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DEPARTMENT OF AGRICULTURE

Animal and Plant Health Inspection Service

9 CFR Parts 92, 93, 94, 95, 96, and 98

[Docket No. APHIS–2008–0010]

RIN 0579–AC68

Bovine Spongiform Encephalopathy; Importation of Bovines and Bovine Products

Corrections

In rule document 2013–28228 appearing on pages 72980–73008 in the issue of December 4, 2013, make the following corrections:

1. On page 72985, in the third column, in the 16th line from the bottom "C□N" should read "CAN".

§ 93.418 [Corrected]

2. On page 72996, in the second column, in the 10th line from the bottom, "C□N" should read "CAN".

3. On the same page, in the third column, in the 1st line "CN" should read "CAN".

[FR Doc. C1–2013–28228 Filed 12–9–13; 8:45 am]

BILLING CODE 1505–01–D

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 25

[Docket No. FAA–2013–1034; Special Conditions No. 25–508–SC]

Special Conditions: Cessna Model 680 Series Airplanes; Aircraft Electronic System Security Protection From Unauthorized External Access

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final special condition; request for comments.

SUMMARY: These special conditions are issued for the Cessna Model 680 Series airplanes. These airplanes will have a novel or unusual design feature associated with the architecture and connectivity capabilities of the airplanes' computer systems and networks. Connectivity to, or access by, external systems and networks may result in security vulnerabilities to the airplanes' systems.

The proposed network architecture includes the following connectivity between systems:

1. Airplane control, communication, display, monitoring and navigation systems,

2. Operator business and administrative support systems, and

3. Passenger entertainment systems, and access by systems external to the airplane.

The applicable airworthiness regulations do not contain adequate or appropriate safety standards for this design feature. These special conditions contain the additional safety standards that the Administrator considers necessary to establish a level of safety equivalent to that established by the existing airworthiness standards.

DATES: The effective date of these special conditions is December 10, 2013. We must receive your comments by January 24, 2014.

ADDRESSES: Send comments identified by docket number [FAA–2013–XXXX] using any of the following methods:

- *Federal regulations Portal:* Go to *http://www.regulations.gov/* and follow the online instructions for sending your comments electronically.

Mail: Send comments to Docket Operations, M–30, U.S. Department of Transportation (DOT), 1200 New Jersey Avenue SE., Room W12–140, West Building Ground Floor, Washington, DC 20590–0001.

Hand Delivery or Courier: Take comments to Docket Operations in Room W12–140 of the West Building Ground Floor at 1200 New Jersey Avenue SE., Washington, DC, between 8 a.m. and 5 p.m., Monday through Friday, except federal holidays.

Fax: Fax comments to Docket Operations at 202–493–2251.

Privacy: The FAA will post all comments it receives, without change, to *http://www.regulations.gov/*, including any personal information the commenter provides. Using the search function of the docket Web site, anyone can find and read the electronic form of all comments received into any FAA docket, including the name of the individual sending the comment (or signing the comment for an association, business, labor union, etc.). DOT's complete Privacy Act Statement can be found in the **Federal Register** published on April 11, 2000 (65 FRY 19477–19478), as well as at *http://DocketsInfo.dot.gov/*.

Docket: Background documents or comments received may be read at *http://www.regulations.gov/* at any time. Follow the online instructions for accessing the docket or go to the Docket Operations in Room W12–140 of the West Building Ground Floor at 1200 New Jersey Avenue SE., Washington, DC, between 9 a.m. and 5 p.m., Monday through Friday, except federal holidays.

FOR FURTHER INFORMATION CONTACT: Varun Khanna, FAA, Airplane and Flight Crew Interface Branch, ANM–111, Transport Airplane Directorate, Aircraft Certification Service, 1601 Lind Avenue SW., Renton, Washington 98057–3356; telephone 425–227–1298; facsimile 425–227–1149.

SUPPLEMENTARY INFORMATION: The FAA has determined that notice of, and opportunity for prior public comment on, these special conditions are impracticable because these procedures would significantly delay issuance of the design approval and thus delivery of the affected aircraft. The FAA has also determined that notice of these special conditions is unnecessary because the substance of these special conditions has been subject to the public comment process in several prior instances with no substantive comments received. The FAA therefore finds that good cause exists for making these special conditions effective upon publication in the **Federal Register**.

Comments Invited

We invite interested people to take part in this rulemaking by sending written comments, data, or views. The most helpful comments reference a specific portion of the special conditions, explain the reason for any recommended change, and include supporting data.

We will consider all comments we receive by the closing date for comments. We may change these special

conditions based on the comments we receive.

Background

On September 21, 2010, Cessna Aircraft Company applied for an amendment to Model 680 Type Certificate No. T00012WI.

The Model 680 "New Sovereign" is a twin-engine pressurized executive jet airplane with standard seating provisions for 14 passenger/crew and allowance for baggage and optional equipment. It will have a maximum takeoff weight of 30,775 pounds with a wingspan of 72.3 feet, a maximum operating altitude of 47,000 feet, and will have two aft-mounted Pratt & Whitney 306D engines.

The proposed Cessna Model 680 avionics architecture is novel or unusual for executive jet airplanes by allowing connection to airplane electronic systems and networks, and access from aircraft external sources (e.g., wireless devices, Internet connectivity) to the previously isolated airplane electronic assets. Cessna's proposed design is considered by the FAA to be an architecture which introduces potential security risks and vulnerabilities not addressed in current regulations and aircraft-level or system-level safety assessment methods. Consequently, this special condition has been produced to address security and safety issues arising from the use of this type of architecture, and foreseeable flight and maintenance applications impacted by these interconnected data networks and the addition of external access points.

Type Certification Basis

Under Title 14, Code of Federal Regulations (14 CFR) 21.17, Cessna must show that the Model 680 series meets the applicable provisions of 14 CFR part 25, as amended by Amendments 25–1 through 25–128. The certification basis for the 680 (S/N –000501 and on) is documented and agreed to within the Cessna Aircraft Company Model 680 Block Point Change G–1 Issue Paper.

If the Administrator finds that the applicable airworthiness regulations (i.e., 14 CFR part 25) do not contain adequate or appropriate safety standards for the Model 680 series because of a novel or unusual design feature, special conditions are prescribed under § 21.16.

Special conditions are initially applicable to the model for which they are issued. Should the type certificate for that model be amended later to include any other model that incorporates the same novel or unusual design feature, the proposed special conditions would also apply to the other model under § 21.101.

In addition to the applicable airworthiness regulations and proposed special conditions, the Cessna Model 680 series airplane must comply with the fuel vent and exhaust emission requirements of 14 CFR part 34 and the noise certification requirements of 14 CFR part 36 and the FAA must issue a finding of regulatory adequacy under § 611 of Public Law 92–574, the "Noise Control Act of 1972."

The FAA issues special conditions, as defined in 14 CFR 11.19, under § 11.38, and they become part of the type-certification basis under § 21.17(a)(2).

Novel or Unusual Design Features

The Cessna Model 680 will incorporate the following novel or unusual design features: Digital systems architecture composed of several connected networks. The proposed architecture and network configuration may be used for, or interfaced with, a diverse set of functions, including:

1. Flight-safety related control, communication, display, monitoring, and navigation systems (aircraft control functions);
2. Operator business and administrative support (operator information services);
3. Passenger information and entertainment systems (passenger entertainment services); and,
4. The capability to allow access to or by systems external to the airplane.

Discussion

The architecture and network configuration in the Cessna Model 680 Series airplanes may allow increased connectivity to, or access by, external airplane sources, airline operations, and maintenance systems to the aircraft control functions and airline information services. The aircraft control functions and airline information services perform functions required for the safe operation and maintenance of the airplane. Previously these functions and services had very limited connectivity with external sources. The architecture and network configuration may allow the exploitation of network security vulnerabilities resulting in intentional or unintentional destruction, disruption, degradation, or exploitation of data, systems, and networks critical to the safety and maintenance of the airplane. This configuration may also include the electronic transmission of field-loadable software (and hardware) applications and databases to the airplane, which would subsequently be loaded into the safety-related equipment and systems. The existing regulations and guidance material did not anticipate these types of airplane system architectures. Furthermore, 14 CFR regulations and current system safety assessment policy and techniques do not address potential security vulnerabilities, which could be exploited by unauthorized access to airplane systems, data buses, and servers. Therefore, these special conditions are issued to ensure that the security (i.e., confidentiality, integrity, and availability) of airplane systems is not compromised by unauthorized wired or wireless electronic connections.

For the reasons discussed above, these special conditions contain the additional safety standards that the Administrator considers necessary to establish a level of safety equivalent to that established by the existing airworthiness standards.

Applicability

As discussed above, these special conditions are applicable to the Cessna Model 680 Series airplanes. Should Cessna apply at a later date for a change to the type certificate to include another model incorporating the same novel or unusual design feature, the special conditions would apply to that model as well.

Conclusion

This action affects only certain novel or unusual design features on one model series of airplanes. It is not a rule of general applicability.

The substance of these special conditions has been subjected to the notice and comment period in several prior instances and has been derived without substantive change from those previously issued. It is unlikely that prior public comment would result in a significant change from the substance contained herein. Therefore, the FAA has determined that prior public notice and comment are unnecessary, and good cause exists for adopting these special conditions upon publication in the **Federal Register.** The FAA is requesting comments to allow interested persons to submit views that may not have been submitted in response to the prior opportunities for comment described above.

List of Subjects in 14 CFR Part 25

Aircraft, Aviation safety, Reporting and recordkeeping requirements.

The authority citation for these special conditions is as follows:

Authority: 49 B.S.C. 106(g), 40113, 44701, 44702, 44704.

The Special Conditions

Accordingly, pursuant to the authority delegated to me by the Administrator, the following special conditions are issued as part of the type certification basis for Cessna Model 680 Series airplanes.

System Security Protection for Aircraft Control Domain and Information Services Domain From External Access

1. The applicant must ensure airplane electronic system security protection from access by unauthorized sources external to the airplane, including those possibly caused by maintenance activity.

2. The applicant must ensure that electronic system security threats are identified and assessed, and that effective electronic system security protection strategies are implemented to protect the airplane from all adverse impacts on safety, functionality, and continued airworthiness.

3. The applicant must establish appropriate procedures to allow the operator to ensure that continued airworthiness of the aircraft is maintained, including all post-type-certification modifications that may have an impact on the approved electronic system security safeguards.

Issued in Renton, Washington, on December 4, 2013.

Jeffrey E. Duven,

Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. 2013–29378 Filed 12–9–13; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 25

[Docket No. FAA–2013–1035; Special Conditions No. 25–507–SC]

Special Conditions: Cessna Model 680 Series Airplanes; Aircraft Electronic System Security Isolation or Protection From Internal Access

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final special condition; request for comments.

SUMMARY: These special conditions are issued for the Cessna Model 680 series airplanes. These airplanes will have novel or unusual design features associated with connectivity of the passenger service computer systems to the airplane critical systems and data networks. The network architecture is composed of several connected networks including the following:

1. Flight-Safety related control and navigation systems,
2. Operator business and administrative support, and
3. Passenger entertainment.

The applicable airworthiness regulations do not contain adequate or appropriate safety standards for this design feature. These special conditions contain the additional safety standards that the Administrator considers necessary to establish a level of safety equivalent to that established by the existing airworthiness standards.

DATES: The effective date of these special conditions is December 10, 2013. We must receive your comments by January 24, 2014.

ADDRESSES: Send comments identified by docket number FAA–XXXX–XXXX using any of the following methods:

- *Federal eRegulations Portal:* Go to *http://www.regulations.gov/* and follow the online instructions for sending your comments electronically.

Mail: Send comments to Docket Operations, M–30, U.S. Department of Transportation (DOT), 1200 New Jersey Avenue SE., Room W12–140, West Building Ground Floor, Washington, DC 20590–0001.

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Docket: Background documents or comments received may be read at *http://www.regulations.gov/* at any time. Follow the online instructions for accessing the docket or go to the Docket Operations in Room W12–140 of the West Building Ground Floor at 1200 New Jersey Avenue SE., Washington, DC, between 9 a.m. and 5 p.m., Monday through Friday, except federal holidays.

FOR FURTHER INFORMATION CONTACT: Varun Khanna, FAA, Airplane and Flight Crew Interface Branch, ANM–111, Transport Airplane Directorate, Aircraft Certification Service, 1601 Lind Avenue SW., Renton, Washington 98057–3356; telephone 425–227–1298; facsimile 425–227–1149.

SUPPLEMENTARY INFORMATION: The FAA has determined that notice of, and opportunity for prior public comment on, these special conditions are impracticable because these procedures would significantly delay issuance of the design approval and thus delivery of the affected aircraft. In addition, the substance of these special conditions has been subject to the public comment process in several prior instances with no substantive comments received. The FAA therefore finds that good cause exists for making these special conditions effective upon publication in the **Federal Register.**

Comments Invited

We invite interested people to take part in this rulemaking by sending written comments, data, or views. The most helpful comments reference a specific portion of the special conditions, explain the reason for any recommended change, and include supporting data.

We will consider all comments we receive by the closing date for comments. We may change these special conditions based on the comments we receive.

Background

On September 21, 2010, Cessna applied for a change to Type Certificate No. T00012WI in the digital systems architecture in the Cessna Model 680 series airplanes.

The Cessna Model 680 "New Sovereign" is a twin-engine pressurized executive jet airplane with standard seating provisions for 14 passenger/crew and allowance for baggage and optional equipment. This airplane will have a maximum takeoff weight of 30,775 pounds with a wingspan of 72.3 feet, a maximum operating altitude of 47,000 feet, and will have two aft-mounted Pratt & Whitney 306D engines.

The proposed Cessna Model 680 architecture is novel or unusual for executive jet airplanes by allowing connection to previously isolated data networks connected to systems that perform functions required for the safe operation of the airplane. This proposed data network and design integration may result in security vulnerabilities from intentional or unintentional corruption of data and systems critical to the safety and maintenance of the

airplane. The existing regulations and guidance material did not anticipate this type of system architecture or electronic access to aircraft systems. Furthermore, regulations and current system safety assessment policy and techniques do not address potential security vulnerabilities, which could be caused by unauthorized access to aircraft data buses and servers. The intent of these special conditions is to ensure that security, integrity, and availability of aircraft systems are not compromised by certain wired or wireless electronic connections between airplane data busses and networks. A separate Cessna Model 680 project special condition addresses aircraft electronic system security protection from unauthorized external access.

Type Certification Basis

Under Title 14, Code of Federal Regulations (14 CFR) 21.17, Cessna must show that the Model 45 series meets the applicable provisions of 14 CFR part 25, as amended by Amendments 25–1 through 25–128.

If the Administrator finds that the applicable airworthiness regulations (i.e., 14 CFR part 25) do not contain adequate or appropriate safety standards for the Model 45 series because of a novel or unusual design feature, special conditions are prescribed under § 21.16.

Special conditions are initially applicable to the model for which they are issued. Should the type certificate for that model be amended later to include any other model that incorporates the same novel or unusual design feature, the proposed special conditions would also apply to the other model under § 21.101.

In addition to the applicable airworthiness regulations and proposed special conditions, the Cessna Model 680 series airplane must comply with the fuel vent and exhaust emission requirements of 14 CFR part 34 and the noise certification requirements of 14 CFR part 36 and the FAA must issue a finding of regulatory adequacy under § 611 of Public Law 92–574, the "Noise Control Act of 1972."

The FAA issues special conditions, as defined in 14 CFR 11.19, under § 11.38, and they become part of the type-certification basis under § 21.17(a)(2).

Novel or Unusual Design Features

The Cessna Model 680 will incorporate the following novel or unusual design features.

The proposed architecture and network configuration may be used for, or interfaced with, a diverse set of functions, including:

1. Flight-safety related control, communication, and navigation systems (aircraft control domain);
2. Operator business and administrative support (operator information domain); and
3. Passenger information and entertainment systems (passenger entertainment domain).

In addition, the operating systems (OS) for current aircraft systems are usually and historically proprietary. Therefore, they are not as susceptible to corruption from worms, viruses, and other malicious actions as more widely used commercial operating systems, because access to the design details of these proprietary OS is limited to the system developer and aircraft integrator. Some systems installed on the Cessna Model 680 series airplanes will use operating systems that are widely used and commercially available from third party software suppliers. The security vulnerabilities of these operating systems may be more widely known than proprietary operating systems currently used by avionics manufacturers.

Discussion

The integrated network configurations in the Cessna Model 680 series airplanes may allow increased connectivity with external network sources and will have more interconnected networks and systems, such as passenger entertainment and information services than previous airplane models. This may allow the exploitation of network security vulnerabilities and increased risks potentially resulting in unsafe conditions for the airplanes and occupants. This potential exploitation of security vulnerabilities may result in intentional or unintentional destruction, disruption, degradation, or exploitation of data and systems critical to the safety and maintenance of the airplane.

Cessna Aircraft Company should develop instructions for the operators to maintain the built-in security safeguards after the airplane enters commercial service. The instructions should address physical security, operational security, audit and monitoring of the effectiveness of security safeguards and key management procedures. A test plan should also be developed and implemented to insure that security requirements are met and there is no inadvertent or malicious change to any system, software or data.

The existing regulations and guidance material did not anticipate these types of system architectures. Furthermore, 14 CFR regulations and current system safety assessment policy and techniques do not address potential security vulnerabilities which could be exploited by unauthorized access to airplane networks and servers.

Therefore, these special conditions are being issued to ensure that the security (i.e., confidentiality, integrity, and availability) of airplane systems is not compromised by unauthorized wired or wireless electronic connections between airplane systems and the passenger entertainment services.

For the reasons discussed above, these special conditions contain the additional safety standards that the Administrator considers necessary to establish a level of safety equivalent to that established by the existing airworthiness standards.

Applicability

As discussed above, these special conditions are applicable to the Cessna Model 680 series airplanes. Should Cessna apply at a later date for a change to the type certificate to include another model incorporating the same novel or unusual design feature, the special conditions would apply to that model as well.

Conclusion

This action affects only certain novel or unusual design features on one model series of airplanes. It is not a rule of general applicability.

The substance of these special conditions has been subjected to the notice and comment period in several prior instances and has been derived without substantive change from those previously issued. It is unlikely that prior public comment would result in a significant change from the substance contained herein. Therefore, because a delay would significantly affect the certification of the airplane, which is imminent, the FAA has determined that prior public notice and comment are unnecessary and impracticable, and good cause exists for adopting these special conditions upon publication in the **Federal Register.** The FAA is requesting comments to allow interested persons to submit views that may not have been submitted in response to the prior opportunities for comment described above.

List of Subjects in 14 CFR Part 25

Aircraft, Aviation safety, Reporting and recordkeeping requirements.

The authority citation for these special conditions is as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701, 44702, 44704.

The Special Conditions

Accordingly, pursuant to the authority delegated to me by the

Administrator, the following special conditions are issued as part of the type certification basis for Cessna Model 680 series airplanes.

Isolation or Security Protection of the Aircraft Control Domain and the Information Services Domain From the Passenger Services Domain

1. The applicant must ensure that the design provides isolation from, or airplane electronic system security protection against, access by unauthorized sources internal to the airplane. The design must prevent inadvertent and malicious changes to, and all adverse impacts upon, airplane equipment, systems, networks, or other assets required for safe flight and operations.

2. The applicant must establish appropriate procedures to allow the operator to ensure that continued airworthiness of the aircraft is maintained, including all post-type-certification modifications that may have an impact on the approved electronic system security safeguards.

Issued in Renton, Washington, on December 4, 2013.

Jeffrey E. Duven,

Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. 2013–29377 Filed 12–9–13; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2013–0023; Directorate Identifier 96–CE–072–AD; Amendment 39–17688; AD 99–01–05 R1]

RIN 2120–AA64

Airworthiness Directives; Various Aircraft Equipped with Wing Lift Struts

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule.

SUMMARY: We are revising Airworthiness Directive (AD) 99–01–05 for certain aircraft equipped with wing lift struts. AD 99–01–05 required repetitively inspecting the wing lift struts for corrosion; repetitively inspecting the wing lift strut forks for cracks; replacing any corroded wing lift strut; replacing any cracked wing lift strut fork; and repetitively replacing the wing lift strut forks at a specified time for certain airplanes. AD 99–01–05 also required incorporating a "NO STEP" placard on the wing lift strut. Since we issued AD 99–01–05, we were informed that paragraph (c) had been misinterpreted and caused confusion. This AD clarifies the intent of the language in paragraph (c) of AD 99–01–05 and retains all other requirements of AD 99–01–05. We are issuing this AD to correct the unsafe condition on these products.

DATES: This AD is effective January 14, 2014.

The Director of the Federal Register approved the incorporation by reference of certain other publications listed in this AD as of February 8, 1999 (63 FR 72132, December 31, 1998).

ADDRESSES: For service information identified in this AD, contact Piper Aircraft, Inc., Customer Services, 2926 Piper Drive, Vero Beach, Florida 32960; telephone: (772) 567–4361; Internet: *www.piper.com*. Copies of the instructions to the F. Atlee Dodge supplemental type certificate (STC) and information about the Jensen Aircraft STCs may be obtained from F. Atlee Dodge, Aircraft Services, LLC., 6672 Wes Way, Anchorage, Alaska 99518–0409, Internet: *www.fadodge.com*. You may review copies of the referenced service information at the FAA, Small Airplane Directorate, 901 Locust, Kansas City, Missouri 64106. For information on the availability of this material at the FAA, call (816) 329–4148.

Examining the AD Docket

You may examine the AD docket on the Internet at *http://www.regulations.gov* by searching for and locating it in Docket No. FAA–2013–00023; or in person at the Docket Management Facility between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The AD docket contains this AD, the regulatory evaluation, any comments received, and other information. The address for the Docket Office (phone: 800–647–5527) is Document Management Facility, U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE., Washington, DC 20590.

FOR FURTHER INFORMATION CONTACT: For Piper Aircraft, Inc. airplanes, contact: Gregory "Keith" Noles, Aerospace Engineer, FAA, Atlanta Aircraft Certification Office, 1701 Columbia Avenue, College Park, Georgia 30337; phone: (404) 474–5551; fax: (404) 474–5606; email: *gregory.noles@faa.gov*.

For FS 2000 Corp, FS 2001 Corp, FS 2002 Corporation, and FS 2003 Corporation airplanes, contact: Jeff Morfitt, Aerospace Engineer, FAA, Seattle Aircraft Certification Office, 1601 Lind Avenue SW, Renton, Washington 98057; phone: (425) 917–6405; fax: (245) 917–6590; email: *jeff.morfitt@faa.gov*.

For LAVIA ARGENTINA S.A. (LAVIASA) airplanes, contact: S.M. Nagarajan, Aerospace Engineer, FAA, Small Airplane Directorate, 901 Locust, Room 301, Kansas City, Missouri 64106; telephone: (816) 329–4145; fax: (816) 329–4090; email: *sarjapur.nagarajan@faa.gov*.

SUPPLEMENTARY INFORMATION:

Discussion

We issued a notice of proposed rulemaking (NPRM) to amend 14 CFR part 39 to revise AD 99–01–05, Amendment 39–10972 (63 FR 72132, December 31, 1998), ("AD 99–01–05"). AD 99–01–05 applied to the specified products. The NPRM published in the **Federal Register** on January 16, 2013 (78 FR 3356). The NPRM proposed to retain all requirements of AD 99–01–05 and clarify our intent of required actions if the seal on a sealed wing lift strut is ever improperly broken.

Comments

We gave the public the opportunity to participate in developing this AD. The following presents the comments received on the proposal and the FAA's response to each comment.

Request to Combine This AD with Another AD

Len J. Buckel stated that AD 99–26–19, Amendment 39–11470 (64 FR 72524, December 28, 1999), ("AD 99–26–19"), and AD 99–01–05 should be combined into one AD.

The commenter stated that since AD 99–01–05 is being revised, it should also be revised to include Piper Aircraft, Inc. (Piper) Model J–2 airplanes, which are covered separately in AD 99–26–19, so that all affected Piper airplanes would be covered in one AD.

We do not agree with the commenter. AD 99–01–05 is being revised only to clarify language about how to maintain a sealed wing lift strut assembly if the seal is ever improperly broken. This revision does not require any additional actions for the owners/operators. The same confusing and misleading language that prompted this revision is also included in AD 99–26–19, which will also be revised. In order to avoid any further confusion, we believe that it is in the best interest of the owners/operators to maintain two separate ADs.

We have not changed the final rule AD action based on this comment.

Request to Further Clarify Paragraph (g)

Jamison Peters of Airframes Alaska stated that stronger and clearer language should be added to this AD that specifies allowing a sealed wing lift strut to be temporarily unsealed in order to perform proper maintenance actions.

The commenter stated that the proposed language in Note 1 to paragraph (g) seems somewhat ambiguous using the word "never" in regards to the seal of a strut being "never broken" but then saying that ". . . nor did we intend to preclude proper maintenance action that may temporarily unseal a sealed strut . . ."

We agree with the commenter that the proposed language could be interpreted as ambiguous or conflicting. We have revised Note 2 to paragraph (g) to further clarify that properly unsealing and resealing a sealed wing lift strut for maintenance, as long as all regulations and issues are considered, is still considered a terminating action for the repetitive inspection requirements of this AD.

Conclusion

We reviewed the relevant data, considered the comments received, and determined that air safety and the public interest require adopting this AD with the change described previously and minor editorial changes. We have determined that these minor changes:

- Are consistent with the intent that was proposed in the NPRM (78 FR 3356, January 16, 2013) for correcting the unsafe condition; and
- Do not add any additional burden upon the public than was already proposed in the NPRM (78 FR 3356, January 16, 2013).

