health insurance, Individuals with disabilities, Military personnel.

Accordingly, 32 CFR Part 199 is amended as follows:

PART 199—[AMENDED]

■ 1. The authority citation for part 199 continues to read as follows:

Authority: 5 U.S.C. 301; 10 U.S.C. chapter 55.

■ 2. Section 199.4 is amended by revising paragraph (e)(19)(v) to read as follows:

§ 199.4 Basic program benefits.

* * * * *

(e) * * *

(19) * * *

(v) *Periods of care.* Hospice care is divided into distinct periods of care. The periods of care that may be elected by the terminally ill CHAMPUS beneficiary shall be as the Director, TRICARE determines to be appropriate, but shall not be less than those offered under Medicare's Hospice Program.

* * * * *

■ 3. Section 199.14 is amended by revising paragraphs (a)(1)(ii)(C)(3), (a)(1)(iii)(A)(2), and (j)(1)(ix) to read as follows:

§ 199.14 Provider reimbursement methods.

* * * * *

(a) * * *

(1) * * *

(ii) * * *

(C) * * *

(3) All services related to heart and liver transplantation for admissions prior to October 1, 1998, which would otherwise be paid under the respective DRG.

* * * * *

(iii) * * *

(A) * * *

(2) Remove DRGs. Those DRGs that represent discharges with invalid data or diagnoses insufficient for DRG assignment purposes are removed from the database.

* * * * *

(j) * * *

(1) * * *

(ix) The allowable charge for physician assistant services other than assistant-at-surgery shall be at the same percentage, used by Medicare, of the allowable charge for a comparable service rendered by a physician performing the service in a similar location. For cases in which the physician assistant and the physician perform component services of a procedure other than assistant-at-surgery (e.g., home, office, or hospital visit), the combined allowable charge for the procedure may not exceed the allowable charge for the procedure rendered by a physician alone. The allowable charge for physician assistant

services performed as an assistant-at-surgery shall be at the same percentage, used by Medicare, of the allowable charge for a physician serving as an assistant surgeon when authorized as CHAMPUS benefits in accordance with the provisions of § 199.4(c)(3)(iii). Physician assistant services must be billed through the employing physician who must be an authorized CHAMPUS provider.

* * * * *

Dated: June 20, 2012.

Patricia L. Toppings,
OSD Federal Register Liaison Officer,
Department of Defense.

[FR Doc. 2012-15509 Filed 6-26-12; 8:45 am]

BILLING CODE 5001-06-P

DEPARTMENT OF DEFENSE**Office of the Secretary****32 CFR Part 199**

[DOD-2011-HA-0058]

RIN 0720-AB51

TRICARE; Constructive Eligibility for TRICARE Benefits of Certain Persons Otherwise Ineligible Under Retroactive Determination of Entitlement to Medicare Part A Hospital Insurance Benefits

AGENCY: Office of the Secretary, Department of Defense.

ACTION: Final rule.

SUMMARY: The Department is publishing this final rule to implement section 706 of the National Defense Authorization Act (NDAA) for Fiscal Year 2010, Public Law 111-84. Specifically, section 706 exempts TRICARE beneficiaries under the age of 65 who become disabled from the requirement to enroll in Medicare Part B for the retroactive months of entitlement to Medicare Part A in order to maintain TRICARE coverage. This statutory amendment and final rule only impact eligibility for the period in which the beneficiary's disability determination is pending before the Social Security Administration. Eligible beneficiaries are still required to enroll in Medicare Part B in order to maintain their TRICARE coverage for future months, but are considered to have coverage under the TRICARE program for the retroactive months of their entitlement to Medicare Part A. This final rule also amends the eligibility section of the TRICARE regulation to more clearly address reinstatement of TRICARE eligibility following a gap in coverage due to lack of enrollment in Medicare Part B.

DATES: *Effective Date:* This final rule is effective July 27, 2012.

FOR FURTHER INFORMATION CONTACT: Ms. Anne Breslin, TRICARE Operations Branch, TRICARE Management Activity (TMA), 5111 Leesburg Pike, Suite 810, Falls Church, VA 22041, telephone (703) 681-0039.

SUPPLEMENTARY INFORMATION:**I. Background**

Prior to the enactment of section 706 of the National Defense Authorization Act for Fiscal Year 2010 (Pub. L. 111-84), 10 U.S.C. 1086(d) provided that a person who would otherwise receive benefits under section 1086 who is entitled to Medicare Part A hospital insurance is not eligible for TRICARE unless the individual is enrolled in Medicare Part B. When a TRICARE beneficiary becomes eligible for Medicare, Medicare becomes the primary payer and TRICARE is the secondary payer. Retroactive Medicare eligibility determinations therefore caused DoD and Medicare to reprocess claims. Section 706 of the Fiscal Year 2010 National Defense Authorization Act amended 10 U.S.C. 1086(d) to exempt TRICARE beneficiaries under the age of 65 who became Medicare eligible due to a retroactive disability determination from the requirement to enroll in Medicare Part B for the retroactive months of entitlement to Medicare Part A in order to maintain TRICARE coverage. This statutory amendment became effective upon enactment of the Fiscal Year 2010 National Defense Authorization Act on October 28, 2009. Prior to this amendment, beneficiaries who did not purchase Medicare Part B to cover the retroactive period lost their TRICARE eligibility during that period of time. As a result, beneficiaries and providers were then subject to TRICARE recoupment action for care provided during the period of retroactive disability. Pursuant to this amendment, TRICARE remains first payer for any claims filed during the retroactive months and disabled TRICARE beneficiaries are relieved of the financial burden of making retroactive payments to avoid a gap in coverage. This final rule amends the Code of Federal Regulations to conform to current statutory authority regarding TRICARE eligibility.

Additionally, due to an earlier administrative omission, this final rule also amends 32 CFR 199.3 to more clearly address reinstatement of TRICARE eligibility following a gap in coverage due to lack of enrollment in Part B. While most TRICARE