We also determined that these changes will not increase the economic burden on any operator or increase the scope of this AD.

Costs of Compliance

We estimate that this AD affects 22,000 airplanes of U.S. registry.

We estimate the following costs to comply with this AD. However, the only difference in the costs presented below and the costs associated with AD 99–01–05 is the change in the labor rate from $65 per hour to $85 per hour:

ESTIMATED COSTS

Action	Labor cost	Parts cost	Cost per product	Cost on U.S. operators
Inspection of the wing lift struts and wing lift strut forks.	8 work-hours × $85 per hour = $680 per inspection cycle.	Not applicable	$680 per inspection cycle.	$14,960,000 per inspection cycle.
Installation placard	1 work-hour × $85 = $85	$30	$115	$2,530,000.

We estimate the following costs to do any necessary replacements that will be required based on the results of the inspection. We have no way of determining the number of aircraft that might need these replacements:

ON-CONDITION COSTS

Action	Labor cost per wing lift strut	Parts cost per wing lift strut	Cost per product per wing lift strut
Replacement of the wing lift strut and/or wing lift strut forks.	4 work-hours × $85 per hour = $340	$440	$780

Authority for This Rulemaking

Title 49 of the United States Code specifies the FAA's authority to issue rules on aviation safety. Subtitle I, section 106, describes the authority of the FAA Administrator. Subtitle VII, Aviation Programs, describes in more detail the scope of the Agency's authority.

We are issuing this rulemaking under the authority described in Subtitle VII, Part A, Subpart III, section 44701, "General requirements." Under that section, Congress charges the FAA with promoting safe flight of civil aircraft in air commerce by prescribing regulations for practices, methods, and procedures the Administrator finds necessary for safety in air commerce. This regulation is within the scope of that authority because it addresses an unsafe condition that is likely to exist or develop on products identified in this rulemaking action.

Regulatory Findings

We have determined that this AD will not have federalism implications under Executive Order 13132. This AD will not have a substantial direct effect 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.

For the reasons discussed above, I certify that this AD:

(1) Is not a "significant regulatory action" under Executive Order 12866,

(2) Is not a "significant rule" under DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979),

(3) Will not affect intrastate aviation in Alaska, and

(4) Will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Incorporation by reference, Safety.

Adoption of the Amendment

Accordingly, under the authority delegated to me by the Administrator, the FAA amends 14 CFR part 39 as follows:

PART 39—AIRWORTHINESS DIRECTIVES

■ 1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701.

§ 39.13 [Amended]

■ 2. The FAA amends § 39.13 by removing Airworthiness Directive (AD) 99–01–05, Amendment 39–10972 (63 FR 72132, December 31, 1998), and adding the following new AD:

99–01–05 R1 Various Aircraft: Amendment 39–17688; Docket No. FAA–2013–0023; Directorate Identifier 96–CE–072–AD.

(a) Effective Date

This AD is effective January 14, 2014

(b) Affected ADs

This AD revises AD 99–01–05, Amendment 39–10972 (63 FR 72132, December 31, 1998), which superseded AD 93–10–06, Amendment 39–8586 (58 FR 29965, May 25, 1993). AD 99–26–19, Amendment 39–11479 (64 FR 72524, December 28, 1999), also relates to the subject of this AD.

(c) Applicability

This AD applies to the following airplanes identified in table 1 of paragraph (c) of this AD, that are:

(1) Equipped with wing lift struts, including airplanes commonly known as a "Clipped Wing Cub," which modify the airplane primarily by removing approximately 40 inches of the inboard portion of each wing; and

(2) certificated in any category.

TABLE 1 TO PARAGRAPH (C) OF THIS AD—APPLICABILITY

Type certificate holder	Aircraft model	Serial No.
FS 2000 Corp	L–14	All.
FS 2001 Corp	J5A (Army L–4F), J5A–80, J5B (Army L–4G), J5C, AE–1, and HE–1.	All.
FS 2002 Corporation	PA–14	14–1 through 14–523.
FS 2003 Corporation	PA–12 and PA–12S	12–1 through 12–4036.
LAVIA ARGENTINA S.A. (LAVIASA)	PA–25, PA–25–235, and PA–25–260	25–1 through 25–8156024.
Piper Aircraft, Inc.	TG–8 (Army TG–8, Navy XLNP–1)	All.
Piper Aircraft, Inc.	E–2 and F–2	All.
Piper Aircraft, Inc.	J3C–40, J3C–50, J3C–50S, (Army L–4, L–4B, L–4H, and L–4J), J3C–65 (Navy NE–1 and NE–2), J3C–65S, J3F–50, J3F–50S, J3F–60, J3F–60S, J3F–65 (Army L–4D), J3F–65S, J3L, J3L–S, J3L–65 (Army L–4C), and J3L–65S.	All.
Piper Aircraft, Inc.	J4, J4A, J4A–S, and J4E (Army L–4E)	4–401 through 4–1649.
Piper Aircraft, Inc.	PA–11 and PA–11S	11–1 through 11–1678.
Piper Aircraft, Inc.	PA–15	15–1 through 15–388.
Piper Aircraft, Inc.	PA–16 and PA–16S	16–1 through 16–736.
Piper Aircraft, Inc.	PA–17	17–1 through 17–215.
Piper Aircraft, Inc.	PA–19 (Army L–18C), and PA–19S	19–1, 19–2, and 19–3.
Piper Aircraft, Inc.	PA–20, PA–20S, PA–20 "115", PA–20S "115", PA–20 "135", and PA–20S "135".	20–1 through 20–1121.
Piper Aircraft, Inc.	PA–22, PA–22–108, PA–22–135, PA–22S–135, PA–22–150, PA–22S–150, PA–22–160, and PA–22S–160.	22–1 through 22–9848.

(d) Subject

Joint Aircraft System Component (JASC)/ Air Transport Association (ATA) of America Code 57, Wings.

(e) Unsafe Condition

(1) The subject of this AD was originally prompted by reports of corrosion damage found on the wing lift struts. We are revising AD 99–01–05, Amendment 39–10972 (63 FR 72132, December 31, 1998), because of reports that paragraph (c) had been misinterpreted and caused confusion. This AD removes the language in paragraph (c) of AD 99–01–05, which caused the confusion.

(2) This AD clarifies the FAA's intention that if a sealed wing lift strut assembly is installed as a replacement part, the repetitive inspection requirement is terminated only if the seal is never improperly broken. If the seal is improperly broken, then that wing lift strut becomes subject to continued repetitive inspections. We did not intend to promote drilling holes into or otherwise unsealing a sealed strut. This AD retains all the actions required in AD 99–01–05 and this AD does not require any actions over that already required by AD 99–01–05. This AD does not add any additional burden to the owners/ operators of the affected airplanes.

(3) We are issuing this AD to detect and correct corrosion and cracking on the front and rear wing lift struts and forks, which could cause the wing lift strut to fail. This failure could result in the wing separating from the airplane.

(f) Paragraph Designation Changes to AD 99–01–05 R1

Since AD 99–01–05, Amendment 39–10972 (63 FR 72132, December 31, 1998), was issued, the AD format has been revised, and certain paragraphs have been rearranged. As a result, the corresponding paragraph identifiers have changed in this AD as listed in the following table:

TABLE 2 TO PARAGRAPH (F) OF THIS AD—REVISED PARAGRAPH IDENTIFIERS

Requirement in AD 99–01–05	Corresponding requirement in AD 99–01–05 R1
paragraph (a)	paragraph (h).
paragraph (a)(1)	paragraph (i)(1).
paragraph (a)(1)(i)	paragraph (i)(1)(i).
paragraph (a)(1)(ii)	paragraph (i)(1)(ii).
paragraph (a)(2)	paragraph (i)(2).
paragraph (a)(2)(i)	paragraph (i)(2)(i).
paragraph (a)(2)(ii)	paragraph (i)(2)(ii).
paragraph (a)(3)	paragraph (j)(1).
paragraph (a)(4)	paragraph (j)(2).
paragraph (a)(5)	paragraph (j)(3).
paragraph (b)	paragraph (k).
paragraph (b)(1)	paragraph (l).
paragraph (b)(1)(i)	paragraph (l)(1).
paragraph (b)(1)(ii)(B) and (b)(1)(iv).	paragraph (l)(2).
paragraph (b)(1)(ii)(C) and (b)(1)(iv).	paragraph (l)(3).
paragraph (b)(1)(ii)(A) and (b)(1)(iv).	paragraph (l)(4).
paragraph (b)(1)(iii), (b)(2), (b)(1)(iv).	paragraph (m)(1).
paragraph (b)(3) through (b)(3)(ii).	paragraph (m)(2).
paragraph (b)(4) through (b)(4)(vi).	paragraph (m)(3) thru (m)(3)(vi).
paragraph (b)(5) through (b)(5)(ii).	paragraph (m)(4).
Paragraph (c)	Removed.
paragraph (d)	paragraph (n)(1).

TABLE 2 TO PARAGRAPH (F) OF THIS AD—REVISED PARAGRAPH IDENTIFIERS—Continued

Requirement in AD 99–01–05	Corresponding requirement in AD 99–01–05 R1
paragraph (d)(1)	paragraph (n)(1)(i).
paragraph (d)(2)	paragraph (n)(1)(ii).
N/A	paragraph (n)(2).

(g) Compliance

Unless already done (compliance with AD 99–01–05, Amendment 39–10972 (63 FR 72132, December 31, 1998)), do the following actions within the compliance times specified in paragraphs (h) through (n) of this AD, including all subparagraphs. Properly unsealing and resealing a sealed wing lift strut is still considered a terminating action for the repetitive inspection requirements of this AD as long as all appropriate regulations and issues are considered, such as static strength, fatigue, material effects, immediate and long-term (internal and external) corrosion protection, resealing methods, etc. Current FAA regulations in 14 CFR 43.13(b) specify that maintenance performed will result in the part's condition to be at least equal to its original or properly altered condition. Any maintenance actions that unseal a sealed wing lift strut should be coordinated with the Atlanta Aircraft Certification Office (ACO) through the local airworthiness authority (e.g., Flight Standards District Office). There are provisions in paragraph (o) of this AD for approving such actions as an alternative method of compliance (AMOC).

(h) Remove Wing Lift Struts

At whichever of the compliance times specified in paragraphs (h)(1) or (h)(2) of this AD that occurs later, remove the wing lift struts following Piper Aircraft Corporation Mandatory Service Bulletin (Piper MSB) No. 528D, dated October 19, 1990, or Piper MSB No. 910A, dated October 10, 1989, as applicable. Before further flight after the removal, do the actions in one of the following paragraphs (i)(1), (i)(2), (j)(1), (j)(2), or (j)(3) of this AD, including all subparagraphs.

(1) Within 1 calendar month after February 8, 1999 (the effective date retained from AD 99–01–05, Amendment 39–10972 (63 FR 72132, December 31, 1998)); or

(2) Within 24 calendar months after the last inspection done in accordance with AD 93–10–06, Amendment 39–8586 (58 FR 29965, May 25, 1993) (which was superseded by AD 99–01–05, Amendment 39–10972 (63 FR 72132, December 31, 1998)), whichever occurs later.

(i) Inspect Wing Lift Struts

Before further flight after the removal required in paragraph (h) of this AD, inspect each wing lift strut following paragraph (i)(1) or (i)(2) of this AD, including all subparagraphs, or do the wing lift strut replacement following one of the options in paragraph (j)(1), (j)(2), or (j)(3) of this AD.

(1) Inspect each wing lift strut for corrosion and perceptible dents following Piper MSB No. 528D, dated October 19, 1990, or Piper MSB No. 910A, dated October 10, 1989, as applicable.

(i) *If no corrosion is visible and no perceptible dents are found on any wing lift strut during the inspection required in paragraph (i)(1) of this AD,* before further flight, apply corrosion inhibitor to each wing lift strut following Piper MSB No. 528D, dated October 19, 1990, or Piper MSB No. 910A, dated October 10, 1989, as applicable.

Repetitively thereafter inspect each wing lift strut at intervals not to exceed 24 calendar months following the procedures in paragraph (i)(1) or (i)(2) of this AD, including all subparagraphs.

(ii) *If corrosion or perceptible dents are found on any wing lift strut during the inspection required in paragraph (i)(1) of this AD or during any repetitive inspection required in paragraph (i)(1)(i) of this AD,* before further flight, replace the affected wing lift strut with one of the replacement options specified in paragraph (j)(1), (j)(2), or (j)(3) of this AD. Do the replacement following the procedures specified in those paragraphs, as applicable.

(2) Inspect each wing lift strut for corrosion following the procedures in the Appendix to this AD. This inspection must be done by a Level 2 or Level 3 inspector certified using the guidelines established by the American Society for Non-destructive Testing or the "Military Standard for Nondestructive Testing Personnel Qualification and Certification" (MIL–STD–410E), which can be found on the Internet at *http://aerospacedefense.thomasnet.com/Asset/MIL-STD-410.pdf.*

(i) *If no corrosion is found on any wing lift strut during the inspection required in paragraph (i)(2) of this AD and all requirements in the Appendix to this AD are met,* before further flight, apply corrosion inhibitor to each wing lift strut following Piper MSB No. 528D, dated October 19, 1990, or Piper MSB No. 910A, dated October 10, 1989, as applicable. Repetitively thereafter inspect each wing lift strut at intervals not to exceed 24 calendar months following the procedures in paragraph (i)(1) or (i)(2) of this AD, including all subparagraphs.

(ii) *If corrosion is found on any wing lift strut during the inspection required in paragraph (i)(2) of this AD or during any repetitive inspection required in paragraph (i)(2)(i) of this AD, or if any requirement in the Appendix of this AD is not met,* before further flight after any inspection in which corrosion is found or the Appendix requirements are not met, replace the affected wing lift strut with one of the replacement options specified in paragraph (j)(1), (j)(2), or (j)(3) of this AD. Do the replacement following the procedures specified in those paragraphs, as applicable.

(j) Wing Lift Strut Replacement Options

Before further flight after the removal required in paragraph (h) of this AD, replace the wing lift struts following one of the options in paragraph (j)(1), (j)(2), or (j)(3) of this AD, including all subparagraphs, or inspect each wing lift strut following paragraph (i)(1) or (i)(2) of this AD.

(1) Install original equipment manufacturer (OEM) part number wing lift struts (or FAA-approved equivalent part numbers) that have been inspected following the procedures in either paragraph (i)(1) or (i)(2) of this AD, including all subparagraphs, and are found to be airworthy. Do the installations following Piper MSB No. 528D, dated October 19, 1990, or Piper MSB No. 910A, dated October 10, 1989, as applicable. Repetitively thereafter inspect the newly installed wing lift struts at intervals not to exceed 24 calendar months following the procedures in either paragraph (i)(1) or (i)(2) of this AD, including all subparagraphs.

(2) Install new sealed wing lift strut assemblies (or FAA-approved equivalent part numbers) (these sealed wing lift strut assemblies also include the wing lift strut forks) following Piper MSB No. 528D, dated October 19, 1990, and Piper MSB No. 910A, dated October 10, 1989, as applicable. Installing one of these new sealed wing lift strut assemblies terminates the repetitive inspection requirements in paragraphs (i)(1) and (i)(2) of this AD, and the wing lift strut fork removal, inspection, and replacement requirement in paragraphs (k) and (l) of this AD, including all subparagraphs, for that wing lift strut assembly.

(3) Install F. Atlee Dodge wing lift strut assemblies following F. Atlee Dodge Aircraft Services, Inc. Installation Instructions No. 3233–I for Modified Piper Wing Lift Struts Supplemental Type Certificate (STC) SA4635NM, dated February 1, 1991, which can be found on the Internet at *http://rgl.faa.gov/Regulatory_and_Guidance_Library/rgstc.nsf/0/E726AAA2831BD20085256CC2000E3DB7?OpenDocument&Highlight=sa4635nm.* Repetitively thereafter inspect the newly installed wing lift struts at intervals not to exceed 60 calendar months following the procedures in paragraph (i)(1) or (i)(2) of this AD, including all subparagraphs.

(k) Remove Wing Lift Strut Forks

For all affected airplane models, except for Models PA–25, PA–25–235, and PA–25–260 airplanes, within the next 100 hours time-in-service (TIS) after February 8, 1999 (the effective date retained from AD 99–01–05, Amendment 39–10972 (63 FR 72132, December 31, 1998)) or within 500 hours TIS after the last inspection done in accordance with AD 93–10–06, Amendment 39–8586 (58 FR 29965, May 25, 1993) (which was superseded by AD 99–01–05), whichever occurs later, remove the wing lift strut forks (unless already replaced in accordance with paragraph (j)(2) of this AD). Do the removal following Piper MSB No. 528D, dated October 19, 1990, or Piper MSB No. 910A, dated October 10, 1989, as applicable. Before further flight after the removal, do the actions in one of the following paragraphs (l) or (m) of this AD, including all subparagraphs.

(l) Inspect and Replace Wing Lift Strut Forks

Before further flight after the removal required in paragraph (k) of this AD, inspect the wing lift strut forks following paragraph (l) of this AD, including all subparagraphs, or do the wing lift strut fork replacement following one of the options in paragraph (m)(1), (m)(2), (m)(3), or (m)(4) of this AD, including all subparagraphs. Inspect the wing

lift strut forks for cracks using magnetic particle procedures, such as those contained in FAA Advisory Circular (AC) 43.13–1B, Chapter 5, which can be found on the Internet *http://rgl.faa.gov/Regulatory_and_Guidance_Library/rgAdvisoryCircular.nsf/0/99c827db9baac81b86256b4500596c4e/$FILE/Chapter%2005.pdf*. Repetitively thereafter inspect at intervals not to exceed 500 hours TIS until the replacement time requirement specified in paragraph (l)(2) or (l)(3) of this AD is reached provided no cracks are found.

(1) *If cracks are found during any inspection required in paragraph (l) of this AD or during any repetitive inspection required in paragraph (l)(2) or (l)(3) of this AD*, before further flight, replace the affected wing lift strut fork with one of the replacement options specified in paragraph (m)(1), (m)(2), (m)(3), or (m)(4) of this AD, including all subparagraphs. Do the replacement following the procedures specified in those paragraphs, as applicable.

(2) *If no cracks are found during the initial inspection required in paragraph (l) of this AD and the airplane is currently equipped with floats or has been equipped with floats at any time during the previous 2,000 hours TIS since the wing lift strut forks were installed*, at or before accumulating 1,000 hours TIS on the wing lift strut forks, replace the wing lift strut forks with one of the replacement options specified in paragraph (m)(1), (m)(2), (m)(3), or (m)(4) of this AD, including all subparagraphs. Do the replacement following the procedures specified in those paragraphs, as applicable. Repetitively thereafter inspect the newly installed wing lift strut forks at intervals not to exceed 500 hours TIS following the procedures specified in paragraph (l) of this AD, including all subparagraphs.

(3) *If no cracks are found during the initial inspection required in paragraph (l) of this AD and the airplane has never been equipped with floats during the previous 2,000 hours TIS since the wing lift strut forks were installed*, at or before accumulating 2,000 hours TIS on the wing lift strut forks, replace the wing lift strut forks with one of the replacement options specified in paragraph (m)(1), (m)(2), (m)(3), or (m)(4) of this AD, including all subparagraphs. Do the replacement following the procedures specified in those paragraphs, as applicable. Repetitively thereafter inspect the newly installed wing lift strut forks at intervals not to exceed 500 hours TIS following the procedures specified in paragraph (l) of this AD, including all subparagraphs.

(m) Wing Lift Strut Fork Replacement Options

Before further flight after the removal required in paragraph (k) of this AD, replace the wing lift strut forks following one of the options in paragraph (m)(1), (m)(2), (m)(3), or (m)(4) of this AD, including all subparagraphs, or inspect the wing lift strut forks following paragraph (1) of this AD, including all subparagraphs.

(1) Install new OEM part number wing lift strut forks of the same part numbers of the existing part (or FAA-approved equivalent part numbers) that were manufactured with rolled threads. Wing lift strut forks manufactured with machine (cut) threads are not to be used. Do the installations following Piper MSB No. 528D, dated October 19, 1990, or Piper MSB No. 910A, dated October 10, 1989, as applicable. Repetitively thereafter inspect and replace the newly installed wing lift strut forks at intervals not to exceed 500 hours TIS following the procedures specified in paragraph (l) of this AD, including all subparagraphs.

(2) Install new sealed wing lift strut assemblies (or FAA-approved equivalent part numbers) (these sealed wing lift strut assemblies also include the wing lift strut forks) following Piper MSB No. 528D, dated October 19, 1990, and Piper MSB No. 910A, dated October 10, 1989, as applicable. This installation may have already been done through the option specified in paragraph (j)(2) of this AD. Installing one of these new sealed wing lift strut assemblies terminates the repetitive inspection requirements in paragraphs (i)(1) and (i)(2) of this AD, and the wing lift strut fork removal, inspection, and replacement requirements in paragraphs (k) and (l) of this AD, including all subparagraphs, for that wing lift strut assembly.

(3) *For the airplanes specified below*, install Jensen Aircraft wing lift strut fork assemblies specified below in the applicable STC following Jensen Aircraft Installation Instructions for Modified Lift Strut Fitting. Installing one of these wing lift strut fork assemblies terminates the repetitive inspection requirement of this AD only for that wing lift strut fork. Repetitively inspect each wing lift strut as specified in paragraph (i)(1) or (i)(2) of this AD, including all subparagraphs.

(i) For Models PA–12 and PA–12S airplanes: STC SA1583NM, which can be found on the Internet at *http://rgl.faa.gov/Regulatory_and_Guidance_Library/rgstc.nsf/0/2E708575849845B285256CC1008213CA?OpenDocument&Highlight=sa1583nm;*

(ii) For Model PA–14 airplanes: STC SA1584NM, which can be found on the Internet at *http://rgl.faa.gov/Regulatory_and_Guidance_Library/rgstc.nsf/0/39872B814471737685256CC1008213D0?OpenDocument&Highlight=sa1584nm;*

(iii) For Models PA–16 and PA–16S airplanes: STC SA1590NM, which can be found on the Internet at *http://rgl.faa.gov/Regulatory_and_Guidance_Library/rgstc.nsf/0/B28C4162E30D941F85256CC1008213F6?OpenDocument&Highlight=sa1590nm;*

(iv) For Models PA–18, PA–18S, PA–18 "105" (Special), PA–18S "105" (Special), PA–18A, PA–18 "125" (Army L–21A), PA–18S "125", PA–18AS "125", PA–18 "135" (Army L–21B), PA–18A "135", PA–18S "135", PA–18AS "135", PA–18 "150", PA–18A "150", PA–18S "150", PA–18AS "150", PA–18A (Restricted), PA–18A "135" (Restricted), and PA–18A "150" (Restricted) airplanes: STC SA1585NM, which can be found on the Internet at *http://rgl.faa.gov/Regulatory_and_Guidance_Library/rgstc.nsf/0/A2BE010FB1CA61A285256CC1008213D6?OpenDocument&Highlight=sa1585nm;*

(v) For Models PA–20, PA–20S, PA–20 "115", PA–20S "115", PA–20 "135", and PA–20S "135" airplanes: STC SA1586NM, which can be found on the Internet at *http://rgl.faa.gov/Regulatory_and_Guidance_Library/rgstc.nsf/0/873CC69D42C87CF585256CC1008213DC?OpenDocument&Highlight=sa1586nm;* and

(vi) For Model PA–22 airplanes: STC SA1587NM, which can be found on the Internet at *http://rgl.faa.gov/Regulatory_and_Guidance_Library/rgstc.nsf/0/B051D04CCC0BED7E85256CC1008213E0?OpenDocument&Highlight=sa1587nm.*

(4) Install F. Atlee Dodge wing lift strut assemblies following F. Atlee Dodge Installation Instructions No. 3233–I for Modified Piper Wing Lift Struts (STC SA4635NM), dated February 1, 1991, which can be found on the Internet at *http://rgl.faa.gov/Regulatory_and_Guidance_Library/rgstc.nsf/0/E726AAA2831BD20085256CC2000E3DB7?OpenDocument&Highlight=sa4635nm.* This installation may have already been done in accordance paragraph (j)(3) of this AD. Installing these wing lift strut assemblies terminates the repetitive inspection requirements of this AD for the wing lift strut fork only. Repetitively inspect the wing lift struts as specified in paragraph (i)(1) or (i)(2) of this AD, including all subparagraphs.

(n) Install Placard

(1) Within 1 calendar month after February 8, 1999 (the effective date retained from AD 99–01–05, Amendment 39–10972 (63 FR 72132, December 31, 1998)), or within 24 calendar months after the last inspection required by AD 93–10–06, Amendment 39–8586 (58 FR 29965, May 25, 1993) (which was superseded by AD 99–01–05), whichever occurs later, and before further flight after any replacement of a wing lift strut assembly required by this AD, do the actions in one of the following paragraphs (n)(1)(i) or (n)(1)(ii) of this AD:

(i) Install "NO STEP" decal, Piper (P/N) 80944–02, on each wing lift strut approximately 6 inches from the bottom of the wing lift strut in a way that the letters can be read when entering and exiting the airplane; or

(ii) Paint the words "NO STEP" approximately 6 inches from the bottom of the wing lift strut in a way that the letters can be read when entering and exiting the airplane. Use a minimum of 1-inch letters using a color that contrasts with the color of the airplane.

(2) The "NO STEP" markings required by paragraph (n)(1)(i) or (n)(1)(ii) of this AD must remain in place for the life of the airplane.

(o) Alternative Methods of Compliance (AMOCs)

(1) The Manager, Atlanta ACO, FAA, has the authority to approve AMOCs for this AD related to Piper Aircraft, Inc. airplanes; the Manager, Seattle ACO, FAA has the authority to approve AMOCs for this AD related to FS 2000 Corp, FS 2001 Corp, FS 2002 Corporation, and FS 2003 Corporation airplanes; and the Manager, Standards Office, FAA, has the authority to approve AMOCs for this AD related to LAVIA ARGENTINA S.A. (LAVIASA) airplanes, if requested using the procedures found in 14 CFR 39.19. In

accordance with 14 CFR 39.19, send your request to your principal inspector or local Flight Standards District Office, as appropriate. If sending information directly to the manager of the ACO, send it to the attention of the appropriate person identified in paragraph (p) of this AD.

(2) Before using any approved AMOC, notify your appropriate principal inspector, or lacking a principal inspector, the manager of the local flight standards district office/certificate holding district office.

(3) AMOCs approved for AD 93–10–06, Amendment 39–8586 (58 FR 29965, May 25, 1993) and AD 99–01–05, Amendment 39–10972 (63 FR 72132, December 31, 1998) are approved as AMOCs for this AD.

(p) Related Information

(1) For more information about this AD related to Piper Aircraft, Inc. airplanes, contact: Gregory "Keith" Noles, Aerospace Engineer, FAA, Atlanta ACO, 1701 Columbia Avenue, College Park, Georgia 30337; phone: (404) 474–5551; fax: (404) 474–5606; email: *gregory.noles@faa.gov*.

(2) For more information about this AD related to FS 2000 Corp, FS 2001 Corp, FS 2002 Corporation, and FS 2003 Corporation airplanes, contact: Jeff Morfitt, Aerospace Engineer, FAA, Seattle ACO, 1601 Lind Avenue SW, Renton, Washington 98057; phone: (425) 917–6405; fax: (245) 917–6590; email: *jeff.morfitt@faa.gov*.

(3) For more information about this AD related to LAVIA ARGENTINA S.A. (LAVIASA) airplanes, contact: S.M. Nagarajan, Aerospace Engineer, FAA, Small Airplane Directorate, 901 Locust, Room 301, Kansas City, Missouri 64106; telephone: (816) 329–4145; fax: (816) 329–4090; email: *sarjapur.nagarajan@faa.gov*.

(q) Material Incorporated by Reference

(1) The Director of the Federal Register approved the incorporation by reference (IBR) of the service information listed in this paragraph under 5 U.S.C. 552(a) and 1 CFR part 51.

(2) You must use this service information as applicable to do the actions required by this AD, unless the AD specifies otherwise.

(3) The following service information was approved for IBR on February 8, 1999 (63 FR 72132, December 31, 1998).

(i) Piper Aircraft Corporation Mandatory Service Bulletin No. 528D, dated October 19, 1990.

(ii) Piper Aircraft Corporation Mandatory Service Bulletin No. 910A, dated October 10, 1989.

(iii) F. Atlee Dodge Aircraft Services, Inc. Installation Instructions No. 3233–I for Modified Piper Wing Lift Struts Supplemental Type Certificate (STC) SA4635NM, dated February 1, 1991.

(iv) Jensen Aircraft Installation Instructions for Modified Lift Strut Fittings, which incorporates pages 1 and 5, Original Issue, dated July 15, 1983; pages 2, 4, and 6, Revision No. 1, dated March 30, 1984; and pages a and 3, Revision No. 2, dated April 20, 1984.

(4) For Piper Aircraft, Inc. service information identified in this AD, contact Piper Aircraft, Inc., Customer Services, 2926 Piper Drive, Vero Beach, Florida 32960; telephone: (772) 567–4361; Internet: *www.piper.com*. Copies of the instructions to the F. Atlee Dodge STC and information about the Jensen Aircraft STCs may be obtained from F. Atlee Dodge, Aircraft Services, LLC., 6672 Wes Way, Anchorage, Alaska 99518–0409, Internet: *www.fadodge.com*.

(5) You may review copies of the referenced service information at the FAA, Small Airplane Directorate, 901 Locust, Kansas City, Missouri 64106. For information on the availability of this material at the FAA, call (816) 329–4148.

(6) You may view this service information that is incorporated by reference at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: *http://www.archives.gov/federal-register/cfr/ibr-locations.html*.

APPENDIX TO AD 99–01–05 R1

Procedures and Requirements for Ultrasonic Inspection of Piper Wing Lift Struts

Equipment Requirements

1. A portable ultrasonic thickness gauge or flaw detector with echo-to-echo digital thickness readout capable of reading to 0.001-inch and an A-trace waveform display will be needed to do this inspection.

2. An ultrasonic probe with the following specifications will be needed to accomplish this inspection: 10 MHz (or higher), 0.283-inch (or smaller) diameter dual element or delay line transducer designed for thickness gauging. The transducer and ultrasonic system shall be capable of accurately measuring the thickness of AISI 4340 steel down to 0.020-inch. An accuracy of +/- 0.002-inch throughout a 0.020-inch to 0.050-inch thickness range while calibrating shall be the criteria for acceptance.

3. Either a precision machined step wedge made of 4340 steel (or similar steel with equivalent sound velocity) or at least three shim samples of same material will be needed to accomplish this inspection. One thickness of the step wedge or shim shall be less than or equal to 0.020-inch, one shall be greater than or equal to 0.050-inch, and at least one other step or shim shall be between these two values.

4. Glycerin, light oil, or similar non-water based ultrasonic couplants are recommended in the setup and inspection procedures. Water-based couplants, containing appropriate corrosion inhibitors, may be utilized, provided they are removed from both the reference standards and the test item after the inspection procedure is completed and adequate corrosion prevention steps are then taken to protect these items.

• **Note:** Couplant is defined as "a substance used between the face of the transducer and test surface to improve transmission of ultrasonic energy across the transducer/strut interface."

• **Note:** If surface roughness due to paint loss or corrosion is present, the surface should be sanded or polished smooth before testing to assure a consistent and smooth surface for making contact with the transducer. Care shall be taken to remove a minimal amount of structural material. Paint repairs may be necessary after the inspection to prevent further corrosion damage from occurring. Removal of surface irregularities will enhance the accuracy of the inspection technique.

Instrument Setup

1. Set up the ultrasonic equipment for thickness measurements as specified in the instrument's user's manual. Because of the variety of equipment available to perform ultrasonic thickness measurements, some modification to this general setup procedure may be necessary. However, the tolerance requirement of step 13 and the record keeping requirement of step 14, must be satisfied.

2. If battery power will be employed, check to see that the battery has been properly charged. The testing will take approximately two hours. Screen brightness and contrast should be set to match environmental conditions.

3. Verify that the instrument is set for the type of transducer being used, i.e. single or dual element, and that the frequency setting is compatible with the transducer.

4. If a removable delay line is used, remove it and place a drop of couplant between the transducer face and the delay line to assure good transmission of ultrasonic energy. Reassemble the delay line transducer and continue.

5. Program a velocity of 0.231-inch/microsecond into the ultrasonic unit unless an alternative instrument calibration procedure is used to set the sound velocity.

6. Obtain a step wedge or steel shims per item 3 of the Equipment Requirements. Place the probe on the thickest sample using couplant. Rotate the transducer slightly back and forth to "ring" the transducer to the sample. Adjust the delay and range settings to arrive at an A-trace signal display with the first backwall echo from the steel near the left side of the screen and the second backwall echo near the right of the screen. Note that when a single element transducer is used, the initial pulse and the delay line/steel interface will be off of the screen to the left. Adjust the gain to place the amplitude of the first backwall signal at approximately 80% screen height on the A-trace.

7. "Ring" the transducer on the thinnest step or shim using couplant. Select positive half-wave rectified, negative half-wave rectified, or filtered signal display to obtain the cleanest signal. Adjust the pulse voltage, pulse width, and damping to obtain the best signal resolution. These settings can vary from one transducer to another and are also user dependent.

8. Enable the thickness gate, and adjust the gate so that it starts at the first backwall echo and ends at the second backwall echo. (Measuring between the first and second backwall echoes will produce a measurement of the steel thickness that is not affected by the paint layer on the strut). If instability of the gate trigger occurs, adjust the gain, gate level, and/or damping to stabilize the thickness reading.

9. Check the digital display reading and if it does not agree with the known thickness

of the thinnest thickness, follow your instrument's calibration recommendations to produce the correct thickness reading. When a single element transducer is used this will usually involve adjusting the fine delay setting.

10. Place the transducer on the thickest step of shim using couplant. Adjust the thickness gate width so that the gate is triggered by the second backwall reflection of the thick section. If the digital display does not agree with the thickest thickness, follow your instruments calibration recommendations to produce the correct thickness reading. A slight adjustment in the velocity may be necessary to get both the thinnest and the thickest reading correct. Document the changed velocity value.

11. Place couplant on an area of the lift strut which is thought to be free of corrosion and "ring" the transducer to surface. Minor adjustments to the signal and gate settings may be required to account for coupling improvements resulting from the paint layer. The thickness gate level should be set just high enough so as not to be triggered by irrelevant signal noise. An area on the upper surface of the lift strut above the inspection area would be a good location to complete this step and should produce a thickness reading between 0.034-inch and 0.041-inch.

12. Repeat steps 8, 9, 10, and 11 until both thick and thin shim measurements are within tolerance and the lift strut measurement is reasonable and steady.

13. Verify that the thickness value shown in the digital display is within +/- 0.002-inch of the correct value for each of the three or more steps of the setup wedge or shims. Make no further adjustments to the instrument settings.

14. Record the ultrasonic versus actual thickness of all wedge steps or steel shims available as a record of setup.

Inspection Procedure

1. Clean the lower 18 inches of the wing lift struts using a cleaner that will remove all dirt and grease. Dirt and grease will adversely affect the accuracy of the inspection technique. Light sanding or polishing may also be required to reduce surface roughness as noted in the Equipment Requirements section.

2. Using a flexible ruler, draw a ¼-inch grid on the surface of the first 11 inches from the lower end of the strut as shown in Piper MSB No. 528D, dated October 19, 1990, or Piper MSB No. 910A, dated October 10, 1989, as applicable. This can be done using a soft (#2) pencil and should be done on both faces of the strut. As an alternative to drawing a complete grid, make two rows of marks spaced every ¼-inch across the width of the strut. One row of marks should be about 11 inches from the lower end of the strut, and the second row should be several inches away where the strut starts to narrow. Lay the flexible ruler between respective tick marks of the two rows and use tape or a rubber band to keep the ruler in place. See Figure 1.

3. Apply a generous amount of couplant inside each of the square areas or along the edge of the ruler. Re-application of couplant may be necessary.

4. Place the transducer inside the first square area of the drawn grid or at the first ¼-inch mark on the ruler and "ring" the transducer to the strut. When using a dual element transducer, be very careful to record the thickness value with the axis of the transducer elements perpendicular to any curvature in the strut. If this is not done, loss of signal or inaccurate readings can result.

5. Take readings inside each square on the grid or at ¼-inch increments along the ruler and record the results. When taking a thickness reading, rotate the transducer slightly back and forth and experiment with the angle of contact to produce the lowest thickness reading possible. Pay close attention to the A-scan display to assure that the thickness gate is triggering off of maximized backwall echoes.

• NOTE: A reading shall not exceed .041 inch. If a reading exceeds .041-inch, repeat steps 13 and 14 of the Instrument Setup section before proceeding further.

6. If the A-trace is unsteady or the thickness reading is clearly wrong, adjust the signal gain and/or gate setting to obtain reasonable and steady readings. If any instrument setting is adjusted, repeat steps 13 and 14 of the Instrument Setup section before proceeding further.

7. In areas where obstructions are present, take a data point as close to the correct area as possible.

• NOTE: The strut wall contains a fabrication bead at approximately 40% of the strut chord. The bead may interfere with accurate measurements in that specific location.

8. A measurement of 0.024-inch or less shall require replacement of the strut prior to further flight.

9. If at any time during testing an area is encountered where a valid thickness measurement cannot be obtained due to a loss of signal strength or quality, the area shall be considered suspect. These areas may have a remaining wall thickness of less than 0.020-inch, which is below the range of this setup, or they may have small areas of localized corrosion or pitting present. The latter case will result in a reduction in signal strength due to the sound being scattered from the rough surface and may result in a signal that includes echoes from the pits as well as the backwall. The suspect area(s) shall be tested with a Maule "Fabric Tester" as specified in Piper MSB No. 528D, dated October 19, 1990, or Piper MSB No. 910A, dated October 10, 1989.

10. Record the lift strut inspection in the aircraft log book.

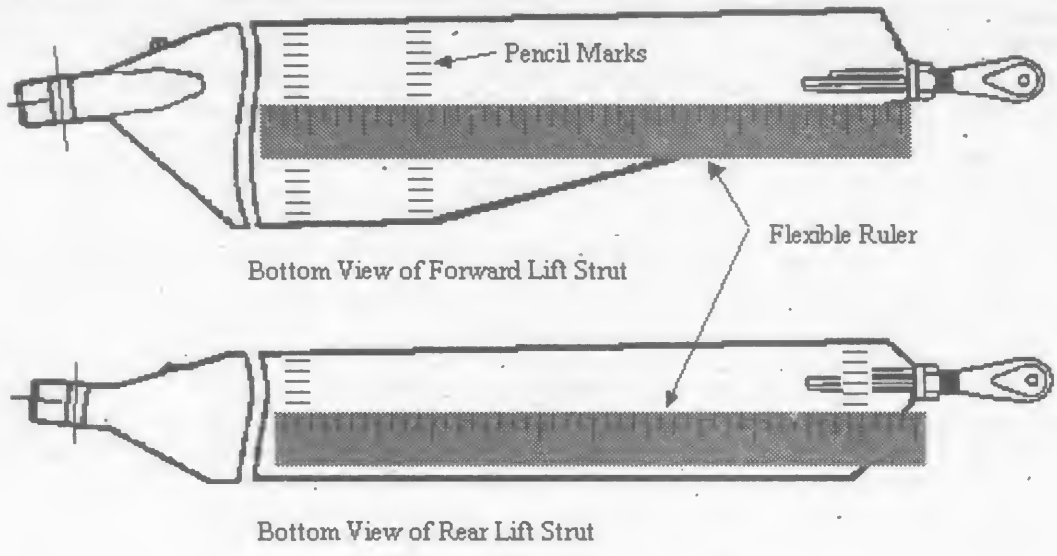

Figure 1

Issued in Kansas City, Missouri, on November 22, 2013.

Earl Lawrence,

Manager, Small Airplane Directorate, Aircraft Certification Service.

[FR Doc. 2013–29396 Filed 12–9–13; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Docket No. FAA–2013–0948; Airspace Docket No. 13–ASW–25]

Amendment of Class D and Class E Airspace; Lake Charles, LA

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule, technical amendment.

SUMMARY: This action amends Class D and Class E airspace within the Lake Charles, LA, area by updating the geographic coordinates for Lake Charles Regional Airport, and the airport name and geographic coordinates for Chennault International Airport, formerly known as Chennault Industrial Airpark. This action does not change the boundaries or operating requirements of the airspace.

DATES: *Effective date:* 0901 UTC, February 6, 2014. The Director of the Federal Register approves this incorporation by reference action under 1 CFR Part 51, subject to the annual revision of FAA Order 7400.9 and publication of conforming amendments.

FOR FURTHER INFORMATION CONTACT: Scott Enander, Central Service Center, Operations Support Group, Federal Aviation Administration, Southwest Region, 2601 Meacham Blvd., Fort Worth, TX 76137; telephone (817) 321–7716.

SUPPLEMENTARY INFORMATION:

The Rule

This action amends Title 14 Code of Federal Regulations (14 CFR) Part 71 by adjusting the geographic coordinates, within the Class D and Class E airspace areas, of Lake Charles Regional Airport, Lake Charles, LA, and Chennault International Airport, formally known as Chennault Industrial Airpark, Lake Charles, LA, to coincide with the FAA's aeronautical database. An administrative correction also is made to the spelling of the Southland Field, Sulphur, LA, navigation aid from Sulphy NDB to Sulphur NDB. This is an administrative change and does not affect the boundaries, altitudes, or operating requirements of the airspace, therefore, notice and public procedures under 5 U.S.C. 553(b) are unnecessary.

The FAA has determined that this regulation only involves an established body of technical regulations for which frequent and routine amendments are necessary to keep them operationally current. Therefore, this regulation: (1) Is not a "significant regulatory action" under Executive Order 12866; (2) is not a "significant rule" under DOT Regulatory Policies and Procedures (44 FR 11034; February 26, 1979); and (3) does not warrant preparation of a regulatory evaluation as the anticipated impact is so minimal. Since this is a routine matter that only affects air traffic procedures and air navigation, it is certified that this rule, when promulgated, does not have a significant economic impact on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

The FAA's authority to issue rules regarding aviation safety is found in Title 49 of the U.S. Code. Subtitle 1, Section 106, describes the authority of the FAA Administrator. Subtitle VII, Aviation Programs, describes in more detail the scope of the agency's authority. This rulemaking is promulgated under the authority described in Subtitle VII, Part A, Subpart I, Section 40103. Under that section, the FAA is charged with prescribing regulations to assign the use of airspace necessary to ensure the safety of aircraft and the efficient use of airspace. This regulation is within the scope of that authority as it amends controlled airspace in the Lake Charles, LA area.

List of Subjects in 14 CFR Part 71

Airspace, Incorporation by reference, Navigation (air).

Adoption of the Amendment

In consideration of the foregoing, the Federal Aviation Administration amends 14 CFR Part 71 as follows:

PART 71—DESIGNATION OF CLASS A, B, C, D, AND E AIRSPACE AREAS; AIR TRAFFIC SERVICE ROUTES; AND REPORTING POINTS

■ 1. The authority citation for 14 CFR Part 71 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40103, 40113, 40120; E.O. 10854, 24 FR 9565, 3 CFR, 1959–1963 Comp., p. 389.

§ 71.1 [Amended]

■ 2. The incorporation by reference in 14 CFR 71.1 of the Federal Aviation Administration Order 7400.9X, Airspace Designations and Reporting Points, dated August 7, 2013, and effective September 15, 2013, is amended as follows:

Paragraph 5000 Class D Airspace.

* * * * *

ASW LA D Lake Charles, LA [Amended]

Lake Charles Regional Airport, LA
(Lat. 30°07′34″ N., long. 93°13′24″ W.)
Lake Charles VORTAC
(Lat. 30°08′29″ N., long. 93°06′20″ W.)

That airspace extending upward from the surface to and including 2,500 feet MSL within a 5-mile radius of Lake Charles Regional Airport and within 1.3 miles each side of the 256° radial of the Lake Charles VORTAC extending from the 5-mile radius to 5.5 miles east of the airport. This Class D airspace area is effective during the specific dates and times established in advance by a Notice to Airmen. The effective date and time will thereafter be continuously published in the Airport/Facility Directory.

ASW LA D Lake Charles, Chennault International Airport, LA [Amended]

Lake Charles, Chennault International Airport, LA
(Lat. 30°12′38″ N., long. 93°08′36″ W.)

That airspace extending upward from the surface to and including 2,500 feet MSL within a 4.5-mile radius of Chennault International Airport, excluding that airspace within the Lake Charles Regional Airport, LA, Class D airspace area. This Class D airspace area is effective during the specific dates and times established in advance by a Notice to Airmen. The effective date and time will thereafter be continuously published in the Airport/Facility Directory.

Paragraph 6002 Class E Airspace Areas Designated as a Surface Area.

* * * * *

ASW LA E2 Lake Charles, LA [Amended]

Lake Charles Regional Airport, LA
(Lat. 30°07′34″ N., long. 93°13′24″ W.)
Lake Charles VORTAC
(Lat. 30°08′29″ N., long. 93°06′20″ W.)

Within a 5-mile radius of Lake Charles Regional Airport and within 1.3 miles each side of the 256° radial of the Lake Charles VORTAC extending from the 5-mile radius to 5.5 miles east of the airport. This Class E airspace area is effective during the specific dates and times established in advance by a Notice to Airmen. The effective date and time will thereafter be continuously published in the Airport/Facility Directory.

Paragraph 6005 Class E Airspace Areas Extending Upward from 700 feet or More Above the Surface of the Earth.

* * * * *

ASW LA E5 Lake Charles, LA [Amended]

Lake Charles Regional Airport, LA
(Lat. 30°07′34″ N., long. 93°13′24″ W.)
Lake Charles, Chennault International Airport, LA
(Lat. 30°12′38″ N., long. 93°08′36″ W.)
Sulphur, Southland Field, LA
(Lat. 30°07′53″ N., long. 93°22′34″ W.)
Sulphur NDB
(Lat. 30°11′55″ N., long. 93°25′14″ W.)

That airspace extending upward from 700 feet above the surface within a 7.5-mile radius of Lake Charles Regional Airport, and within a 7-mile radius of Chennault International Airport, and within 3.5 miles each side of the 155° bearing from Chennault International Airport extending from the 7-mile radius to 16.7 miles southeast of the airport, and within a 6.5-mile radius of Southland Field, and within 2.5 miles each side of the 326° bearing from the Sulphur NDB extending from the 6.5-mile radius of Southland Field to 7.5 miles northwest of the airport.

Issued in Fort Worth, Texas, on November 25, 2013.

David P. Medina,

Manager Operations Support Group, ATO Central Service Center.

[FR Doc. 2013–29214 Filed 12–9–13; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Docket No. FAA–2013–0950; Airspace Docket No. 13–AGL–34]

Amendment of Class D and Class E Airspace; Grand Forks, ND

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule, technical amendment.

SUMMARY: This action amends Class D and Class E airspace within the Grand Forks, ND, area by updating the geographic coordinates for Grand Forks International Airport and Grand Forks Air Force Base (AFB). This action does not change the boundaries or operating requirements of the airspace.

DATES: Effective date: 0901 UTC, February 6, 2014. The Director of the Federal Register approves this incorporation by reference action under 1 CFR Part 51, subject to the annual revision of FAA Order 7400.9 and publication of conforming amendments.

FOR FURTHER INFORMATION CONTACT: Scott Enander, Central Service Center. Operations Support Group, Federal Aviation Administration, Southwest Region, 2601 Meacham Blvd., Fort Worth, TX 76137; telephone 817–321–7716.

SUPPLEMENTARY INFORMATION:

The Rule

This action amends Title 14 Code of Federal Regulations (14 CFR) Part 71 by adjusting the geographic coordinates, within the Class D and Class E airspace areas, of Grand Forks International Airport and Grand Forks AFB, Grand Forks, ND, to coincide with the FAA's aeronautical database. This is an administrative change and does not affect the boundaries, altitudes, or operating requirements of the airspace, therefore, notice and public procedures under 5 U.S.C. 553(b) are unnecessary.

The FAA has determined that this regulation only involves an established body of technical regulations for which frequent and routine amendments are necessary to keep them operationally current. Therefore, this regulation: (1) Is not a "significant regulatory action" under Executive Order 12866; (2) is not a "significant rule" under DOT Regulatory Policies and Procedures (44 FR 11034; February 26, 1979); and (3) does not warrant preparation of a regulatory evaluation as the anticipated impact is so minimal. Since this is a routine matter that only affects air traffic procedures and air navigation, it is certified that this rule, when promulgated, does not have a significant economic impact on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

The FAA's authority to issue rules regarding aviation safety is found in Title 49 of the U.S. Code. Subtitle 1, Section 106, describes the authority of the FAA Administrator. Subtitle VII, Aviation Programs, describes in more detail the scope of the agency's authority. This rulemaking is promulgated under the authority described in Subtitle VII, Part A, Subpart I, Section 40103. Under that section, the FAA is charged with prescribing regulations to assign the use of airspace necessary to ensure the safety of aircraft and the efficient use of airspace. This regulation is within the scope of that authority as it amends controlled airspace in the Grand Forks, ND area.

List of Subjects in 14 CFR Part 71

Airspace, Incorporation by reference, Navigation (air)

Adoption of the Amendment

In consideration of the foregoing, the Federal Aviation Administration amends 14 CFR Part 71 as follows:

PART 71—DESIGNATION OF CLASS A, B, C, D, AND E AIRSPACE AREAS; AIR TRAFFIC SERVICE ROUTES; AND REPORTING POINTS

■ 1. The authority citation for 14 CFR Part 71 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40103, 40113, 40120; E.O. 10854, 24 FR 9565, 3 CFR, 1959–1963 Comp., p. 389.

§ 71.1 [Amended]

■ 2. The incorporation by reference in 14 CFR 71.1 of the Federal Aviation Administration Order 7400.9X, Airspace Designations and Reporting Points, dated August 7, 2013, and effective September 15, 2013, is amended as follows:

Paragraph 5000 Class D Airspace.

* * * * *

AGL ND D Grand Forks, ND [Amended]

Grand Forks International Airport, ND
(Lat. 47°5′50″ N., long. 97°10′26″ W.)

That airspace extending upward from the surface to and including 3,300 feet MSL within a 4.2-mile radius of Grand Forks International Airport. This Class D airspace area is effective during the specific dates and times established in advance by a Notice to Airmen. The effective date and time will thereafter be continuously published in the Airport/Facility Directory.

AGL ND D Grand Forks AFB, ND [Amended]

Grand Forks, Grand Forks AFB, ND
(Lat. 47°57′41″ N., long. 97°24′03″ W.)

That airspace extending upward from the surface to and including 3,400 feet MSL within a 4.9-mile radius of Grand Forks AFB, and within 2.3 miles each side of the 174° bearing from the airport extending from the 4.9-mile radius to 5.6 miles south of the airport, excluding that airspace within the Grand Forks International Airport, ND, Class D airspace area. This Class D airspace area is effective during the specific dates and times established in advance by a Notice to Airmen. The effective date and time will thereafter be continuously published in the Airport/Facility Directory.

Paragraph 6002 Class E Airspace Areas Designated as a Surface Area.

* * * * *

AGL ND E2 Grand Forks, ND [Amended]

Grand Forks International Airport, ND
(Lat. 47°56′50″ N., long. 97°10′26″ W.)
Grand Forks VOR/DME
(Lat. 47°57′17″ N., long. 97°11′07″ W.)

Within a 4.2-mile radius of Grand Forks International Airport and within 2.5 miles each side of the 007° radial of the Grand Forks VOR/DME extending from the 4.2-mile radius of the airport to 7 miles north of the VOR/DME, and within 2.5 miles each side of the 173° radial of the Grand Forks VOR/DME extending from the 4.2-mile radius of the airport to 7 miles south of the VOR/DME. This Class E airspace area is effective during the specific dates and times established in advance by a Notice to Airmen. The effective date and time will thereafter be continuously published in the Airport/Facility Directory.

Paragraph 6004 Class E Airspace Areas Designated as an Extension to a Class D or Class E Surface Area.

* * * * *

AGL ND E4 Grand Forks, ND [Amended]

Grand Forks International Airport, ND
(Lat. 47°56′50″ N., long. 97°10′26″ W.)
Grand Forks VOR/DME
(Lat. 47°57′17″ N., long. 97°11′07″ W.)

That airspace extending upward from the surface within 2.5 miles each side of the 007° radial of the Grand Forks VOR/DME extending from the 4.2-mile radius of the airport to 7 miles north of the VOR/DME, and within 2.5 miles each side of the 173° radial of the Grand Forks VOR/DME extending from the 4.2-mile radius of the airport to 7 miles south of the VOR/DME. This Class E airspace area is effective during the specific dates and times established in advance by a Notice to Airmen. The effective date and time will thereafter be continuously published in the Airport/Facility Directory.

Paragraph 6005 Class E Airspace Areas Extending Upward from 700 feet or More Above the Surface of the Earth.

* * * * *

AGL ND E5 Grand Forks, ND [Amended]

Grand Forks International Airport, ND
(Lat. 47°56′50″ N., long. 97°10′26″ W.)
Grand Forks, Grand Forks AFB, ND
(Lat. 47°57′41″ N., long. 97°24′03″ W.)

That airspace extending upward from 700 feet above the surface within a 7-mile radius of Grand Forks International Airport, and within a 7-mile radius of Grand Forks AFB, and within 3 miles each side of the Grand Forks International Airport ILS Localizer north course extending from the 7-mile radius to 10 miles north of the airport, and that airspace extending upward from 1,200 feet above the surface within a 34-mile radius of Grand Forks AFB, within the state of North Dakota.

Issued in Fort Worth, Texas, on November 25, 2013.

David P. Medina,

Manager, Operations Support Group ATO Central Service Center.

[FR Doc. 2013–29222 Filed 12–9–13; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Docket No. FAA–2013–0941; Airspace Docket No. 13–AGL–32]

Amendment of Class E Airspace; Green Bay, WI

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule, technical amendment.

SUMMARY: This action amends Class E airspace within the Green Bay, WI, area by updating the geographic coordinates for Austin-Straubel International Airport. This action does not change the boundaries or operating requirements of the airspace.

DATES: Effective date: 0901 UTC, February 6, 2014. The Director of the Federal Register approves this incorporation by reference action under 1 CFR Part 51, subject to the annual revision of FAA Order 7400.9 and publication of conforming amendments.

FOR FURTHER INFORMATION CONTACT: Scott Enander, Central Service Center, Operations Support Group, Federal Aviation Administration, Southwest Region, 2601 Meacham Blvd., Fort Worth, TX 76137; telephone 817 321–7716.

SUPPLEMENTARY INFORMATION:

The Rule

This action amends Title 14 Code of Federal Regulations (14 CFR) Part 71 by adjusting the geographic coordinates, within Class E airspace, of Austin-Straubel International Airport, Green Bay, WI, to coincide with the FAA's aeronautical database. This is an administrative change and does not affect the boundaries, altitudes, or operating requirements of the airspace, therefore, notice and public procedures under 5 U.S.C. 553(b) are unnecessary.

The FAA has determined that this regulation only involves an established body of technical regulations for which frequent and routine amendments are necessary to keep them operationally current. Therefore, this regulation: (1) Is not a "significant regulatory action" under Executive Order 12866; (2) is not a "significant rule" under DOT Regulatory Policies and Procedures (44 FR 11034; February 26, 1979); and (3) does not warrant preparation of a regulatory evaluation as the anticipated impact is so minimal. Since this is a routine matter that only affects air traffic procedures and air navigation, it is

certified that this rule, when promulgated, does not have a significant economic impact on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

The FAA's authority to issue rules regarding aviation safety is found in Title 49 of the U.S. Code. Subtitle 1, Section 106, describes the authority of the FAA Administrator. Subtitle VII, Aviation Programs, describes in more detail the scope of the agency's authority. This rulemaking is promulgated under the authority described in Subtitle VII, Part A, Subpart I, Section 40103. Under that section, the FAA is charged with prescribing regulations to assign the use of airspace necessary to ensure the safety of aircraft and the efficient use of airspace. This regulation is within the scope of that authority as it amends controlled airspace at Austin-Straubel International Airport, Green Bay, WI.

List of Subjects in 14 CFR Part 71

Airspace, Incorporation by reference, Navigation (air)

Adoption of the Amendment

In consideration of the foregoing, the Federal Aviation Administration amends 14 CFR part 71 as follows:

PART 71—DESIGNATION OF CLASS A, B, C, D, AND E AIRSPACE AREAS; AIR TRAFFIC SERVICE ROUTES; AND REPORTING POINTS

■ 1. The authority citation for 14 CFR Part 71 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40103, 40113, 40120; E.O. 10854, 24 FR 9565, 3 CFR, 1959–1963 Comp., p. 389.

§ 71.1 [Amended]

■ 2. The incorporation by reference in 14 CFR 71.1 of the Federal Aviation Administration Order 7400.9X, Airspace Designations and Reporting Points, dated August 7, 2013, and effective September 15, 2013, is amended as follows:

Paragraph 6002 Class E Airspace Areas Designated as a Surface Area.

* * * * *

AGL WI E2 Green Bay, WI [Amended]

Green Bay, Austin Straubel International Airport, WI
(Lat. 44°29′05″ N., long. 88°07′47″ W.)

Within a 5-mile radius of the Austin Straubel International Airport. This Class E airspace area is effective during the specific dates and times established in advance by a Notice to Airmen. The effective date and time will thereafter be continuously published in the Airport/Facility Directory.

Paragraph 6005 Class E Airspace Areas Extending Upward from 700 feet or More Above the Surface of the Earth.

* * * * *

AGL WI E5 Green Bay, WI [Amended]

Green Bay, Austin Straubel International Airport, WI
(Lat. 44°29′05″ N., long. 88°07′47″ W.)

That airspace extending upward from 700 feet above the surface within a 6.9-mile radius of the Austin Straubel International Airport and within 2 miles each side of the 180° bearing from the airport extending from the 6.9-mile radius to 12 miles south of the airport.

Issued in Fort Worth, Texas, on November 25, 2013.

David P. Medina,

Manager Operations Support Group, ATO Central Service Center.

[FR Doc. 2013–29219 Filed 12–9–13; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Docket No. FAA–2013–0947; Airspace Docket No. 13–AGL–33]

Amendment of Class E Airspace; Grand Rapids, MI

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule, technical amendment.

SUMMARY: This action amends Class E airspace within the Grand Rapids, MI, area by updating the airport name and geographic coordinates for Gerald R. Ford International Airport, formerly known as Kent County International Airport. This action does not change the boundaries or operating requirements of the airspace.

DATES: *Effective date:* 0901 UTC, February 6, 2014. The Director of the Federal Register approves this incorporation by reference action under 1 CFR Part 51, subject to the annual revision of FAA Order 7400.9 and publication of conforming amendments.

FOR FURTHER INFORMATION CONTACT: Scott Enander, Central Service Center, Operations Support Group, Federal Aviation Administration, Southwest Region, 2601 Meacham Blvd., Fort Worth, TX 76137; telephone 817–321–7716.

SUPPLEMENTARY INFORMATION:

The Rule

This action amends Title 14 Code of Federal Regulations (14 CFR) Part 71 by adjusting the geographic coordinates within the Class E airspace areas, of Gerald R. Ford International Airport, Grand Rapids, MI, formerly called Kent County International Airport, to coincide with the FAA's aeronautical database. This is an administrative change and does not affect the boundaries, altitudes, or operating requirements of the airspace, therefore, notice and public procedures under 5 U.S.C. 553(b) are unnecessary.

The FAA has determined that this regulation only involves an established body of technical regulations for which frequent and routine amendments are necessary to keep them operationally current. Therefore, this regulation: (1) Is not a "significant regulatory action" under Executive Order 12866; (2) is not a "significant rule" under DOT Regulatory Policies and Procedures (44 FR 11034; February 26, 1979); and (3) does not warrant preparation of a regulatory evaluation as the anticipated impact is so minimal. Since this is a routine matter that only affects air traffic procedures and air navigation, it is certified that this rule, when promulgated, does not have a significant economic impact on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

The FAA's authority to issue rules regarding aviation safety is found in Title 49 of the U.S. Code. Subtitle 1, Section 106, describes the authority of the FAA Administrator. Subtitle VII, Aviation Programs, describes in more detail the scope of the agency's authority. This rulemaking is promulgated under the authority described in Subtitle VII, Part A, Subpart I, Section 40103. Under that section, the FAA is charged with prescribing regulations to assign the use of airspace necessary to ensure the safety of aircraft and the efficient use of airspace. This regulation is within the scope of that authority as it amends controlled airspace at Gerald R. Ford International Airport, Grand Rapids, MI.

List of Subjects in 14 CFR Part 71

Airspace, Incorporation by reference, Navigation (air).

Adoption of the Amendment

In consideration of the foregoing, the Federal Aviation Administration amends 14 CFR part 71 as follows:

PART 71—DESIGNATION OF CLASS A, B, C, D, AND E AIRSPACE AREAS; AIR TRAFFIC SERVICE ROUTES; AND REPORTING POINTS

■ 1. The authority citation for 14 CFR part 71 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40103, 40113, 40120; E.O. 10854, 24 FR 9565, 3 CFR, 1959–1963 Comp., p. 389.

§ 71.1 [Amended]

■ 2. The incorporation by reference in 14 CFR 71.1 of the Federal Aviation Administration Order 7400.9X, Airspace Designations and Reporting Points, dated August 7, 2013, and effective September 15, 2013, is amended as follows:

Paragraph 6002 Class E Airspace Areas Designated as a Surface Area.

* * * * *

AGL MI E2 Grand Rapids, MI [Amended]

Grand Rapids, Gerald R. Ford International Airport, MI
(Lat. 42°52′51″ N., long. 85°31′22″ W.)

Within a 5-mile radius of Gerald R. Ford International Airport. This Class E airspace area is effective during the specific dates and times established in advance by a Notice to Airmen. The effective date and time will thereafter be continuously published in the Airport/Facility Directory.

Paragraph 6005 Class E Airspace Areas Extending Upward from 700 feet or More Above the Surface of the Earth.

* * * * *

AGL MI E5 Grand Rapids, MI [Amended]

Grand Rapids, Gerald R. Ford International Airport, MI
(Lat. 42°52′51″ N., long. 85°31′22″ W.)
Spectrum Medical Center/Downtown Campus, MI, Point in Space Coordinates
(Lat. 42°57′09″ N., long. 85°39′48″ W.)

That airspace extending upward from 700 feet above the surface within a 7-mile radius of Gerald R. Ford International Airport, and within a 6-mile radius of the Point in Space serving Spectrum Medical Center/Downtown Campus.

Issued in Fort Worth, Texas, on November 25, 2013.

David P. Medina,

Manager Operations Support Group, ATO Central Service Center.

[FR Doc. 2013–29220 Filed 12–9–13; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Docket No. FAA–2013–0658; Airspace Docket No. 13–ASW–17]

Amendment of Class E Airspace; Del Rio, TX

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule.

SUMMARY: This action amends Class E airspace at Del Rio, TX. Controlled airspace is necessary to accommodate new circling approach requirements at Laughlin Air Force Base (AFB). The FAA is taking this action to enhance the safety and management of Instrument Flight Rules (IFR) operations at the airport. Geographic coordinates are also updated.

DATES: *Effective date:* 0901 UTC, February 6, 2014. The Director of the Federal Register approves this incorporation by reference action under 1 CFR Part 51, subject to the annual revision of FAA Order 7400.9 and publication of conforming amendments.

FOR FURTHER INFORMATION CONTACT: Scott Enander, Central Service Center, Operations Support Group, Federal Aviation Administration, Southwest Region, 2601 Meacham Blvd., Fort Worth, TX 76137; telephone 817–321–7716.

SUPPLEMENTARY INFORMATION:

History

On August 26, 2013, the FAA published in the **Federal Register** a notice of proposed rulemaking (NPRM) to amend Class E airspace for the Del Rio, TX, area, creating additional controlled airspace at Laughlin AFB (78 FR 52716) Docket No. FAA–2013–0658. Interested parties were invited to participate in this rulemaking effort by submitting written comments on the proposal to the FAA. No comments were received. Class E airspace designations are published in paragraph 6003 of FAA Order 7400.9X dated August 7, 2013, and effective September 15, 2013, which is incorporated by reference in 14 CFR 71.1. The Class E airspace designations listed in this document will be published subsequently in the Order.

The Rule

This action amends Title 14 Code of Federal Regulations (14 CFR) Part 71 by amending Class E airspace designated as an extension to a Class C surface area at Laughlin AFB, Del Rio, TX. An additional segment to the north is needed to contain approach category E military aircraft conducting circling approaches to the airport, to retain the safety and management of IFR aircraft in Class E airspace to/from the en route environment. Geographic coordinates are also updated to coincide with the FAA's aeronautical database.

The FAA has determined that this regulation only involves an established body of technical regulations for which frequent and routine amendments are necessary to keep them operationally current. Therefore, this regulation: (1) Is not a "significant regulatory action" under Executive Order 12866; (2) is not a "significant rule" under DOT Regulatory Policies and Procedures (44 FR 11034; February 26, 1979); and (3) does not warrant preparation of a regulatory evaluation as the anticipated impact is so minimal. Since this is a routine matter that only affects air traffic procedures and air navigation, it is certified that this rule, when promulgated, does not have a significant economic impact on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

The FAA's authority to issue rules regarding aviation safety is found in Title 49 of the U.S. Code. Subtitle 1, Section 106, describes the authority of the FAA Administrator. Subtitle VII, Aviation Programs, describes in more detail the scope of the agency's authority. This rulemaking is promulgated under the authority described in Subtitle VII, Part A, Subpart I, Section 40103. Under that section, the FAA is charged with prescribing regulations to assign the use of airspace necessary to ensure the safety of aircraft and the efficient use of airspace. This regulation is within the scope of that authority as it establishes additional controlled airspace at Laughlin AFB, Del Rio, TX.

Environmental Review

The FAA has determined that this action qualifies for categorical exclusion under the National Environmental Policy Act in accordance with FAA Order 1050.1E, "Environmental Impacts: Policies and Procedures," paragraph 311a. This airspace action is not expected to cause any potentially significant environmental impacts, and no extraordinary circumstances exist that warrant preparation of an environmental assessment.

List of Subjects in 14 CFR Part 71

Airspace, Incorporation by reference, Navigation (air)

Adoption of the Amendment

In consideration of the foregoing, the Federal Aviation Administration amends 14 CFR Part 71 as follows:

PART 71—DESIGNATION OF CLASS A, B, C, D, AND E AIRSPACE AREAS; AIR TRAFFIC SERVICE ROUTES; AND REPORTING POINTS

■ 1. The authority citation for 14 CFR Part 71 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40103, 40113, 40120; E.O. 10854, 24 FR 9565, 3 CFR, 1959–1963 Comp., p. 389.

§ 71.1 [Amended]

■ 2. The incorporation by reference in 14 CFR 71.1 of the Federal Aviation Administration Order 7400.9X, Airspace Designations and Reporting Points, dated August 7, 2013, and effective September 15, 2013, is amended as follows:

Paragraph 6003 Class E airspace designated as an extension.

* * * * *

ASW TX E3 Del Rio, TX [Amended]

Del Rio, Laughlin AFB, TX
(Lat. 29°21′34″ N., long. 100°46′40″ W.)
Laughlin VORTAC
(Lat. 29°21′39″ N., long. 100°46′18″ W.)

That airspace extending upward from the surface within 2 miles each side of the 003° radial of the Laughlin VORTAC extending from the 5-mile radius of Laughlin AFB to 10 miles north of the airport, and from the 060° radial of the Laughlin VORTAC clockwise to the 195° radial, extending from the 5-mile radius of Laughlin AFB to the 5.5-mile radius, and 2.6 miles each side of the 145° radial of the Laughlin VORTAC extending from the 5.5-mile radius of Laughlin AFB to 6.6 miles southeast of the airport, and 2.6 miles each side of the 305° radial of the Laughlin VORTAC extending from the 5-mile radius of Laughlin AFB to 6.6 miles northwest of Laughlin AFB, and from the 333° radial of the Laughlin VORTAC clockwise to the 342° radial, extending from the 5-mile radius of Laughlin AFB to the 5.5-mile radius. This Class E airspace area is effective during the specific dates and times established in advance by a Notice to Airmen. The effective date and time will thereafter be continuously published in the Airport/Facility Directory.

Issued in Fort Worth, Texas, on November 25, 2013.

David P. Medina,

Manager, Operations Support Group, ATO Central Service Center.

[FR Doc. 2013–29221 Filed 12–9–13; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

24 CFR Parts 50, 55, and 58

[Docket No. FR–5423–C–03]

RIN 2501–AD51

Floodplain Management and Protection of Wetlands; Correction

AGENCY: Office of the General Counsel, HUD.

ACTION: Final rule; correction.

SUMMARY: HUD is correcting a final rule published in the **Federal Register** on November 15, 2013. The November 15, 2013, final rule revised HUD's regulations governing the protection of wetlands and floodplains. Upon publication, HUD discovered that it inadvertently duplicated an activity that the final rule exempts from the 8 Step Process for floodplains and wetlands management compliance. As a result, this document corrects this duplication by removing the duplication.

DATES: *Effective Date:* December 16, 2013.

FOR FURTHER INFORMATION CONTACT: Aaron Santa Anna, Assistant General Counsel for Regulations, Office of General Counsel, Department of Housing and Urban Development, 451 7th Street SW., Room 10276, Washington, DC 20410–0500; telephone number 202–708–3055 (this is not a toll-free number). Persons with hearing or speech impairments may access this number through TTY by calling the Federal Relay Service at 800–877–8339 (this is a toll-free number).

SUPPLEMENTARY INFORMATION: On November 15, 2013 (78 FR 68719), HUD published a final rule that revised its regulations governing the protection of wetlands and floodplains codified at 24 CFR part 55. Section 55.12(c) of the rule lists activities exempt from the applicability of 24 CFR part 55. Among other things, the final rule added to the list of exempted activities the approval of financial assistance for restoring and preserving the functions and values of floodplains and wetlands. Upon review of the published final rule, HUD discovered that this exemption was added at §§ 55.12(c)(3) and (c)(12). These duplicated paragraphs are identical. As a result, HUD is correcting this final rule by deleting § 55.12(c)(12).

In FR Doc. 2013–27427 appearing on page 68719 in the **Federal Register** of Friday, November 15, 2013, the following correction is made:

§ 55.12 [Corrected]

■ 1. On page 68732, in the second column, remove § 55.12(c)(12).

Dated: December 3, 2013.

Aaron Santa Anna,

Assistant General Counsel for Regulations.

[FR Doc. 2013–29338 Filed 12–9–13; 8:45 am]

BILLING CODE 4210–67–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 165

[Docket No. USCG–2013–0962]

Safety Zone; Nike Fireworks, Upper New York Bay, Ellis Island, NY

AGENCY: Coast Guard, DHS.

ACTION: Notice of enforcement of regulation.

SUMMARY: The Coast Guard will enforce a safety zone in the Captain of the Port New York Zone on the specified date and time. This action is necessary to ensure the safety of vessels and spectators from hazards associated with fireworks displays. During the enforcement period, no person or vessel may enter the safety zone without permission from the Captain of the Port (COTP).

DATES: The regulation for the safety zone described in 33 CFR 165.160 will be enforced on December 12, 2013 from 8:00 p.m. to 9:30 p.m.

FOR FURTHER INFORMATION CONTACT: If you have questions on this notice, call or email Lieutenant Junior Grade Kristopher Kesting, U.S. Coast Guard; telephone 718–354–4163, email *Kristopher.R.Kesting@uscg.mil.*

SUPPLEMENTARY INFORMATION:

The Coast Guard will enforce the safety zone listed in 33 CFR 165.160 on the specified date and time as indicated in Table 1 below. This regulation was published in the **Federal Register** on November 9, 2011 (76 FR 69614).

TABLE 1

1. Nike Fireworks Ellis Island Safety Zone, 33 CFR 165.160(2.2).	• Launch site: A barge located between Federal Anchorages 20–A and 20–B, in approximate position 40°41′45″ N, 074°02′09″ W (NAD 1983), about 365 yards east of Ellis Island. This Safety Zone is a 360-yard radius from the barge. • Date: December 12, 2013. • Time: 8:00 p.m.–9:30 p.m.

Under the provisions of 33 CFR 165.160, a vessel may not enter the regulated area unless given express permission from the COTP or the designated representative. Spectator vessels may transit outside the regulated area but may not anchor, block, loiter in, or impede the transit of other vessels. The Coast Guard may be assisted by other Federal, State, or local law enforcement agencies in enforcing this regulation.

This notice is issued under authority of 33 CFR 165.160(a) and 5 U.S.C. 552(a). In addition to this notice in the **Federal Register**, the Coast Guard will provide mariners with advanced notification of enforcement periods via the Local Notice to Mariners and marine information broadcasts. If the COTP determines that the regulated area need not be enforced for the full duration stated in this notice, a Broadcast Notice to Mariners may be used to grant general permission to enter the regulated area.

Dated: November 20, 2013.

G. Loebl,

Captain, U.S. Coast Guard, Captain of the Port New York.

[FR Doc. 2013–29370 Filed 12–9–13; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 165

[Docket No. USCG–2013–0930]

RIN 1625–AA00

Safety Zone: Sausalito Lighted Boat Parade Fireworks Display, San Francisco Bay, Sausalito, CA

AGENCY: Coast Guard, DHS.

ACTION: Temporary final rule.

SUMMARY: The Coast Guard is establishing a temporary safety zone in the navigable waters of the San Francisco Bay off of Spinnaker Point near Sausalito, CA in support of the Sausalito Lighted Boat Parade Fireworks Display on December 14, 2013. This safety zone is established to help protect participants and spectators from the dangers associated with pyrotechnics. Unauthorized persons or vessels are prohibited from entering into, transiting through, or remaining in the safety zone without permission of the Captain of the Port or their designated representative.

DATES: This rule is effective on December 14, 2013. This rule will be enforced from 11 a.m. to 8 p.m. on December 14, 2013.

ADDRESSES: Documents mentioned in this preamble are part of docket USCG–2013–0930. To view documents mentioned in this preamble as being available in the docket, go to *http://www.regulations.gov*, type the docket number in the "SEARCH" box and click "SEARCH." Click on Open Docket Folder on the line associated with this rulemaking. You may also visit the Docket Management Facility in Room W12–140 on the ground floor of the Department of Transportation West Building, 1200 New Jersey Avenue SE., Washington, DC 20590, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

FOR FURTHER INFORMATION CONTACT: If you have questions on this rule, call or email Lieutenant Junior Grade William Hawn, U.S. Coast Guard Sector San Francisco; telephone (415) 399–7442 or email at *D11-PF-MarineEvents@uscg.mil*. If you have questions on viewing or submitting material to the docket, call Program Manager, Docket Operations, telephone (202) 366–9826.

SUPPLEMENTARY INFORMATION:

Table of Acronyms

DHS Department of Homeland Security
FR **Federal Register**
NPRM Notice of Proposed Rulemaking

A. Regulatory History and Information

The Coast Guard is issuing this temporary final rule without prior notice and opportunity to comment pursuant to authority under section 4(a) of the Administrative Procedure Act (APA) (5 U.S.C. 553(b)). This provision authorizes an agency to issue a rule without prior notice and opportunity to comment when the agency for good cause finds that those procedures are "impracticable, unnecessary, or contrary to the public interest."

Under 5 U.S.C. 553(b)(B), the Coast Guard finds that good cause exists for not publishing a notice of proposed rulemaking (NPRM) with respect to this rule because the event would occur before the rulemaking process would be completed. Because of the dangers posed by the pyrotechnics used in fireworks displays, the safety zone is necessary to provide for the safety of event participants, spectators, spectator craft, and other vessels transiting the event area. For the safety concerns noted, it is in the public interest to have these regulations in effect during the event. Under 5 U.S.C. 553(d)(3), the Coast Guard finds that good cause exists for making this rule effective less than 30 days after publication in the **Federal Register**.

B. Basis and Purpose

The legal basis for the proposed rule is 33 U.S.C 1231; 46 U.S.C Chapter 701, 3306, 3703; 50 U.S.C. 191, 195; 33 CFR 1.05–1, 6.04–1, 6.04–6, 160.5; Public Law 107–295, 116 Stat. 2064; Department of Homeland Security Delegation No. 0170.1, which collectively authorize the Coast Guard to establish safety zones.

Sausalito On-the-Waterfront Foundation will sponsor the Sausalito Lighted Boat Parade Fireworks Display on December 14, 2013 off of Spinnaker Point near Sausalito, CA in approximate position 37°51′31″ N, 122°28′28″ W (NAD83) as depicted in National Oceanic and Atmospheric Administration (NOAA) Chart 18653. This safety zone establishes a temporary restricted area on the waters 100 feet surrounding the fireworks barge during the loading, transit and arrival of the pyrotechnics from the loading site to the launch site until the commencement of the fireworks display. Upon the commencement of the 10 minute fireworks display, the safety zone will increase in size and encompass the navigable waters around the fireworks barge within a radius of 420 feet. The fireworks display is meant for entertainment purposes. The restricted area around the fireworks barge is necessary to protect spectators, vessels, and other property from the hazards associated with pyrotechnics.

C. Discussion of the Final Rule

The Coast Guard will enforce a safety zone in navigable waters around and under a fireworks barge within a radius

of 100 feet during the loading, transit, and arrival of the fireworks barge to the display location until the start of the fireworks display. From 11 a.m. until 5:30 p.m. on December 14, 2013, the fireworks barge will be loaded at Pier 50 in San Francisco, CA. From 5:30 p.m. to 7 p.m. on December 14, 2013 the loaded fireworks barge will transit from Pier 50 to the launch site off of Spinnaker Point near Sausalito, CA in approximate position 37°51′31″ N, 122°28′28″ W (NAD 83) where it will remain until the commencement of the fireworks display. Upon the commencement of the 10 minute fireworks display, scheduled to begin at 7:45 p.m. on December 14, 2013, the safety zone will increase in size and encompass the navigable waters around and under the fireworks barge within a radius 420 feet in approximate position 37°51′31″ N, 122°28′28″ W (NAD 83) for the Sausalito Lighted Boat Parade Fireworks Display. At the conclusion of the fireworks display the safety zone shall terminate.

The effect of the temporary safety zone will be to restrict navigation in the vicinity of the fireworks barge while the fireworks are set up, and until the conclusion of the scheduled display. Except for persons or vessels authorized by the Coast Guard Patrol Commander, no person or vessel may enter or remain in the restricted area. These regulations are needed to keep spectators and vessels away from the immediate vicinity of the fireworks barge to help protect the participants, spectators, and transiting vessels.

D. Regulatory Analyses

We developed this rule after considering numerous statutes and executive orders related to rulemaking. Below we summarize our analyses based on 13 of these statutes and executive orders.

1. Regulatory Planning and Review

This rule is not a significant regulatory action under section 3(f) of Executive Order 12866, Regulatory Planning and Review, as supplemented by Executive Order 13563, Improving Regulation and Regulatory Review, and does not require an assessment of potential costs and benefits under section 6(a)(3) of Executive Order 12866 or under section 1 of Executive Order 13563. The Office of Management and Budget has not reviewed it under those Orders.

We expect the economic impact of this rule will not rise to the level of necessitating a full Regulatory Evaluation. The safety zone is limited in duration, and is limited to a narrowly tailored geographic area. Although this rule restricts access to the waters encompassed by the safety zone, the effect of this rule is expected to be minimal because the local waterway users will be notified via public Broadcast Notice to Mariners prior to the activation of the safety zone. The entities most likely to be affected are waterfront facilities, commercial vessels, and pleasure craft engaged in recreational activities.

2. Impact on Small Entities

The Regulatory Flexibility Act of 1980 (RFA), 5 U.S.C. 601–612, as amended, requires federal agencies to consider the potential impact of regulations on small entities during rulemaking. The Coast Guard certifies under 5 U.S.C. 605(b) that this rule will not have a significant economic impact on a substantial number of small entities.

This rule may affect owners and operators of waterfront facilities, commercial vessels, and pleasure craft engaged in recreational activities and sightseeing. This safety zone would not have a significant economic impact on a substantial number of small entities for the following reasons. This safety zone would be activated, and thus subject to enforcement, for a limited duration. When the safety zone is activated, vessel traffic can navigate around the safety zone. The maritime public will be advised in advance of this safety zone via Broadcast Notice to Mariners.

3. Assistance for Small Entities

Under section 213(a) of the Small Business Regulatory Enforcement Fairness Act of 1996 (Pub. L. 104–121), we want to assist small entities in understanding this rule. If the rule would affect your small business, organization, or governmental jurisdiction and you have questions concerning its provisions or options for compliance, please contact the person listed in the **FOR FURTHER INFORMATION CONTACT**, above.

Small businesses may send comments on the actions of Federal employees who enforce, or otherwise determine compliance with, Federal regulations to the Small Business and Agriculture Regulatory Enforcement Ombudsman and the Regional Small Business Regulatory Fairness Boards. The Ombudsman evaluates these actions annually and rates each agency's responsiveness to small business. If you wish to comment on actions by employees of the Coast Guard, call 1–888–REG–FAIR (1–888–734–3247). The Coast Guard will not retaliate against small entities that question or complain about this rule or any policy or action of the Coast Guard.

4. Collection of Information

This rule will not call for a new collection of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3520).

5. Federalism

A rule has implications for federalism under Executive Order 13132, Federalism, if it has a substantial direct effect 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. We have analyzed this rule under that Order and determined that this rule does not have implications for federalism.

6. Protest Activities

The Coast Guard respects the First Amendment rights of protesters. Protesters are asked to contact the person listed in the **FOR FURTHER INFORMATION CONTACT** section to coordinate protest activities so that your message can be received without jeopardizing the safety or security of people, places or vessels.

7. Unfunded Mandates Reform Act

The Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1531–1538) requires Federal agencies to assess the effects of their discretionary regulatory actions. In particular, the Act addresses actions that may result in the expenditure by a State, local, or tribal government, in the aggregate, or by the private sector of $100,000,000 (adjusted for inflation) or more in any one year. Though this rule will not result in such an expenditure, we do discuss the effects of this rule elsewhere in this preamble.

8. Taking of Private Property

This rule will not cause a taking of private property or otherwise have taking implications under Executive Order 12630, Governmental Actions and Interference with Constitutionally Protected Property Rights.

9. Civil Justice Reform

This rule meets applicable standards in sections 3(a) and 3(b)(2) of Executive Order 12988, Civil Justice Reform, to minimize litigation, eliminate ambiguity, and reduce burden.

10. Protection of Children

We have analyzed this rule under Executive Order 13045, Protection of Children from Environmental Health Risks and Safety Risks. This rule is not an economically significant rule and

does not create an environmental risk to health or risk to safety that may disproportionately affect children.

11. Indian Tribal Governments

This rule does not have tribal implications under Executive Order 13175, Consultation and Coordination with Indian Tribal Governments, because it does not have a substantial direct effect on one or more Indian tribes, on the relationship between the Federal Government and Indian tribes, or on the distribution of power and responsibilities between the Federal Government and Indian tribes.

12. Energy Effects

This action is not a "significant energy action" under Executive Order 13211, Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use.

13. Technical Standards

This rule does not use technical standards. Therefore, we did not consider the use of voluntary consensus standards.

14. Environment

We have analyzed this rule under Department of Homeland Security Management Directive 023–01 and Commandant Instruction M16475.lD, which guide the Coast Guard in complying with the National Environmental Policy Act of 1969 (NEPA) (42 U.S.C. 4321–4370f), and have determined that this action is one of a category of actions that do not individually or cumulatively have a significant effect on the human environment. This rule involves a safety zone of limited size and duration. This rule is categorically excluded from further review under paragraph 34(g) of Figure 2–1 of the Commandant Instruction. An environmental analysis checklist supporting this determination and a Categorical Exclusion Determination are available in the docket where indicated under **ADDRESSES**. We seek any comments or information that may lead to the discovery of a significant environmental impact from this rule.

List of Subjects in 33 CFR Part 165

Harbors, Marine safety, Navigation (water), Reporting and recordkeeping requirements, Security measures, and Waterways.

For the reasons discussed in the preamble, the Coast Guard amends 33 CFR part 165 as follows:

PART 165—REGULATED NAVIGATION AREAS AND LIMITED ACCESS AREAS

■ 1. The authority citation for part 165 continues to read as follows:

Authority: 33 U.S.C. 1231; 46 U.S.C. Chapter 701; 50 U.S.C. 191, 195; 33 CFR 1.05–1(g), 6.04–1, 6.04–6, and 160.5; Pub. L. 107–295, 116 Stat. 2064; Department of Homeland Security Delegation No. 0170.1.

■ 2. Add temporary § 165.T11–608 to read as follows:

§ 165.T11–608 Safety zone; Sausalito Lighted Boat Parade Fireworks Display, San Francisco Bay, Sausalito, CA.

(a) *Location.* This temporary safety zone is established for the navigable waters of the San Francisco Bay off of Spinnaker Point near Sausalito, CA as depicted in National Oceanic and Atmospheric Administration (NOAA) Chart 18653. From 11 a.m. until 7:45 p.m. on December 14, 2013, the temporary safety zone applies to the nearest point of the fireworks barge within a radius of 100 feet during the loading, transit, and arrival of the fireworks barge from Pier 50 to the launch site off of Spinnaker Point near Sausalito, CA in approximate position 37°51′31″ N, 122°28′28″ W (NAD83). From 7:45 p.m. until 8 p.m. on December 14, 2013, the temporary safety zone will increase in size and encompass the navigable waters around and under the fireworks barge in approximate position 37°51′31″ N, 122°28′28″ W (NAD83) within a radius of 420 feet.

(b) *Enforcement Period.* The zone described in paragraph (a) of this section will be enforced from 11 a.m. through 8 p.m. on December 14, 2013. The Captain of the Port San Francisco (COTP) will notify the maritime community of periods during which this zone will be enforced via Broadcast Notice to Mariners in accordance with 33 CFR 165.7.

(c) *Definitions.* As used in this section, "designated representative" means a Coast Guard Patrol Commander, including a Coast Guard coxswain, petty officer, or other officer on a Coast Guard vessel or a Federal, State, or local officer designated by or assisting the COTP in the enforcement of the safety zone.

(d) *Regulations.* (1) Under the general regulations in 33 CFR Part 165, Subpart C, entry into, transiting or anchoring within this safety zone is prohibited unless authorized by the COTP or a designated representative.

(2) The safety zone is closed to all vessel traffic, except as may be permitted by the COTP or a designated representative.

(3) Vessel operators desiring to enter or operate within the safety zone must contact the COTP or a designated representative to obtain permission to do so. Vessel operators given permission to enter or operate in the safety zone must comply with all directions given to them by the COTP or a designated representative. Persons and vessels may request permission to enter the safety zone on VHF–23A or through the 24-hour Command Center at telephone (415) 399–3547.

Dated: November 20, 2013.

Gregory G. Stump,

Captain, U.S. Coast Guard, Captain of the Port San Francisco.

[FR Doc. 2013–29366 Filed 12–9–13; 8:45 am]

BILLING CODE 9110–04–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[EPA–R10–OAR–2013–0419 FRL–9900–70–Region 10]

Approval and Promulgation of Implementation Plans; State of Oregon; Revised Format for Materials Incorporated by Reference

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule; notice of administrative change.

SUMMARY: The EPA is revising the format for materials submitted by the State of Oregon that are incorporated by reference (IBR) into the Oregon State Implementation Plan (SIP). The regulations affected by this format change have all been previously submitted by the State of Oregon and approved by the EPA. This format revision will primarily affect the "Identification of plan" section, as well as the format of the SIP materials that will be available for public inspection at the National Archives and Records Administration (NARA), the Air and Radiation Docket and Information Center located at the EPA Headquarters in Oregon, DC, and the EPA Regional Office. The EPA is also adding a table in the "Identification of plan" section which summarizes the approval actions that the EPA has taken on the non-regulatory and quasi-regulatory portions of the Oregon SIP.

DATES: This action is effective January 9, 2014.

ADDRESSES: SIP materials which are incorporated by reference into 40 CFR part 52 are available for inspection at the following locations:

US Environmental Protection Agency, Region 10, Office of Air, Waste, and Toxics (OAWT–107), 1200 Sixth Avenue, Seattle, Oregon 98101;
Air and Radiation Docket and Information Center, EPA Headquarters Library, Infoterra Room (Room Number 3334), EPA West Building, 1301 Constitution Ave., NW., Oregon, DC 20460; and
National Archives and Records Administration (NARA).

If you wish to obtain materials from a docket in the EPA Headquarters Library, please call the Office of Air and Radiation (OAR) Docket/Telephone number: 202–566–1742. For information on the availability of this material at NARA, call 202–741–6030, or go to: *http://www.archives.gov/federal-register/cfr/ibr-locations.html.*

FOR FURTHER INFORMATION CONTACT: Justin A. Spenillo, EPA Region 10, (206) 553–6125, *spenillo.justin@epa.gov.*

SUPPLEMENTARY INFORMATION: Throughout this document, wherever "we", "us" or "our" are used, we mean the EPA. Information is organized as follows:

Table of Contents

I. Background

A. What a SIP Is

Each State has a SIP containing the control measures and strategies used to attain and maintain the national ambient air quality standards (NAAQS). The SIP is extensive, containing such elements as air pollution control regulations, emission inventories, monitoring network, attainment demonstrations, and enforcement mechanisms.

B. How the EPA Enforces SIPs

Each state must formally adopt the control measures and strategies in the SIP after the public has had an opportunity to comment on them. They are then submitted to the EPA as SIP revisions upon which the EPA must formally act. Once these control measures and strategies are approved by the EPA, after notice and comment, they are incorporated into the Federally approved SIP and are identified in part 52 (Approval and Promulgation of Implementation Plans), title 40 of the Code of Federal Regulations (40 CFR part 52). The actual state regulations approved by the EPA are not reproduced in their entirety in 40 CFR part 52, but are "incorporated by reference" (IBR'd) which means that the EPA has approved a given state regulation with a specific effective date. This format allows both the EPA and the public to know which measures are contained in a given SIP and ensures that the state is enforcing the regulations. It also allows the EPA and the public to take enforcement action, should a state not enforce its SIP-approved regulations.

C. How the State and the EPA Updates the SIP

The SIP is a living document which the state can revise as necessary to address the unique air pollution problems in the state. Therefore, the EPA must, from time to time, take action on SIP revisions containing new and/or revised regulations in order to make them part of the SIP. On May 22, 1997 (62 FR 27968), the EPA revised the procedures for IBR'ing Federally-approved SIPs, as a result of consultations between the EPA and the Office of the Federal Register (OFR).

The EPA began the process of developing: (1) A revised SIP document for each state that would be IBR'd under the provisions of title 1 CFR part 51; (2) a revised mechanism for announcing the EPA approval of revisions to an applicable SIP and updating both the IBR document and the CFR; and (3) a revised format of the "Identification of Plan" sections for each applicable subpart to reflect these revised IBR procedures. The description of the revised SIP document, IBR procedures, and "Identification of Plan" format are discussed in further detail in the May 22, 1997, **Federal Register** document.

D. How the EPA Compiles the SIPs

The Federally-approved regulations, source-specific permits, and nonregulatory provisions (entirely or portions of) submitted by each state agency have been compiled by the EPA into a "SIP compilation." The SIP compilation contains the updated regulations, source-specific permits, and nonregulatory provisions approved by the EPA through previous rulemaking actions in the **Federal Register**.

E. How the EPA Organizes the SIP Compilation

Each compilation contains three parts. Part one contains the regulations, part two contains the source-specific requirements that have been approved as part of the SIP, and part three contains nonregulatory provisions that have been EPA approved. Each part consists of a table of identifying information for each SIP-approved regulation, each SIP-approved source-specific permit, and each nonregulatory SIP provision. In this action, the EPA is publishing the tables summarizing the applicable SIP requirements for Oregon. The EPA Regional Offices have the primary responsibility for updating the compilations and ensuring their accuracy.

F. Where You Can Find a Copy of the SIP Compilation

The EPA Region 10 developed and will maintain the compilation for Oregon. A copy of the full text of Oregon's regulatory and source-specific SIP compilation will also be maintained at NARA and the EPA's Air Docket and Information Center.

G. The Format of the New Identification of Plan Section

In order to better serve the public, the EPA revised the organization of the "Identification of Plan" section and included additional information to clarify the enforceable elements of the SIP. The revised Identification of Plan section contains five subsections:

1. Purpose and scope.
2. Incorporation by reference.
3. EPA-approved regulations and statutes.
4. EPA-approved source-specific permits.
5. EPA-approved nonregulatory and quasi-regulatory provisions such as air quality attainment plans, rate of progress plans, maintenance plans, monitoring networks, and small business assistance programs.

H. When a SIP Revision Becomes Federally Enforceable

All revisions to the applicable SIP become Federally enforceable as of the effective date of the revisions to paragraphs (c), (d), or (e) of the applicable Identification of Plan section found in each subpart of 40 CFR part 52.

I. The Historical Record of SIP Revision Approvals

To facilitate enforcement of previously approved SIP provisions and provide a smooth transition to the new SIP processing system, the EPA retains the original Identification of Plan

section, previously appearing in the CFR as the first or second section of part 52 for each state subpart. After an initial two-year period, the EPA will review its experience with the new system and enforceability of previously approved SIP measures and will decide whether or not to retain the Identification of Plan appendices for some further period. Although the EPA is retaining the original Identification of Plan section, other sections of part 52 are either duplicative of the new Identification of Plan section or out of date. The EPA is therefore removing sections 52.2479 "Contents of the federally approved, State submitted implementation plan", 52.2491 "Section 110(a)(2) infrastructure requirements", and 52.2499 "Interstate Transport for the 1997 8-hour ozone and $PM_{2.5}$ NAAQS" as part of the general "housekeeping" discussed below.

II. What the EPA Is Doing in This Action

Today's rule constitutes a "housekeeping" exercise to ensure that all revisions to the state programs that have occurred are accurately reflected in 40 CFR part 52. State SIP revisions are controlled by EPA regulations at 40 CFR part 51. When the EPA receives a formal SIP revision request, the Agency must publish the proposed revision in the **Federal Register** and provide for public comment before approval.

The EPA has determined that today's rule falls under the "good cause" exemption in section 553(b)(3)(B) of the Administrative Procedures Act (APA) which, upon finding "good cause," authorizes agencies to dispense with public participation and section 553(d)(3) which allows an agency to make a rule effective immediately (thereby avoiding the 30-day delayed effective date otherwise provided for in the APA). Today's rule simply codifies provisions which are already in effect as a matter of law in Federal and approved state programs. Under section 553 of the APA, an agency may find good cause where procedures are "impractical, unnecessary, or contrary to the public interest." Public comment is "unnecessary" and "contrary to the public interest" since the codification only reflects existing law. Immediate notice in the CFR benefits the public by removing outdated citations.

III. Statutory and Executive Order Reviews

A. General Requirements

Under Executive Order 12866 (58 FR 51735, October 4, 1993), this action is not a "significant regulatory action" and is therefore not subject to review by the Office of Management and Budget. This rule is not subject to Executive Order 13211, "Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use" (66 FR 28355, May 22, 2001) because it is not a significant regulatory action under Executive Order 12866. Because the agency has made a "good cause" finding that this action is not subject to notice-and-comment requirements under the Administrative Procedure Act or any other statute as indicated in the **SUPPLEMENTARY INFORMATION** section above, it is not subject to the regulatory flexibility provisions of the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*), or to sections 202 and 205 of the Unfunded Mandates Reform Act of 1995 (UMRA) (Pub. L. 104–4). In addition, this action does not significantly or uniquely affect small governments or impose a significant intergovernmental mandate, as described in sections 203 and 204 of UMRA. This rule also does not have a substantial direct effect on one or more Indian tribes, on the relationship between the Federal government and Indian tribes, or on the distribution of power and responsibilities between the Federal government and Indian tribes, as specified by Executive Order 13175 (65 FR 67249, November 9, 2000), nor will it 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, as specified in Executive Order 13132 (64 FR 43255, August 10, 1999). This rule also is not subject to Executive Order 13045 (62 FR 1985, April 23, 1997), because it is not economically significant. This rule does not involve technical standards; thus the requirements of section 12(d) of the National Technology Transfer and Advancement Act of 1995 (15 U.S.C. 272 note) do not apply. The rule also does not involve special consideration of environmental justice related issues as required by Executive Order 12898 (59 FR 7629, February 16, 1994). In issuing this rule, the EPA has taken the necessary steps to eliminate drafting errors and ambiguity, minimize potential litigation, and provide a clear legal standard for affected conduct, as required by section 3 of Executive Order 12988 (61 FR 4729, February 7, 1996). The EPA has complied with Executive Order 12630 (63 FR 8859, March 15, 1998) by examining the takings implications of the rule in accordance with the "Attorney General's Supplemental Guidelines for the Evaluation of Risk and Avoidance of Unanticipated Takings" issued under the executive order. This rule does not impose an information collection burden under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*). The EPA's compliance with these statutes and Executive Orders for the underlying rules are discussed in previous actions taken on the State's rules.

B. Submission to Congress and the Comptroller General

The Congressional Review Act (5 U.S.C. 801 *et seq.*), as added by the Small Business Regulatory Enforcement Fairness Act of 1996, generally provides that before a rule may take effect, the agency promulgating the rule must submit a rule report, which includes a copy of the rule, to each House of the Congress and to the Comptroller General of the United States. Section 808 allows the issuing agency to make a rule effective sooner than otherwise provided by the CRA if the agency makes a good cause finding that notice and public procedure is impracticable, unnecessary or contrary to the public interest. Today's action simply codifies provisions which are already in effect as a matter of law in Federal and approved State programs. 5 U.S.C. 802(2). As stated previously, the EPA has made such a good cause finding, including the reasons therefore, and established an effective date of January 9, 2014. The 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**. The changes in format to the "Identification of plan" section for the State of Oregon are not a 'major rule' as defined by 5 U.S.C. 804(2).

C. Petitions for Judicial Review

The EPA has also determined that the provisions of section 307(b)(1) of the Clean Air Act pertaining to petitions for judicial review are not applicable to this action. Prior EPA rulemaking actions for each individual component of the Oregon SIP compilations had previously afforded interested parties the opportunity to file a petition for judicial review in the United States Court of Appeals for the appropriate circuit within 60 days of such rulemaking action. Thus, the EPA sees no need in this action to reopen the 60-day period for filing such petitions for judicial review for these "Identification of plan" reorganization actions for Oregon.

List of Subjects in 40 CFR Part 52

Environmental protection, Air pollution control, Carbon monoxide,

Incorporation by reference, Intergovernmental relations, Nitrogen dioxide, Ozone, Particulate matter, Reporting and recordkeeping requirements, Sulfur dioxide, Volatile organic compounds.

Dated: August 26, 2013.

Michelle L. Pirzadeh,

Acting Regional Administrator, Region 10.

Part 52 of chapter I, title 40 of the Code of Federal Regulations is amended as follows:

PART 52—APPROVAL AND PROMULGATION OF IMPLEMENTATION PLANS

■ 1. The authority citation for part 52 continues to read as follows:

Authority: 42 U.S.C. 7401 et seq.

Subpart MM—Oregon

§ 52.1970 [Redesignated as § 52.1974]

■ 2. Section 52.1970 is redesignated as § 52.1974.

■ 3. Add a new § 52.1970 to read as follows:

§ 52.1970 Identification of plan.

(a) Purpose and scope. This section sets forth the applicable State implementation plan for the State of Oregon under section 110 of the Clean Air Act, 42 U.S.C. 7401–7671q and 40 CFR Part 51 to meet national ambient air quality standards.

(b) Incorporation by reference.

(1) Material listed in paragraphs (c) and (d) of this section with an EPA approval date prior to September 1, 2013, was approved for incorporation by reference by the Director of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR Part 51. Material is incorporated as it exists on the date of the approval, and notice of any change in the material will be published in the **Federal Register**. Entries in paragraphs (c) and (d) of this section with the EPA approval dates after September 1, 2013, will be incorporated by reference in the next update to the SIP compilation.

(2) EPA Region 10 certifies that the rules/regulations provided by the EPA in the SIP compilation at the addresses in paragraph (b)(3) of this section are an exact duplicate of the officially promulgated State rules/regulations which have been approved as part of the State Implementation Plan as of September 1, 2013.

(3) Copies of the materials incorporated by reference may be inspected at the Region 10 EPA Office at 1200 Sixth Avenue, Seattle WA, 98101; the EPA, Air and Radiation Docket and Information Center, EPA Headquarters Library, Infoterra Room (Room Number 3334), EPA West Building, 1301 Constitution Ave. NW., Oregon, DC; or the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call (202) 741–6030, or go to: *http://www.archives.gov/federal-register/cfr/ibr-locations.html.*

(c) EPA approved regulations and statutes.

TABLE 1—EPA APPROVED OREGON STATE STATUTES

State Citation	Title/subject	State effective date	EPA approval date	Explanations
ORS 477.515	Permits	1971	11/1/2001, 66 FR 55105.	Permits required for fires on forestlands; waiver, permit conditions, smoke management plan; restricted areas, rules and excepted areas.

TABLE 2—EPA APPROVED OREGON ADMINISTRATIVE RULES (OAR)

State citation	Title/subject	State effective date	EPA approval date	Explanations
CHAPTER 340—DEPARTMENT OF ENVIRONMENTAL QUALITY				
Division 21—General Emission Standards for Particulate Matter				
Industrial Contingency Requirements for PM–10 Nonattainment Areas				
021–200	Purpose	5/1/1995	9/21/1999, 64 FR 51051.	
021–205	Relation to Other Rules	3/10/1993	2/25/1997, 62 FR 8385.	
021–210	Applicability	3/10/1993	2/25/1997, 62 FR 8385.	
021–215	Definitions	3/10/1993	2/25/1997, 62 FR 8385.	
021–220	Compliance Schedule for Existing Sources.	3/10/1993	2/25/1997, 62 FR 8385.	
021–225	Wood-Waste Boilers	3/10/1993	2/25/1997, 62 FR 8385.	
021–230	Wood Particle Dryers at Particleboard Plants.	3/10/1993	2/25/1997, 62 FR 8385.	
021–235	Hardboard Manufacturing Plants.	1/29/1996	2/25/1997, 62 FR 8385.	
021–240	Air Conveying Systems	3/10/1993	2/25/1997, 62 FR 8385.	
021–245	Fugitive Emissions	3/10/1993	2/25/1997, 62 FR 8385.	
Division 200 General Air Pollution Procedures and Definitions				
200–0010	Purpose and Application	11/8/2007	12/27/2011, 76 FR 80747.	
200–0020	General Air Quality Definitions.	5/17/2012	6/20/2013, 78 FR 37124	Including Table 1, 2, 3, 4, 5.
200–0025	Abbreviations and Acronyms.	5/1/2011	12/27/2011, 76 FR 80747.	
200–0030	Exceptions	9/17/2008	12/27/2011, 76 FR 80747.	

TABLE 2—EPA APPROVED OREGON ADMINISTRATIVE RULES (OAR)—Continued

State citation	Title/subject	State effective date	EPA approval date	Explanations
Division 202 Ambient Air Quality Standards and PSD Increments				
202–0010	Definitions	5/1/2011	12/27/2011; 76 FR 80747.	
Ambient Air Quality Standards				
202–0050	Purpose and Scope of Ambient Air Quality Standards.	7/1/2001	1/22/2003, 68 FR 2891.	
202–0060	Suspended Particulate Matter.	5/1/2011	12/27/2011, 76 FR 80747.	
202–0070	Sulfur Dioxide	7/1/2001	1/22/2003, 68 FR 2891.	
202–0080	Carbon Monoxide	7/1/2001	1/22/2003, 68 FR 2891.	
202–0090	Ozone	5/21/2010	12/27/2011, 76 FR 80747.	
202–0100	Nitrogen Dioxide	7/1/2001	1/22/2003, 68 FR 2891.	
202–0130	Ambient Air Quality Standard for Lead.	5/21/2010	12/27/2011, 76 FR 80747.	
Prevention of Significant Deterioration Increments				
202–0200	General	10/14/1999	1/22/2003, 68 FR 2891.	
202–0210	Ambient Air Increments	5/1/2011	12/27/2011, 76 FR 80747	Including Table 1.
202–0220	Ambient Air Ceilings	7/1/2001	1/22/2003, 68 FR 2891.	
Division 204 Designation of Air Quality Areas				
204–0010	Definitions	12/21/2011	4/11/2013, 78 FR 21547.	
204–0020	Designation of Air Quality Control Regions.	10/14/1999	1/22/2003, 68 FR 2891.	
204–0030	Designation of Nonattainment Areas.	12/21/2011	4/11/2013, 78 FR 21547.	
204–0040	Designation of Maintenance Areas.	12/21/2011	4/11/2013, 78 FR 21547.	
204–0050	Designation of Prevention of Significant Deterioration Areas.	10/14/1999	1/22/2003, 68 FR 2891.	
204–0060	Redesignation of Prevention of Significant Deterioration Areas.	10/14/1999	1/22/2003, 68 FR 2891.	
204–0070	Special Control Areas	10/14/1999	1/22/2003, 68 FR 2891.	
204–0080	Motor Vehicle Inspection Boundary Designations.	10/14/1999	1/22/2003, 68 FR 2891.	
204–0090	Oxygenated Gasoline Control Areas.	12/15/2004	1/24/2006, 71 FR 3768.	
Division 206 Air Pollution Emergencies				
206–0010	Introduction	5/21/2010	12/27/2011, 76 FR 80747.	
206–0020	Definitions	10/14/1999	1/22/2003, 68 FR 2891.	
206–0030	Episode Stage Criteria for Air Pollution Emergencies.	5/21/2010	12/27/2011, 76 FR 80747	Including Table 2.
206–0040	Special Conditions	10/14/1999	1/22/2003, 68 FR 2891.	
206–0050	Source Emission Reduction Plans.	10/14/1999	1/22/2003, 68 FR 2891.	
206–0060	Regional Air Pollution Authorities.	10/14/1999	1/22/2003, 68 FR 2891.	
206–0070	Operations Manual	10/14/1999	1/22/2003, 68 FR 2891.	
Division 208 Visible Emissions and Nuisance Requirements				
208–0010	Definitions	11/8/2007	12/27/2011, 76 FR 80747.	
Visible Emissions				
208–0100	Applicability	2/5/2001	12/27/2011; 76 FR 80747.	
208–0110	Visible Air Contaminant Limitations.	11/8/2007	12/27/2011; 76 FR 80747.	
Fugitive Emissions Requirements				
208–0200	Applicability	2/5/2001	12/27/2011; 76 FR 80747.	

TABLE 2—EPA APPROVED OREGON ADMINISTRATIVE RULES (OAR)—Continued

State citation	Title/subject	State effective date	EPA approval date	Explanations
208–0210	Requirements	2/5/2001	12/27/2011; 76 FR 80747.	
Division 209 Public Participation				
209–0010	Purpose	7/1/2001	1/22/2003, 68 FR 2891.	
209–0020	Applicability	7/1/2001	1/22/2003, 68 FR 2891.	
209–0030	Public Notice Categories and Timing.	7/1/2001	1/22/2003, 68 FR 2891.	
209–0040	Public Notice Information	11/8/2007	12/27/2011, 76 FR 80747.	
209–0050	Public Notice Procedures	7/1/2001	1/22/2003, 68 FR 2891.	
209–0060	Persons Required to Be Notified.	7/1/2001	1/22/2003, 68 FR 2891.	
209–0070	Hearing and Meeting Procedures.	11/8/2007	12/27/2011, 76 FR 80747.	
209–0080	Issuance or Denial of a Permit.	11/8/2007	12/27/2011, 76 FR 80747.	
Division 210 Stationary Source Notification Requirements				
210–0010	Applicability	10/14/1999	1/22/2003, 68 FR 2891.	
210–0020	Definitions	10/14/1999	1/22/2003, 68 FR 2891.	
Registration				
210–0100	Registration in General	5/17/2012	6/20/2013, 78 FR 37124.	
210–0110	Registration Requirements	5/17/2012	6/20/2013, 78 FR 37124.	
210–0120	Re-Registration and Maintaining Registration.	5/17/2012	6/20/2013, 78 FR 37124.	
Notice of Construction and Approval of Plans				
210–0205	Applicability	9/17/2008	12/27/2011, 76 FR 80747.	
210–0215	Requirement	7/1/2001	1/22/2003, 68 FR 2891.	
210–0225	Types of Construction/Modification Changes.	7/1/2001	1/22/2003, 68 FR 2891.	
210–0230	Notice to Construct	7/1/2001	1/22/2003, 68 FR 2891.	
210–0240	Construction Approval	7/1/2001	1/22/2003, 68 FR 2891.	
210–0250	Approval to Operate	5/17/2012	6/20/2013, 78 FR 37124.	
Division 212 Stationary Source Testing and Monitoring				
212–0010	Definitions	10/14/1999	1/22/2003, 68 FR 2891.	
Sampling, Testing and Measurement				
212–0110	Applicability	10/14/1999	1/22/2003, 68 FR 2891.	
212–0120	Program	7/1/2001	1/22/2003, 68 FR 2891.	
212–0130	Stack Heights and Dispersion Techniques.	7/1/2001	1/22/2003, 68 FR 2891.	
212–0140	Methods	7/1/2001	1/22/2003, 68 FR 2891.	
212–0150	Department Testing	7/1/2001	1/22/2003, 68 FR 2891.	
Compliance Assurance Monitoring				
212–0200	Purpose and Applicability	7/1/2001	1/22/2003, 68 FR 2891.	
212–0210	Monitoring Design Criteria	7/1/2001	1/22/2003, 68 FR 2891.	
212–0220	Submittal Requirements	7/1/2001	1/22/2003, 68 FR 2891.	
212–0230	Deadlines for Submittals	7/1/2001	1/22/2003, 68 FR 2891.	
212–0240	Approval of Monitoring Plans.	7/1/2001	1/22/2003, 68 FR 2891.	
212–0250	Operation of Approved Monitoring.	7/1/2001	1/22/2003, 68 FR 2891.	
212–0260	Quality Improvement Plan (QIP) Requirements.	7/1/2001	1/22/2003, 68 FR 2891.	
212–0270	Reporting and Recordkeeping Requirements.	7/1/2001	1/22/2003, 68 FR 2891.	
212–0280	Savings Provisions	7/1/2001	1/22/2003, 68 FR 2891.	
Division 214 Stationary Source Reporting Requirements				
214–0010	Definitions	11/8/2007	12/27/2011, 76 FR 80747.	

TABLE 2—EPA APPROVED OREGON ADMINISTRATIVE RULES (OAR)—Continued

State citation	Title/subject	State effective date	EPA approval date	Explanations
	Reporting			
214–0100	Applicability	10/14/1999	1/22/2003, 68 FR 2891.	
214–0110	Request for Information	7/1/2001	1/22/2003, 68 FR 2891.	
214–0114	Records; Maintaining and Reporting.	7/1/2001	1/22/2003, 68 FR 2891.	
214–0120	Enforcement	10/14/1999	1/22/2003, 68 FR 2891.	
214–0130	Information Exempt from Disclosure.	7/1/2001	1/22/2003, 68 FR 2891.	
	Emission Statements for VOC and NO_X Sources			
214–0200	Purpose and Applicability	7/1/2001	1/22/2003, 68 FR 2891.	
214–0210	Requirements	7/1/2001	1/22/2003, 68 FR 2891.	
214–0220	Submission of Emission Statement.	7/1/2001	1/22/2003, 68 FR 2891.	
	Excess Emissions and Emergency Provision			
214–0300	Purpose and Applicability	11/8/2007	12/27/2011, 76 FR 80747.	
214–0310	Planned Startup and Shutdown.	11/8/2007	12/27/2011, 76 FR 80747.	
214–0320	Scheduled Maintenance	11/8/2007	12/27/2011, 76 FR 80747.	
214–0330	All Other Excess Emissions	11/8/2007	12/27/2011, 76 FR 80747.	
214–0340	Reporting Requirements	11/8/2007	12/27/2011, 76 FR 80747.	
214–0350	Enforcement Action Criteria	11/8/2007	12/27/2011, 76 FR 80747.	
214–0360	Emergency as an Affirmative Defense.	11/8/2007	12/27/2011, 76 FR 80747.	
	Division 216 Air Contaminant Discharge Permits			
216–0010	Purpose	7/1/2001	1/22/2003, 68 FR 2891.	
216–0020	Applicability	5/1/2011	12/27/2011, 76 FR 80747	Including Table 1, 2.
216–0025	Types of Permits	7/1/2001	1/22/2003, 68 FR 2891.	
216–0030	Definitions	7/1/2001	1/22/2003, 68 FR 2891.	
216–0040	Application Requirements	5/1/2011	12/27/2011, 76 FR 80747.	
216–0052	Construction ACDP	7/1/2001	1/22/2003, 68 FR 2891.	
216–0054	Short Term Activity ACDPs	7/1/2001	1/22/2003, 68 FR 2891.	
216–0056	Basic ACDPs	7/1/2001	1/22/2003, 68 FR 2891.	
216–0060	General Air Contaminant Discharge Permits.	5/1/2011	12/27/2011, 76 FR 80747.	
216–0064	Simple ACDP	5/1/2011	12/27/2011, 76 FR 80747.	
216–0066	Standard ACDPs	7/1/2001	1/22/2003, 68 FR 2891.	
216–0070	Permitting Multiple Sources at a Single Adjacent or Contiguous Site.	7/1/2001	1/22/2003, 68 FR 2891.	
216–0082	Termination or Revocation of an ACDP.	11/8/2007	12/27/2011, 76 FR 80747.	
216–0084	Department Initiated Modification.	7/1/2001	1/22/2003, 68 FR 2891.	
216–0090	Sources Subject to ACDPs and Fees.	7/1/2001	1/22/2003, 68 FR 2891.	
216–0094	Temporary Closure	7/1/2001	1/22/2003, 68 FR 2891.	
	Division 222—Stationary Source Plant Site Emission Limits			
222–0010	Policy	7/1/2001	1/22/2003, 68 FR 2891.	
222–0020	Applicability	8/29/2008	12/27/2011, 76 FR 80747.	
222–0030	Definitions	10/14/1999	1/22/2003, 68 FR 2891.	
	Criteria for Establishing Plant Site Emission Limits			
222–0040	Generic Annual PSEL	7/1/2001	1/22/2003, 68 FR 2891.	
222–0041	Source Specific Annual PSEL.	10/8/2002	1/22/2003, 68 FR 2891.	
222–0042	Short Term PSEL	7/1/2001	1/22/2003, 68 FR 2891.	
222–0043	General Requirements for All PSEL.	7/1/2001	1/22/2003, 68 FR 2891.	
222–0045	Unassigned Emissions	7/1/2001	1/22/2003, 68 FR 2891.	
222–0070	Plant Site Emission Limits for Insignificant Activities.	7/1/2001	1/22/2003, 68 FR 2891.	

TABLE 2—EPA APPROVED OREGON ADMINISTRATIVE RULES (OAR)—Continued

State citation	Title/subject	State effective date	EPA approval date	Explanations
222–0080	Plant Site Emission Limit Compliance.	7/1/2001	1/22/2003, 68 FR 2891.	
222–0090	Combining and Splitting Sources.	7/1/2001	1/22/2003, 68 FR 2891.	
Division 223—Regional Haze				
223–0010	Purpose	12/10/2010	7/5/2011, 76 FR 38997.	
223–0020	Definitions	12/10/2010	7/5/2011, 76 FR 38997.	
223–0030	BART and Additional Regional Haze Requirements for the Foster-Wheeler Boiler at the Boardman Coal-Fired Power Plant (Federal Acid Rain Program Facility ORISPL Code 6106).	12/10/2010	7/5/2011, 76 FR 38997.	
223–0040	Federally Enforceable Permit Limits.	12/10/2010	7/5/2011, 76 FR 38997.	
223–0050	Alternative Regional Haze Requirements for the Foster-Wheeler Boiler at the Boardman Coal-Fired Power Plant (Federal Acid Rain Program Facility ORISPL Code 6106).	12/10/2010	7/5/2011, 76 FR 38997.	
223–0080	Alternative Requirements for the Foster-Wheeler Boiler at the Boardman Coal-Fired Power Plant (Federal Acid Rain Program Facility ORISPL Code 6106) Based Upon Permanently Ceasing the Burning of Coal Within Five Years of EPA Approval of the Revision to the Oregon Clean Air Act State Implementation Plan Incorporating OAR Chapter 340, Division 223.	12/10/2010	7/5/2011, 76 FR 38997.	
Division 224—Major New Source Review				
224–0010	Applicability and General Prohibitions.	5/1/2011	12/27/2011, 76 FR 80747.	
224–0020	Definitions	10/14/1999	1/22/2003, 68 FR 2891.	
224–0030	Procedural Requirements	4/14/2004	6/19/2006, 71 FR 35163.	
224–0040	Review of New Sources and Modifications for Compliance with Regulations.	7/1/2001	1/22/2003, 68 FR 2891.	
224–0050	Requirements for Sources in Nonattainment Areas.	5/1/2011	12/27/2011, 76 FR 80747.	
224–0060	Requirements for Sources in Maintenance Areas.	5/1/2011	12/27/2011, 76 FR 80747.	
224–0070	Prevention of Significant Deterioration Requirements for Sources in Attainment or Unclassified Areas.	5/1/2011	12/27/2011, 76 FR 80747.	
224–0080	Exemptions	4/14/2004	6/19/2006, 71 FR 35163.	
224–0100	Fugitive and Secondary Emissions.	7/1/2001	1/22/2003, 68 FR 2891.	
Division 225—Air Quality Analysis Requirements				
225–0010	Purpose	7/1/2001	1/22/2003, 68 FR 2891.	
225–0020	Definitions	5/1/2011	12/27/2011, 76 FR 80747.	
225–0030	Procedural Requirements	5/1/2011	12/27/2011, 76 FR 80747.	
225–0040	Air Quality Models	7/1/2001	1/22/2003, 68 FR 2891.	

TABLE 2—EPA APPROVED OREGON ADMINISTRATIVE RULES (OAR)—Continued

State citation	Title/subject	State effective date	EPA approval date	Explanations
225–0045	Requirements for Analysis in Maintenance Areas.	5/1/2011	12/27/2011, 76 FR 80747.	
225–0050	Requirements for Analysis in PSD Class II and Class III Areas.	5/1/2011	12/27/2011, 76 FR 80747.	
225–0060	Requirements for Demonstrating Compliance with Standards and Increments in PSD Class I Areas.	5/1/2011	12/27/2011, 76 FR 80747.	
225–0070	Requirements for Demonstrating Compliance with AQRV Protection.	7/1/2001	1/22/2003, 68 FR 2891.	
225–0090	Requirements for Demonstrating a Net Air Quality Benefit.	5/1/2011	12/27/2011, 76 FR 80747 ...	Except (2)(a)(C).
Division 226—General Emission Standards				
226–0010	Definitions	7/1/2001	1/22/2003, 68 FR 2891.	
Highest and Best Practicable Treatment and Control				
226–0100	Policy and Application	7/1/2001	1/22/2003, 68 FR 2891.	
226–0110	Pollution Prevention	7/1/2001	1/22/2003, 68 FR 2891.	
226–0120	Operating and Maintenance Requirements.	7/1/2001	1/22/2003, 68 FR 2891.	
226–0130	Typically Achievable Control Technology.	7/1/2001	1/22/2003, 68 FR 2891.	
226–0140	Additional Control Requirements for Stationary Sources of Air Contaminants.	7/1/2001	1/22/2003, 68 FR 2891.	
Grain Loading Standards				
226–0200	Applicability	10/14/1999	1/22/2003, 68 FR 2891.	
226–0210	Particulate Emission Limitations for Sources Other Than Fuel Burning and Refuse Burning Equipment.	7/1/2001	1/22/2003, 68 FR 2891.	
Particulate Emissions from Process Equipment				
226–0300	Applicability	7/1/2001	1/22/2003, 68 FR 2891.	
226–0310	Emission Standard	7/1/2001	1/22/2003, 68 FR 2891.	
226–0320	Determination of Process Weight.	7/1/2001	1/22/2003, 68 FR 2891.	
Alternative Emission Controls				
226–0400	Alternative Emission Controls (Bubble).	7/1/2001	1/22/2003, 68 FR 2891.	
Division 228—Requirements for Fuel Burning Equipment and Fuel Sulfur Content				
228–0010	Applicability	10/14/1999	1/22/2003, 68 FR 2891.	
228–0020	Definitions	5/17/2012	6/20/2013, 78 FR 37124.	
Sulfur Content of Fuels				
228–0100	Residual Fuel Oils	10/14/1999	1/22/2003, 68 FR 2891.	
228–0110	Distillate Fuel Oils	10/14/1999	1/22/2003, 68 FR 2891.	
228–0120	Coal	10/14/1999	1/22/2003, 68 FR 2891.	
228–0130	Exemptions	10/14/1999	1/22/2003, 68 FR 2891.	
General Emission Standards for Fuel Burning Equipment				
228–0200	Sulfur Dioxide Standards	5/17/2012	6/20/2013, 78 FR 37124.	
228–0210	Grain Loading Standards	5/17/2012	6/20/2013, 78 FR 37124.	

TABLE 2—EPA APPROVED OREGON ADMINISTRATIVE RULES (OAR)—Continued

State citation	Title/subject	State effective date	EPA approval date	Explanations
Division 232—Emission Standards for VOC Point Sources				
232–0010	Introduction	11/8/2007	12/27/2011, 76 FR 80747.	
232–0020	Applicability	4/12/2007	12/19/2011, 76 FR 78571.	
232–0030	Definitions	12/26/2001	8/3/2005, 70 FR 44481.	
232–0040	General Non-categorical Requirements.	10/14/1999	1/22/2003, 68 FR 2891.	
232–0050	Exemptions	10/14/1999	1/22/2003, 68 FR 2891.	
232–0060	Compliance Determination	10/14/1999	1/22/2003, 68 FR 2891.	
232–0070	Gasoline Dispensing Facilities.	10/14/1999	1/22/2003, 68 FR 2891.	
232–0080	Bulk Gasoline Plants	10/14/1999	1/22/2003, 68 FR 2891.	
232–0085	Gasoline Delivery Vessel(s)	10/14/1999	1/22/2003, 68 FR 2891.	
232–0090	Bulk Gasoline Terminals	10/14/1999	1/22/2003, 68 FR 2891.	
232–0100	Testing Vapor Transfer and Collection Systems.	10/14/1999	1/22/2003, 68 FR 2891.	
232–0110	Loading Gasoline onto Marine Tank Vessels.	6/1/2001	1/22/2003, 68 FR 2891.	
232–0120	Cutback and Emulsified Asphalt.	10/14/1999	1/22/2003, 68 FR 2891.	
232–0130	Petroleum Refineries	10/14/1999	1/22/2003, 68 FR 2891.	
232–0140	Petroleum Refinery Leaks	10/14/1999	1/22/2003, 68 FR 2891.	
232–0150	Liquid Storage	10/14/1999	1/22/2003, 68 FR 2891.	
232–0160	Surface Coating in Manufacturing.	10/14/1999	1/22/2003, 68 FR 2891.	
232–0170	Aerospace Component Coating Operations.	10/14/1999	1/22/2003, 68 FR 2891.	
232–0180	Degreasers	10/14/1999	1/22/2003, 68 FR 2891.	
232–0190	Open Top Vapor Degreasers.	10/14/1999	1/22/2003, 68 FR 2891.	
232–0200	Conveyorized Degreasers	10/14/1999	1/22/2003, 68 FR 2891.	
232–0210	Asphaltic and Coal Tar Pitch Used for Roofing Coating.	10/14/1999	1/22/2003, 68 FR 2891.	
232–0220	Flat Wood Coating	10/14/1999	1/22/2003, 68 FR 2891.	
232–0230	Rotogravure and Flexographic Printing.	10/14/1999	1/22/2003, 68 FR 2891.	
Division 234—Emission Standards for Wood Products Industries				
234–0010	Definitions	11/8/2007	12/27/2011; 76 FR 80747	Except (24), (26)(a), (44).
Wigwam Waste Burners				
234–0100	Wigwam Waste Burners	11/8/2007	12/27/2011; 76 FR 80747.	
234–0140	Existing Administrative Agency Orders.	11/8/2007	12/27/2011; 76 FR 80747.	
Kraft Pulp Mills				
234–0200	Statement of Policy and Applicability.	10/14/1999	1/22/2003, 68 FR 2891.	
234–0210	Emission Limitations	11/8/2007	12/27/2011; 76 FR 80747	Except (1).
234–0220	More Restrictive Emission Limits.	10/14/1999	1/22/2003, 68 FR 2891.	
234–0240	Monitoring	11/8/2007	12/27/2011; 76 FR 80747	Except (1).
234–0250	Reporting	11/8/2007	12/27/2011; 76 FR 80747	Except (1), (2).
234–0270	Chronic Upset Conditions	10/14/1999	1/22/2003, 68 FR 2891.	
Neutral Sulfite Semi-Chemical (NSSC) Pulp Mills				
234–0300	Applicability	10/14/1999	1/22/2003, 68 FR 2891.	
234–0310	Emission Limitations	10/14/1999	1/22/2003, 68 FR 2891	Except (1).
234–0320	More Restrictive Emission Limits.	10/14/1999	1/22/2003, 68 FR 2891	Except (2).
234–0330	Plans and Specifications	10/14/1999	1/22/2003, 68 FR 2891.	
234–0340	Monitoring	10/14/1999	1/22/2003, 68 FR 2891	Except (2).
234–0350	Reporting	10/14/1999	1/22/2003, 68 FR 2891	Except (1).
234–0360	Upset Conditions	10/14/1999	1/22/2003, 68 FR 2891	Except (3)(a)(A).

TABLE 2—EPA APPROVED OREGON ADMINISTRATIVE RULES (OAR)—Continued

State citation	Title/subject	State effective date	EPA approval date	Explanations
	Sulfite Pulp Mills			
234–0400	Statement of Policy and Applicability.	10/14/1999	1/22/2003, 68 FR 2891.	
234–0410	Minimum Emission Standards.	10/14/1999	1/22/2003, 68 FR 2891.	
234–0420	Monitoring and Reporting	10/14/1999	1/22/2003, 68 FR 2891.	
234–0430	Exceptions	10/14/1999	1/22/2003, 68 FR 2891.	
	Board Products Industries (Veneer, Plywood, Particleboard, Hardboard)			
234–0500	Applicability and General Provisions.	11/8/2007	12/27/2011; 76 FR 80747.	
234–0510	Veneer and Plywood Manufacturing Operations.	11/8/2007	12/27/2011; 76 FR 80747.	
234–0520	Particleboard Manufacturing Operations.	11/8/2007	12/27/2011; 76 FR 80747.	
234–0530	Hardboard Manufacturing Operations.	11/8/2007	12/27/2011; 76 FR 80747.	
	Division 236—Emission Standards for Specific Industries			
236–0010	Definitions	11/8/2007	12/27/2011, 76 FR 80747.	
	Primary Aluminum Standards			
236–0100	Statement of Purpose	10/14/1999	1/22/2003, 68 FR 2891.	
236–0110	Applicability	10/14/1999	1/22/2003, 68 FR 2891.	
236–0120	Emission Standards	10/14/1999	1/22/2003, 68 FR 2891	Except (1)(a), (3)(a) & (3)(e).
236–0130	Special Problem Areas	10/14/1999	1/22/2003, 68 FR 2891.	
236–0140	Monitoring	10/14/1999	1/22/2003, 68 FR 2891	Except references to fluorides
236–0150	Reporting	10/14/1999	1/22/2003, 68 FR 2891	Except (1)(d) & (1)(e).
	Laterite Ore Production of Ferronickel			
236–0200	Statement of Purpose	10/14/1999	1/22/2003, 68 FR 2891.	
236–0210	Applicability	10/14/1999	1/22/2003, 68 FR 2891.	
236–0220	Emission Standards	10/14/1999	1/22/2003, 68 FR 2891.	
236–0230	Monitoring and Reporting	10/14/1999	1/22/2003, 68 FR 2891.	
	Hot Mix Asphalt Plants			
236–0400	Applicability	10/14/1999	1/22/2003, 68 FR 2891.	
236–0410	Control Facilities Required	11/8/2007	12/27/2011, 76 FR 80747.	
236–0420	Other Established Air Quality Limitations.	10/14/1999	1/22/2003, 68 FR 2891.	
236–0430	Portable Hot Mix Asphalt Plants.	10/14/1999	1/22/2003, 68 FR 2891.	
236–0440	Ancillary Sources of Emission—Housekeeping of Plant Facilities.	10/14/1999	1/22/2003, 68 FR 2891.	
	Division 240—Rules for Areas with Unique Air Quality Needs			
240–0010	Purpose	10/14/1999	1/22/2003, 68 FR 2891.	
240–0020	Emission Limitations	7/1/2001	1/22/2003, 68 FR 2891.	
240–0030	Definitions	1/4/2005	6/19/2006, 71 FR 35163.	
	The Medford-Ashland Air Quality Maintenance Area and the Grants Pass Urban Growth Area			
240–0100	Applicability	1/4/2005	6/19/2006, 71 FR 35163.	
240–0110	Wood Waste Boilers	1/4/2005	6/19/2006, 71 FR 35163.	
240–0120	Veneer Dryer Emission Limitations.	1/4/2005	6/19/2006, 71 FR 35163.	
240–0130	Air Conveying Systems (Medford-Ashland AQMA Only).	1/4/2005	6/19/2006, 71 FR 35163.	
240–0140	Wood Particle Dryers at Particleboard Plants.	1/4/2005	6/19/2006, 71 FR 35163.	

TABLE 2—EPA APPROVED OREGON ADMINISTRATIVE RULES (OAR)—Continued

State citation	Title/subject	State effective date	EPA approval date	Explanations
240–0150	Hardboard Manufacturing Plants.	1/4/2005	6/19/2006, 71 FR 35163.	
240–0160	Wigwam Waste Burners	7/1/2001	1/22/2003, 68 FR 2891.	
240–0170	Charcoal Producing Plants	7/1/2001	1/22/2003, 68 FR 2891.	
240–0180	Control of Fugitive Emissions (Medford-Ashland AQMA Only).	1/4/2005	6/19/2006, 71 FR 35163.	
240–0190	Requirement for Operation and Maintenance Plans (Medford-Ashland AQMA Only).	1/4/2005	6/19/2006, 71 FR 35163.	
240–0210	Continuous Monitoring	1/4/2005	6/19/2006, 71 FR 35163.	
240–0220	Source Testing	1/4/2005	6/19/2006, 71 FR 35163.	
240–0230	New Sources	1/4/2005	6/19/2006, 71 FR 35163.	
240–0250	Open Burning	7/1/2001	1/22/2003, 68 FR 2891.	
	La Grande Urban Growth Area			
240–0300	Applicability	10/14/1999	1/22/2003, 68 FR 2891.	
240–0310	Compliance Schedule for Existing Sources.	7/1/2001	1/22/2003, 68 FR 2891.	
240–0320	Wood-Waste Boilers	7/1/2001	1/22/2003, 68 FR 2891.	
240–0330	Wood Particle Dryers at Particleboard Plants.	7/1/2001	1/22/2003, 68 FR 2891.	
240–0340	Hardboard Manufacturing Plants.	7/1/2001	1/22/2003, 68 FR 2891.	
240–0350	Air Conveying Systems	7/1/2001	1/22/2003, 68 FR 2891.	
240–0360	Fugitive Emissions	7/1/2001	1/22/2003, 68 FR 2891.	
	The Lakeview Urban Growth Area			
240–0400	Applicability	7/1/2001	1/22/2003, 68 FR 2891.	
240–0410	Control of Fugitive Emissions.	7/1/2001	1/22/2003, 68 FR 2891.	
240–0420	Requirement for Operation and Maintenance Plans.	7/1/2001	1/22/2003, 68 FR 2891.	
240–0430	Source Testing	7/1/2001	1/22/2003, 68 FR 2891.	
240–0440	Open Burning	7/1/2001	1/22/2003, 68 FR 2891.	
	Division 242—Rules Applicable to the Portland Area			
	Employee Commute Options Program			
242–0010	What is the Employee Commute Options Program?	4/12/2007	12/19/2011, 76 FR 78571.	
242–0020	Who is Subject to ECO?	4/12/2007	12/19/2011, 76 FR 78571.	
242–0030	What Does ECO Require?	4/12/2007	12/19/2011, 76 FR 78571.	
242–0040	How Does the Department Enforce ECO?	4/12/2007	12/19/2011, 76 FR 78571.	
242–0050	Definitions of Terms Used in These Rules.	4/12/2007	12/19/2011, 76 FR 78571.	
242–0060	Should All Employees at a Work Site be Counted?	10/14/1999	1/22/2003, 68 FR 2891.	
242–0070	What are the Major Requirements of ECO?	4/12/2007	12/19/2011, 76 FR 78571.	
242–0080	What are the Registration Requirements?	4/12/2007	12/19/2011, 76 FR 78571.	
242–0090	What are the Requirements for an Employee Survey?	4/12/2007	12/19/2011, 76 FR 78571.	
242–0100	Special Requirements for Employers Intending to Comply Without an Approved Plan.	10/14/1999	1/22/2003, 68 FR 2891.	
242–0110	What if an Employer Does Not Meet the Target Auto Trip Rate?	4/12/2007	12/19/2011, 76 FR 78571.	
242–0120	How Will Employers Demonstrate Progress Toward the Target Auto Trip Rate?	4/12/2007	12/19/2011, 76 FR 78571.	

TABLE 2—EPA APPROVED OREGON ADMINISTRATIVE RULES (OAR)—Continued

State citation	Title/subject	State effective date	EPA approval date	Explanations
242–0130	What is the Schedule Employers Must Follow to Implement ECO?	10/14/1999	1/22/2003, 68 FR 2891.	
242–0140	How Should Employers Account for Changes in Work Force Size?	10/14/1999	1/22/2003, 68 FR 2891.	
242–0150	How Can an Employer Reduce Auto Commute Trips to a Work Site?	10/14/1999	1/22/2003, 68 FR 2891.	
242–0160	What Should be Included in an Auto Trip Reduction Plan?	4/12/2007	12/19/2011, 76 FR 78571.	
242–0170	When Will the Department Act on a Submitted Auto Trip Reduction Plan?	10/14/1999	1/22/2003, 68 FR 2891.	
242–0180	What is a Good Faith Effort?	4/12/2007	12/19/2011, 76 FR 78571.	
242–0190	How Does the ECO Program Affect New Employers, Expanding Employers and Employers Relocating Within the Portland AQMA?	4/12/2007	12/19/2011, 76 FR 78571.	
242–0200	Can a New or Relocating Employer Comply with ECO Through Restricted Parking Ratios?	4/12/2007	12/19/2011, 76 FR 78571.	
242–0210	Can an Existing Employer Comply with ECO Through Restricted Parking Ratios?	4/12/2007	12/19/2011, 76 FR 78571.	
242–0220	What if an Employer Has More Than One Work Site Within the Portland AQMA?	4/12/2007	12/19/2011, 76 FR 78571.	
242–0230	Can Employers Submit a Joint Plan?	10/14/1999	1/22/2003, 68 FR 2891.	
242–0240	Are There Alternatives to Trip Reduction?	4/12/2007	12/19/2011, 76 FR 78571.	
242–0250	What Alternatives Qualify as Equivalent Emission Reductions?	10/14/1999	1/22/2003, 68 FR 2891.	
242–0260	Can Employers Get Credit for Existing Trip Reduction Programs?	4/12/2007	12/19/2011, 76 FR 78571.	
242–0270	Are Exemptions Allowed if an Employer is Unable to Reduce Trips or Take Advantage of Alternate Compliance Options?	4/12/2007	12/19/2011, 76 FR 78571.	
242–0280	Participation in the Industrial Emission Management Program.	4/12/2007	12/19/2011, 76 FR 78571.	
242–0290	What Kind of Records Must be Kept and for How Long?	4/12/2007	12/19/2011, 76 FR 78571.	
	Voluntary Maximum Parking Ratio Program			
242–0300	What is the Voluntary Parking Ratio Program?	10/14/1999	1/22/2003, 68 FR 2891.	
242–0310	Who can Participate in the Voluntary Parking Ratio Program?	10/14/1999	1/22/2003, 68 FR 2891.	
242–0320	Definitions of Terms and Land Uses.	10/14/1999	1/22/2003, 68 FR 2891.	
242–0330	How Does a Property Owner Comply with the Voluntary Parking Ratio Program?	10/14/1999	1/22/2003, 68 FR 2891.	

TABLE 2—EPA APPROVED OREGON ADMINISTRATIVE RULES (OAR)—Continued

State citation	Title/subject	State effective date	EPA approval date	Explanations
242–0340	What are the Incentives for Complying with the Voluntary Parking Ratio Program?	10/14/1999	1/22/2003, 68 FR 2891.	
242–0350	Why Do I Need a Parking Ratio Permit?	10/14/1999	1/22/2003, 68 FR 2891.	
242–0360	What is Required to Obtain a Parking Ratio Permit?	10/14/1999	1/22/2003, 68 FR 2891.	
242–0370	How is the Parking Ratio Program Enforced?	10/14/1999	1/22/2003, 68 FR 2891.	
242–0380	When Will the Department Act on a Submitted Permit Application?	10/14/1999	1/22/2003, 68 FR 2891.	
242–0390	What are the Applicable Parking Ratios?	10/14/1999	1/22/2003, 68 FR 2891.	
	Industrial Emission Management Program			
242–0400	Applicability	4/12/2007	12/19/2011, 76 FR 78571.	
242–0410	Definition of Terms	4/12/2007	12/19/2011, 76 FR 78571.	
242–0420	Unused PSEL Donation Program.	4/12/2007	12/19/2011, 76 FR 78571.	
242–0430	Industrial Growth Allowances.	4/12/2007	12/19/2011, 76 FR 78571.	
242–0440	Industrial Growth Allowance Allocation.	4/12/2007	12/19/2011, 76 FR 78571.	
	Gasoline Vapors From Gasoline Transfer and Dispensing Operations			
242–0500	Purpose and Applicability	10/14/1999	1/22/2003, 68 FR 2891.	
242–0510	Definitions	10/14/1999	1/22/2003, 68 FR 2891.	
242–0520	General Provisions	10/14/1999	1/22/2003, 68 FR 2891.	
	Motor Vehicle Refinishing			
242–0600	Applicability	10/14/1999	1/22/2003, 68 FR 2891.	
242–0610	Definitions	10/14/1999	1/22/2003, 68 FR 2891.	
242–0620	Requirements for Motor Vehicle Refinishing in Portland AQMA.	10/14/1999	1/22/2003, 68 FR 2891.	
242–0630	Inspecting and Testing Requirements.	10/14/1999	1/22/2003, 68 FR 2891.	
	Spray Paint			
242–0700	Applicability	10/14/1999	1/22/2003, 68 FR 2891.	
242–0710	Definitions	10/14/1999	1/22/2003, 68 FR 2891.	
242–0720	Spray Paint Standards and Exemptions.	10/14/1999	1/22/2003, 68 FR 2891.	
242–0730	Requirements for Manufacture, Sale, and Use of Spray Paint.	10/14/1999	1/22/2003, 68 FR 2891.	
242–0740	Recordkeeping and Reporting Requirements.	10/14/1999	1/22/2003, 68 FR 2891.	
242–0750	Inspection and Testing Requirements.	10/14/1999	1/22/2003, 68 FR 2891.	
	Area Source Common Provisions			
242–0760	Applicability	10/14/1999	1/22/2003, 68 FR 2891.	
242–0770	Compliance Extensions	10/14/1999	1/22/2003, 68 FR 2891.	
242–0780	Exemption from Disclosure to the Public.	10/14/1999	1/22/2003, 68 FR 2891.	
242–0790	Future Review	10/14/1999	1/22/2003, 68 FR 2891.	
	Division 250—General Conformity			
250–0010	Purpose	10/14/1999	1/22/2003, 68 FR 2891.	
250–0020	Applicability	10/14/1999	1/22/2003, 68 FR 2891.	
250–0030	Definitions	10/14/1999	1/22/2003, 68 FR 2891.	
250–0040	Conformity Analysis	10/14/1999	1/22/2003, 68 FR 2891.	
250–0050	Reporting Requirements	10/14/1999	1/22/2003, 68 FR 2891.	

TABLE 2—EPA APPROVED OREGON ADMINISTRATIVE RULES (OAR)—Continued

State citation	Title/subject	State effective date	EPA approval date	Explanations
250–0060	Public Participation	10/14/1999	1/22/2003, 68 FR 2891.	
250–0070	Frequency of Conformity Determinations.	10/14/1999	1/22/2003, 68 FR 2891.	
250–0080	Criteria for Determining Conformity of General Federal Actions.	10/14/1999	1/22/2003, 68 FR 2891.	
250–0090	Procedures for Conformity Determinations of General Federal Actions.	10/14/1999	1/22/2003, 68 FR 2891.	
250–0100	Mitigation of Air Quality Impacts.	10/14/1999	1/22/2003, 68 FR 2891.	
Division 252—Transportation Conformity				
252–0010	Purpose	10/14/1999	1/22/2003, 68 FR 2891.	
252–0030	Definitions	3/5/2010	10/4/2012, 77 FR 60627.	
252–0060	Consultation	3/5/2010	10/4/2012, 77 FR 60627.	
252–0070	Timeframe of Conformity Determinations.	3/5/2010	10/4/2012, 77 FR 60627	Except last two sentences.
252–0230	Written Comments	3/5/2010	10/4/2012, 77 FR 60627.	
Division 256—Motor Vehicles				
256–0010	Definitions	7/12/2005	12/19/2011, 76 FR 78571.	
Visible Emissions				
256–0100	Visible Emissions—General Requirements, Exclusions.	7/12/2005	12/19/2011, 76 FR 78571.	
256–0130	Motor Vehicle Fleet Operation.	7/12/2005	12/19/2011, 76 FR 78571.	
Certification of Pollution Control Systems				
256–0200	County Designations	10/14/1999	11/22/2004, 69 FR 67819.	
Emission Control System Inspection				
256–0300	Scope	7/12/2005	12/19/2011, 76 FR 78571.	
256–0310	Government-Owned Vehicle, Permanent Fleet Vehicle and United States Government Vehicle Testing Requirements.	7/12/2005	12/19/2011, 76 FR 78571.	
256–0330	Department of Defense Personnel Participating in the Privately Owned Vehicle Import Control Program.	10/14/1999	11/22/2004, 69 FR 67819.	
256–0340	Light Duty Motor Vehicle and Heavy Duty Gasoline Motor Vehicle Emission Control Test Method for Basic Program.	7/12/2005	12/19/2011, 76 FR 78571.	
256–0350	Light Duty Motor Vehicle Emission Control Test Method for Enhanced Program.	7/12/2005	12/19/2011, 76 FR 78571.	
256–0355	Emissions Control Test Method for OBD Test Program.	10/25/2000	11/22/2004, 69 FR 67819.	
256–0356	Emissions Control Test Method for On-Site Vehicle Testing for Automobile Dealerships.	10/4/2001	11/22/2004, 69 FR 67819.	
256–0370	Renewal of Registration for Light Duty Motor Vehicles and Heavy Duty Gasoline Motor Vehicles Temporarily Operating Outside of Oregon.	10/14/1999	11/22/2004, 69 FR 67819.	

TABLE 2—EPA APPROVED OREGON ADMINISTRATIVE RULES (OAR)—Continued

State citation	Title/subject	State effective date	EPA approval date	Explanations
256–0380	Light Duty Motor Vehicle Emission Control Test Criteria for Basic Program.	7/12/2005	12/19/2011, 76 FR 78571.	
256–0390	Heavy Duty Gasoline Motor Vehicle Emission Control Test Criteria.	7/12/2005	12/19/2011, 76 FR 78571.	
256–0400	Light Duty Motor Vehicle Emission Control Standards for Basic Program.	10/14/1999	11/22/2004, 69 FR 67819.	
256–0410	Light Duty Motor Vehicle Emission Control Standards for Enhanced Program.	10/14/1999	11/22/2004, 69 FR 67819.	
256–0420	Heavy-Duty Gasoline Motor Vehicle Emission Control Standards.	10/14/1999	11/22/2004, 69 FR 67819.	
256–0440	Criteria for Qualifications of Persons Eligible to Inspect Motor Vehicles and Motor Vehicle Pollution Control Systems and Execute Certificates.	10/25/2000	11/22/2004, 69 FR 67819.	
256–0450	Gas Analytical System Licensing Criteria for Basic Program.	10/14/1999	11/22/2004, 69 FR 67819.	
256–0460	Gas Analytical System Licensing Criteria for Enhanced Program.	10/14/1999	11/22/2004, 69 FR 67819.	
256–0465	Test Equipment Licensing Criteria for OBD Test Program.	10/25/2000	11/22/2004, 69 FR 67819.	
256–0470	Agreement with Independent Contractor; Qualifications of Contractor; Agreement Provisions.	10/14/1999	11/22/2004, 69 FR 67819.	
Division 258—Motor Vehicle Fuel Specifications				
258–0010	Definitions	10/14/1999	1/22/2003, 68 FR 2891.	
Oxygenated Gasoline				
258–0100	Policy	10/14/1999	1/22/2003, 68 FR 2891.	
258–0110	Purpose and General Requirements.	10/14/1999	1/22/2003, 68 FR 2891.	
258–0120	Sampling and Testing for Oxygen Content.	10/14/1999	1/22/2003, 68 FR 2891.	
258–0130	Compliance Options	10/14/1999	1/22/2003, 68 FR 2891.	
258–0140	Per Gallon Oxygen Content Standard.	10/14/1999	1/22/2003, 68 FR 2891.	
258–0150	Average Oxygen Content Standard.	10/14/1999	1/22/2003, 68 FR 2891.	
258–0160	Minimum Oxygen Content	10/14/1999	1/22/2003, 68 FR 2891.	
258–0170	Oxygenated Gasoline Blending.	10/14/1999	1/22/2003, 68 FR 2891.	
258–0180	Registration	10/14/1999	1/22/2003, 68 FR 2891.	
258–0190	CAR, Distributor and Retail Outlet Operating Permits.	10/14/1999	1/22/2003, 68 FR 2891.	
258–0200	Owners of Gasoline at Terminals, Distributors and Retail Outlets Required to Have Indirect Source Operating Permits.	10/14/1999	1/22/2003, 68 FR 2891.	
258–0210	Recordkeeping	10/14/1999	1/22/2003, 68 FR 2891.	
258–0220	Reporting	10/14/1999	1/22/2003, 68 FR 2891.	
258–0230	Prohibited Activities	10/14/1999	1/22/2003, 68 FR 2891.	
258–0240	Inspection and Sampling	10/14/1999	1/22/2003, 68 FR 2891.	
258–0250	Liability for Violation of a Prohibited Activity.	10/14/1999	1/22/2003, 68 FR 2891.	

TABLE 2—EPA APPROVED OREGON ADMINISTRATIVE RULES (OAR)—Continued

State citation	Title/subject	State effective date	EPA approval date	Explanations
258–0260	Defenses for Prohibited Activities.	10/14/1999	1/22/2003, 68 FR 2891.	
258–0270	Inability to Produce Conforming Gasoline Due to Extraordinary Circumstances.	10/14/1999	1/22/2003, 68 FR 2891.	
258–0280	Quality Assurance Program	10/14/1999	1/22/2003, 68 FR 2891.	
258–0290	Attest Engagements Guidelines When Prohibited Activities Alleged.	10/14/1999	1/22/2003, 68 FR 2891.	
258–0300	Dispenser Labeling	10/14/1999	1/22/2003, 68 FR 2891.	
258–0310	Contingency Provision for Carbon Monoxide Nonattainment Areas.	10/14/1999	1/22/2003, 68 FR 2891.	
	Standard for Automotive Gasoline			
258–0400	Reid Vapor Pressure for Gasoline.	10/14/1999	1/22/2003, 68 FR 2891.	
	Division 262—Heat Smart Program for Residential Woodstoves and Other Solid Fuel Heating Devices			
262–0400	Purpose and Applicability of Rules.	3/15/2011	6/20/2013, 78 FR 37124.	
262–0450	Definitions	5/17/2012	6/20/2013, 78 FR 37124.	
262–0500	Certification of Solid Fuel Burning Devices for Sale as New.	3/15/2011	6/20/2013, 78 FR 37124.	
262–0600	New and Used Solid Fuel Burning Devices Sold in Oregon.	5/17/2012	6/20/2013, 78 FR 37124.	
262–0700	Removal and Destruction of Used Solid Fuel Burning Devices.	3/15/2011	6/20/2013, 78 FR 37124.	
262–0800	Wood Burning and Other Heating Devices Curtailment Program.	3/15/2011	6/20/2013, 78 FR 37124.	
262–0900	Materials Prohibited from Burning.	3/15/2011	6/20/2013, 78 FR 37124.	
	Division 264—Rules for Open Burning			
264–0010	How to Use These Open Burning Rules.	12/15/2000	4/25/2013, 78 FR 24347.	
264–0020	Policy	12/15/2000	4/25/2013, 78 FR 24347.	
264–0030	Definitions	12/15/2000	4/25/2013, 78 FR 24347.	
264–0040	Exemptions, Statewide	9/17/2008	12/27/2011, 76 FR 80747.	
264–0050	General Requirements Statewide.	12/15/2000	4/25/2013, 78 FR 24347.	
264–0060	General Prohibitions Statewide.	12/15/2000	4/25/2013, 78 FR 24347.	
264–0070	Open Burning Conditions	12/15/2000	4/25/2013, 78 FR 24347.	
264–0075	Delegation of Authority	12/15/2000	4/25/2013, 78 FR 24347.	
264–0078	Open Burning Control Areas.	12/15/2000	4/25/2013, 78 FR 24347.	
264–0080	County Listing of Specific Open Burning Rules.	12/15/2000	4/25/2013, 78 FR 24347.	
	Open Burning Requirements			
264–0100	Baker, Clatsop, Crook, Curry, Deschutes, Gilliam, Grant, Harney, Hood River, Jefferson, Klamath, Lake, Lincoln, Malheur, Morrow, Sherman, Tillamook, Umatilla, Union, Wallowa, Wasco and Wheeler Counties.	12/15/2000	4/25/2013, 78 FR 24347.	
264–0110	Benton, Linn, Marion, Polk, and Yamhill Counties.	12/15/2000	4/25/2013, 78 FR 24347.	

TABLE 2—EPA APPROVED OREGON ADMINISTRATIVE RULES (OAR)—Continued

State citation	Title/subject	State effective date	EPA approval date	Explanations
264–0120	Clackamas County	12/15/2000	4/25/2013, 78 FR 24347.	
264–0130	Multnomah County	12/15/2000	4/25/2013, 78 FR 24347.	
264–0140	Washington County	12/15/2000	4/25/2013, 78 FR 24347.	
264–0150	Columbia County	12/15/2000	4/25/2013, 78 FR 24347.	
264–0160	Lane County	12/15/2000	4/25/2013, 78 FR 24347.	
264–0170	Coos, Douglas, Jackson and Josephine Counties.	12/15/2000	4/25/2013, 78 FR 24347.	
264–0180	Letter Permits	12/15/2000	4/25/2013, 78 FR 24347.	
264–0190	Forced Air Pit Incinerators	12/15/2000	4/25/2013, 78 FR 24347.	
Division 266—Field Burning Rules (Willamette Valley)				
266–0010	Introduction	10/14/1999	1/22/2003, 68 FR 2891.	
266–0020	Policy	10/14/1999	1/22/2003, 68 FR 2891.	
266–0030	Definitions	10/14/1999	1/22/2003, 68 FR 2891.	
266–0040	General Requirements	10/14/1999	1/22/2003, 68 FR 2891.	
266–0050	Registration, Permits, Fees, Records.	10/14/1999	1/22/2003, 68 FR 2891.	
266–0060	Acreage Limitations, Allocations.	10/14/1999	1/22/2003, 68 FR 2891.	
266–0070	Daily Burning Authorization Criteria.	10/14/1999	1/22/2003, 68 FR 2891.	
266–0080	Burning by Public Agencies (Training Fires).	10/14/1999	1/22/2003, 68 FR 2891.	
266–0090	Preparatory Burning	10/14/1999	1/22/2003, 68 FR 2891.	
266–0100	Experimental Burning	10/14/1999	1/22/2003, 68 FR 2891.	
266–0110	Emergency Burning Cessation.	10/14/1999	1/22/2003, 68 FR 2891.	
266–0120	Propane Flaming	10/14/1999	1/22/2003, 68 FR 2891.	
266–0130	Stack Burning	10/14/1999	1/22/2003, 68 FR 2891.	
Division 268—Emission Reduction Credits				
268–0010	Applicability	7/1/2001	1/22/2003, 68 FR 2891.	
268–0020	Definitions	10/14/1999	1/22/2003, 68 FR 2891.	
268–0030	Emission Reduction Credits	7/1/2001	1/22/2003, 68 FR 2891.	
OREGON DEPARTMENT OF FORESTRY—CHAPTER 629				
629–24–301	Maintenance of Productivity and Related Values.	8/1/1987	11/1/2001, 66 FR 55105	Statewide Visibility Plan.
629–43–043	Smoke Management Plan	4/13/1987	11/1/2001, 66 FR 55105	Statewide Visibility Plan.
DEPARTMENT OF OREGON STATE POLICE OFFICE OF STATE FIRE MARSHALL—CHAPTER 837				
Division 110—Field Burning and Propaning Rules				
837–110–0010	Field Preparation	2/7/1994	11/1/2001, 66 FR 55105	Statewide Visibility Plan.
837–110–0020	Firefighting Water Supplies	2/7/1994	11/1/2001, 66 FR 55105	Statewide Visibility Plan.
837–110–0030	Firefighting Equipment	2/7/1994	11/1/2001, 66 FR 55105	Statewide Visibility Plan.
837–110–0040	Ignition Criteria	2/7/1994	11/1/2001, 66 FR 55105	Statewide Visibility Plan.
837–110–0050	Prohibited Use	2/7/1989	11/1/2001, 66 FR 55105	Statewide Visibility Plan.
837–110–0060	Communication	2/7/1989	11/1/2001, 66 FR 55105	Statewide Visibility Plan.
837–110–0070	Fire Safety Watch	2/7/1994	11/1/2001, 66 FR 55105	Statewide Visibility Plan.
837–110–0080	Fire Safety Buffer Zones	2/7/1994	11/1/2001, 66 FR 55105	Statewide Visibility Plan.
837–110–0090	Ban on Burning	2/7/1994	11/1/2001, 66 FR 55105	Statewide Visibility Plan.
Propaning				
837–110–0110	Field Preparation	2/7/1994	11/1/2001, 66 FR 55105	Statewide Visibility Plan.
837–110–0120	Firefighting Water Supplies	2/7/1994	11/1/2001, 66 FR 55105	Statewide Visibility Plan.
837–110–0130	Firefighting Equipment	2/7/1994	11/1/2001, 66 FR 55105	Statewide Visibility Plan.
837–110–0140	Communication	2/7/1989	11/1/2001, 66 FR 55105	Statewide Visibility Plan.
837–110–0150	Fire Safety Watch	2/7/1994	11/1/2001, 66 FR 55105	Statewide Visibility Plan.
837–110–0160	Ban on Burning	8/11/1993	11/1/2001, 66 FR 55105	Statewide Visibility Plan.

TABLE 3—EPA APPROVED CITY AND COUNTY ORDINANCES

Agency and ordinance	Title or subject	Date	EPA approval date	Explanation
City of Grants Pass Ordinance No. 4671.	Bans Open Burning	7/18/1990	12/17/1993, 58 FR 65934.	Grants Pass PM–10 Attainment Plan.
City of Eugene Ordinance No. 19731.	An Ordinance Restricting the Use of Solid Fuel Space Heating Devices During Air Pollution Episodes.	11/5/1990	8/24/1994, 59 FR 43483.	Eugene-Springfield PM–10 Attainment Plan.
Lane County Ordinance No. 9–90.	Restricts Use of Solid Fuel Space Heating Devices During Air Pollution Episodes.	12/19/1990	8/24/1994, 59 FR 43483.	Eugene-Springfield PM–10 Attainment Plan.
City of Springfield Ordinance No. 5546.	Restricts Use of Solid Fuel Space Heating Devices During Air Pollution Episodes.	12/17/1990	8/24/1994, 59 FR 43483.	Eugene-Springfield PM–10 Attainment Plan.
Union County Ordinance 1991–6.	Field Burning Smoke Management Program	6/5/1991	2/15/1995, 60 FR 8563.	La Grande PM–10 Attainment Plan.
Klamath County Clean Air Ordinance 63.	Adopts a Mandatory Air Quality Program and Establishes Boundaries and Enforcement Controls.	7/31/1991	4/14/1997, 62 FR 18047.	Klamath Falls PM–10 Attainment Plan.
City of Klamath Falls Ordinance 6630.	An Ordinance Consenting to the Application of the Klamath County Air Quality Program Ordinance Within City Limits.	9/16/1991	4/14/1997, 62 FR 18047.	Klamath Falls PM–10 Attainment Plan.
City of Oakridge Ordinance 815.	Restricts Use of Solid Fuel Space Heating Devices During Air Pollution Episodes.	8/15/96	3/15/1999, 64 FR 12751.	Oakridge PM–10 Attainment Plan.
Town of Lakeview Resolution No. 402.	Establishes a Lakeview Air Quality Improvement Program.	2/28/1994	9/21/1999, 64 FR 51051.	Lakeview PM–10 Attainment Plan.
Lake County Commissioners Resolution.	Establishment of a Lakeview Urban Growth Boundary Air Quality Improvement Program.	3/15/1995	9/21/1999, 64 FR 51051.	Lakeview PM–10 Attainment Plan.
Town of Lakeview Ordinance No. 748.	Prohibits Use of Solid Fuel Burning Devices, Provides Certain Exemptions and Establishes Enforcement Controls.	2/28/1995	9/21/1999, 64 FR 51051.	Lakeview PM–10 Attainment Plan.
Town of Lakeview Ordinance No. 749.	Prohibits Waste Burning; Restricts Open Burning, Repeals Ordinance No. 581.	2/28/1995	9/21/1999, 64 FR 51051.	Lakeview PM–10 Attainment Plan.
Lake County Ordinance No. 29.	Prohibits Use of Solid Fuel Burning Devices, Provides Certain Exemptions and Establishes Enforcement Controls.	3/15/1995	9/21/1999, 64 FR 51051.	Lakeview PM–10 Attainment Plan.
Lake County Ordinance No. 30.	Prohibits Waste Burning and Restricts Open Burning.	3/15/1995	9/21/1999, 64 FR 51051.	Lakeview PM–10 Attainment Plan.
Medford Ordinance No. 6484.	Woodstove Curtailment	11/17/1989	7/24/2002, 67 FR 48388.	Medford Carbon Monoxide (CO) Maintenance Plan.
Union County Ordinance No. 1992–4.	Management and Control of Field Burning	7/1/1992	11/1/2001, 66 FR 55105.	Statewide Visibility Plan.
Jefferson County Ordinance No. 0–58–89.	Management and Control of Field Burning	5/31/1989	11/1/2001, 66 FR 55105.	Statewide Visibility Plan.
Codified Ordinances of Jackson County 1810.01.	Definitions	5/2/1990	6/19/2006, 71 FR 35163.	Medford-Ashland PM–10 Attainment Plan.
Codified Ordinances of Jackson County 1810.02.	Exceptions to chapter	8/22/2001	6/19/2006, 71 FR 35163.	Medford-Ashland PM–10 Attainment Plan.
Codified Ordinances of Jackson County 1810.03.	Requirements for solid fuel heating device installation.	12/20/1989	6/19/2006, 71 FR 35163.	Medford-Ashland PM–10 Attainment Plan.
Codified Ordinances of Jackson County 1810.04.	Solid fuel burning device omission standard	5/2/1990	6/19/2006, 71 FR 35163.	Medford-Ashland PM–10 Attainment Plan.
Codified Ordinances of Jackson County 1810.05.	Restriction of woodburning and emissions on high pollution days.	5/2/1990	6/19/2006, 71 FR 35163.	Medford-Ashland PM–10 Attainment Plan.
Codified Ordinances of Jackson County 1810.06.	Trackout	12/4/1985	6/19/2006, 71 FR 35163.	Medford-Ashland PM–10 Attainment Plan.
Codified Ordinances of Jackson County 1810.07.	Open burning	8/22/2001	6/19/2006, 71 FR 35163.	Medford-Ashland PM–10 Attainment Plan.
Codified Ordinances of Jackson County 1810.08.	Burning of material emitting dense smoke or noxious odors in solid fuel burning devices.	12/20/1989	6/19/2006, 71 FR 35163.	Medford-Ashland PM–10 Attainment Plan.
Codified Ordinances of Jackson County Exhibit A.	[Map 1]	5/2/1990	6/19/2006, 71 FR 35163.	Medford-Ashland PM–10 Attainment Plan.

TABLE 3—EPA APPROVED CITY AND COUNTY ORDINANCES—Continued

Agency and ordinance	Title or subject	Date	EPA approval date	Explanation
Codified Ordinances of Jackson County Exhibit B.	Proposed Curtailment Boundary Jackson County.	5/2/1990	6/19/2006, 71 FR 35163.	Medford-Ashland PM–10 Attainment Plan.
Codified Ordinances of Jackson County Exhibit C.	[Map 2]	5/2/1990	6/19/2006, 71 FR 35163.	Medford-Ashland PM–10 Attainment Plan.
Codified Ordinances of Jackson County Exhibit D.	Boundary Description Medford-Ashland Air Quality Maintenance Area.	5/2/1990	6/19/2006, 71 FR 35163.	Medford-Ashland PM–10 Attainment Plan.
Code of the City of Medford, Oregon: 5.550.	Outside Burning	3/16/2000	6/19/2006, 71 FR 35163.	Medford-Ashland PM–10 Attainment Plan.
Code of the City of Medford, Oregon: 7.220.	Definitions	9/17/1998	6/19/2006, 71 FR 35163.	Medford-Ashland PM–10 Attainment Plan.
Code of the City of Medford, Oregon: 7.222.	Operation of Solid Fuel Burning Device Prohibition.	9/17/1998	6/19/2006, 71 FR 35163.	Medford-Ashland PM–10 Attainment Plan.
Code of the City of Medford, Oregon: 7.224.	Exemptions	9/17/1998	6/19/2006, 71 FR 35163.	Medford-Ashland PM–10 Attainment Plan.
Code of the City of Medford, Oregon: 7.240.	Installation of Solid-Fuel Heating Devices	8/2/1990	6/19/2006, 71 FR 35163.	Medford-Ashland PM–10 Attainment Plan.
Code of the City of Medford, Oregon: 7.242.	Prohibited Materials	9/17/1998	6/19/2006, 71 FR 35163.	Medford-Ashland PM–10 Attainment Plan.
City of Central Point Municipal Code: 8.01.010.	Definitions	1998	6/19/2006, 71 FR 35163.	Medford-Ashland PM–10 Attainment Plan.
City of Central Point Municipal Code: 8.01.012.	Requirements for solid fuel burning device installation.	1998	6/19/2006, 71 FR 35163.	Medford-Ashland PM–10 Attainment Plan.
City of Central Point Municipal Code: 8.01.014.	Solid fuel burning device emission standard	1998	6/19/2006, 71 FR 35163.	Medford-Ashland PM–10 Attainment Plan.
City of Central Point Municipal Code: 8.01.020.	Operation of solid fuel device prohibition	1998	6/19/2006, 71 FR 35163.	Medford-Ashland PM–10 Attainment Plan.
City of Central Point Municipal Code: 8.01.030.	Exemptions	1998	6/19/2006, 71 FR 35163.	Medford-Ashland PM–10 Attainment Plan.
City of Central Point Municipal Code: 8.01.032.	Prohibited materials	1998	6/19/2006, 71 FR 35163.	Medford-Ashland PM–10 Attainment Plan.
City of Central Point Municipal Code: 8.04.040 H..	Penalty and abatement	1979	6/19/2006, 71 FR 35163.	Medford-Ashland PM–10 Attainment Plan.
City of Central Point Municipal Code: 8.04.095.	Trackout prohibited	1994	6/19/2006, 71 FR 35163.	Medford-Ashland PM–10 Attainment Plan.
City of Ashland Municipal Code: 10.30.005.	Definitions	1998	6/19/2006, 71 FR 35163.	Medford-Ashland PM–10 Attainment Plan.
City of Ashland Municipal Code: 10.30.010.	Outdoor and Indoor Burning Restricted	1998	6/19/2006, 71 FR 35163.	Medford-Ashland PM–10 Attainment Plan.
City of Ashland Municipal Code: 10.30.020.	Period When Outdoor Burning is Authorized	2000	6/19/2006, 71 FR 35163.	Medford-Ashland PM–10 Attainment Plan.
City of Ashland Municipal Code: 10.30.030.	Requirements for Permitted Fires	1993	6/19/2006, 71 FR 35163.	Medford-Ashland PM–10 Attainment Plan.
City of Ashland Municipal Code: 10.30.040.	Permits Required	1993	6/19/2006, 71 FR 35163.	Medford-Ashland PM–10 Attainment Plan.
City of Ashland Municipal Code: 9.24.010.	Definitions	1998	6/19/2006, 71 FR 35163.	Medford-Ashland PM–10 Attainment Plan.
City of Ashland Municipal Code: 9.24.020.	Requirements for Solid Fuel Heating Device Installation.	1998	6/19/2006, 71 FR 35163.	Medford-Ashland PM–10 Attainment Plan.
City of Ashland Municipal Code: 9.24.030.	Solid Fuel Burning Device Emission Standard.	1998	6/19/2006, 71 FR 35163.	Medford-Ashland PM–10 Attainment Plan.

TABLE 3—EPA APPROVED CITY AND COUNTY ORDINANCES—Continued

Agency and ordinance	Title or subject	Date	EPA approval date	Explanation
City of Ashland Municipal Code: 9.24.040.	Restriction of Woodburning an Emissions on High Pollution Days.	1998	6/19/2006, 71 FR 35163.	Medford-Ashland PM–10 Attainment Plan.
City of Ashland Municipal Code: 9.24.050.	Prohibited Materials	1998	6/19/2006, 71 FR 35163.	Medford-Ashland PM–10 Attainment Plan.
City of Talent Ordinance #565.	An ordinance of the city of Talent adopting a uniform fire code.	8/20/1992	6/19/2006, 71 FR 35163.	Medford-Ashland PM–10 Attainment Plan.
City of Talent Ordinance #98–635–0.	An ordinance regulating the use of solid fuel burning devices within the city of Talent, Oregon.	3/4/1998	6/19/2006, 71 FR 35163.	Medford-Ashland PM–10 Attainment Plan.
City of Phoenix code: 8.16.050.	Burn days	1982	6/19/2006, 71 FR 35163.	Medford-Ashland PM–10 Attainment Plan.
City of Phoenix code: 8.16.090.	Prohibited materials	1982	6/19/2006, 71 FR 35163.	Medford-Ashland PM–10 Attainment Plan.
City of Phoenix code: 8.20.010.	Definitions	1998	6/19/2006, 71 FR 35163.	Medford-Ashland PM–10 Attainment Plan.
City of Phoenix code: 8.20.020.	Requirements for solid fuel heating device installation.	1998	6/19/2006, 71 FR 35163.	Medford-Ashland PM–10 Attainment Plan.
City of Phoenix code: 8.20.030.	Solid fuel burning device emission standard	1998	6/19/2006, 71 FR 35163.	Medford-Ashland PM–10 Attainment Plan.
City of Phoenix code: 8.20.040.	Restriction of woodburning and emissions on high pollution days.	1998	6/19/2006, 71 FR 35163.	Medford-Ashland PM–10 Attainment Plan.
City of Phoenix code: 8.20.050.	Prohibited materials	1998	6/19/2006, 71 FR 35163.	Medford-Ashland PM–10 Attainment Plan.
City of Jacksonville code: Ordinance 375.	An ordinance amending chapter 8.08.100 of the Jacksonville Municipal Code.	4/21/1992	6/19/2006, 71 FR 35163.	Medford-Ashland PM–10 Attainment Plan.
City of Jacksonville Code Chapter 8.10.	Woodheating	February 1992	6/19/2006, 71 FR 35163.	Medford-Ashland PM–10 Attainment Plan.
City of Eagle Point Code: 8.08.160.	Outside burning of refuse or rubbish	2000	6/19/2006, 71 FR 35163.	Medford-Ashland PM–10 Attainment Plan.
City of Eagle Point Code: 8.08.170.	Open burning restricted	1990	6/19/2006, 71 FR 35163.	Medford-Ashland PM–10 Attainment Plan.
City of Eagle Point Code: 8.08.180.	Purposes for open burning permit	1990	6/19/2006, 71 FR 35163.	Medford-Ashland PM–10 Attainment Plan.
City of Eagle Point Code: 8.08.190.	Times when open burning fire allowed	1990	6/19/2006, 71 FR 35163.	Medford-Ashland PM–10 Attainment Plan.
City of Eagle Point Code: 8.08.200.	Public nuisance.	1990	6/19/2006, 71 FR 35163.	Medford-Ashland PM–10 Attainment Plan.

TABLE 4—EPA APPROVED LANE REGIONAL AIR PROTECTION AGENCY (LRAPA) RULES FOR OREGON

LRAPA citation	Title/subject	State effective date	EPA approval date	Explanations
Title 11—Policy and General Provisions				
11–005	Policy	10/9/1979	9/9/1993, 58 FR 47385.	
11–010	Construction and Validity	10/9/1979	9/9/1993, 58 FR 47385.	
Title 12—Definitions				
12–001	Definitions of Words and Terms Used in LRAPA Rules and Regulations.	3/8/1994	8/3/2001, 66 FR 40616.	
Title 16—Home Wood Heating Curtailment Program Enforcement				
16–001	Purpose	7/13/1993	8/24/1994, 59 FR 43483.	
16–010	Definitions	7/13/1993	8/24/1994, 59 FR 43483.	
16–100	Civil Penalty Schedule	7/13/1993	8/24/1994, 59 FR 43483.	
16–110	Classification of Violations	7/13/1993	8/24/1994, 59 FR 43483.	
16–120	Notice of Violation	7/13/1993	8/24/1994, 59 FR 43483.	
16–130	Appeal of Civil Penalty	7/13/1993	8/24/1994, 59 FR 43483.	
16–140	Conducting Contested Case Evidentiary Hearings.	7/13/1993	8/24/1994, 59 FR 43483.	
16–150	Evidentiary Rules	7/13/1993	8/24/1994, 59 FR 43483.	
16–160	Final Orders	7/13/1993	8/24/1994, 59 FR 43483.	
16–170	Default Orders	7/13/1993	8/24/1994, 59 FR 43483.	

TABLE 4—EPA APPROVED LANE REGIONAL AIR PROTECTION AGENCY (LRAPA) RULES FOR OREGON—Continued

LRAPA citation	Title/subject	State effective date	EPA approval date	Explanations
Title 29—Incinerator Regulations				
29–0010	Definitions	9/26/2011	4/11/2013, 78 FR 21547 ...	Except 1–5, and 7 through 14.
29–0030	Designation of Nonattainment Areas.	9/26/2011	4/11/2013, 78 FR 21547.	
29–0040	Designation of Maintenance Areas.	9/26/2011	4/11/2013, 78 FR 21547.	
Title 30—Incinerator Regulations				
30–005	Purpose and Applicability	3/8/1994	8/3/2001, 66 FR 40616.	
30–010	Definitions	3/8/1994	8/3/2001, 66 FR 40616.	
30–015	Best Available Control Technology for Solid and Infectious Waste Incinerators.	3/8/1994	8/3/2001, 66 FR 40616.	
30–020	Emission Limitations for Solid and Infectious Waste Incinerators.	3/8/1994	8/3/2001, 66 FR 40616	Except (2) & (8).
30–025	Design and Operation for Solid and Infectious Waste Incinerators.	3/8/1994	8/3/2001, 66 FR 40616	Except (9).
30–030	Continuous Emission Monitoring for Solid and Infectious Waste Incinerators.	3/8/1994	8/3/2001, 66 FR 40616	Except (1)(l) & (2)(E).
30–035	Reporting and Testing for Solid and Infectious Waste Incinerators.	3/8/1994	8/3/2001, 66 FR 40616.	
30–040	Compliance for Solid and Infectious Waste Incinerators.	3/8/1994	8/3/2001, 66 FR 40616.	
30–045	Emission Limitations of Crematory Incinerators.	3/8/1994	8/3/2001, 66 FR 40616	Except for (3).
30–050	Design and Operation of Crematory Incinerators.	3/8/1994	8/3/2001, 66 FR 40616.	
30–055	Monitoring and Reporting for Crematory Incinerators.	3/8/1994	8/3/2001, 66 FR 40616.	
30–060	Compliance of Crematory Incinerators.	3/8/1994	8/3/2001, 66 FR 40616.	
Title 32—Emission Standards				
32–001	Definitions	11/10/1994	8/3/2001, 66 FR 40616.	
32–005	Highest and Best Practicable Treatment and Control Required.	11/10/1994	8/3/2001, 66 FR 40616.	
32–006	Pollution Prevention	11/10/1994	8/3/2001, 66 FR 40616.	
32–007	Operating and Maintenance Requirements.	11/10/1994	8/3/2001, 66 FR 40616.	
32–008	Typically Achievable Control Technology (TACT).	11/10/1994	8/3/2001, 66 FR 40616.	
32–009	Additional Control Requirements for Stationary Sources of Air Contaminants.	11/10/1994	8/3/2001, 66 FR 40616.	
32–010	Visible Air Contaminant Limitations.	11/10/1994	8/3/2001, 66 FR 40616.	
32–015	Particulate Matter Weight Standards.	11/10/1994	8/3/2001, 66 FR 40616.	
32–020	Particulate Matter Weight Standards—Existing Combustion Sources.	11/10/1994	8/3/2001, 66 FR 40616.	
32–030	Particulate Matter Weight Standards—New Combustion Sources.	11/10/1994	8/3/2001, 66 FR 40616.	
32–045	Process Weight Emission Limitations.	11/10/1994	8/3/2001, 66 FR 40616.	
32–055	Particulate Matter Size Standard.	11/10/1994	8/3/2001, 66 FR 40616.	

TABLE 4—EPA APPROVED LANE REGIONAL AIR PROTECTION AGENCY (LRAPA) RULES FOR OREGON—Continued

LRAPA citation	Title/subject	State effective date	EPA approval date	Explanations
32–060	Air Conveying Systems	9/26/2011	4/11/2013, 78 FR 21547.	
32–065	Sulfur Content of Fuels	9/26/2011	4/11/2013, 78 FR 21547	Except paragraphs 1 and 2.
32–070	Sulfur Dioxide Emission Limitations.	11/10/1994	8/3/2001, 66 FR 40616.	
32–090	Other Emissions	11/10/1994	8/3/2001, 66 FR 40616.	
Table 1	Table of Allowable Rate of Particulate Emissions—Based on Process Weight.	11/10/1994	8/3/2001, 66 FR 40616.	
Title 33—Prohibited Practices and Control of Special Classes of Industry				
33–030	Concealment and Masking of Emissions.	11/10/1994	8/3/2001, 66 FR 40616.	
33–045	Gasoline Tanks	11/10/1994	8/3/2001, 66 FR 40616.	
33–060	Board Products Industries (Hardwood, Particleboard, Plywood, Veneer).	11/10/1994	8/3/2001, 66 FR 40616.	
33–065	Charcoal Producing Plants	11/10/1994	8/3/2001, 66 FR 40616.	
33–070	Kraft Pulp Mills	11/10/1994	8/3/2001, 66 FR 40616	Except for (1)Definitions for Non-Condensibles, Other Sources, and TRS; (3)(A), (6)(B), (7)(A), (7)(B), (8)(C)(1)(a), & (8)(C)(2)(a).
33–075	Hot Mix Asphalt Plants	11/10/1994	8/3/2001, 66 FR 40616.	
Title 34—Stationary Source Rules and Permitting Procedures				
34–001	General Policy and Rule Organization.	6/13/2000	8/3/2001, 66 FR 40616.	
34–005	Definitions	6/13/2000	8/3/2001, 66 FR 40616.	
Rules Applicable to All Stationary Sources				
34–010	Applicability	6/13/2000	8/3/2001, 66 FR 40616.	
34–015	Request for Information	6/13/2000	8/3/2001, 66 FR 40616.	
34–020	Information Exempt from Disclosure.	6/13/2000	8/3/2001, 66 FR 40616.	
34–030	Source Registration	6/13/2000	8/3/2001, 66 FR 40616.	
34–040	Compliance Schedules for Existing Sources Affected by New Rules.	6/13/2000	8/3/2001, 66 FR 40616.	
Rules Applicable to Sources Required to Have ACDP or Title V Operating Permits				
34–050	Applicability	6/13/2000	8/3/2001, 66 FR 40616.	
34–060	Plant Site Emission Limit Rules.	6/13/2000	8/3/2001, 66 FR 40616	except for (6) & (8).
34–070	Sampling, Testing and Monitoring of Air Contaminant Emissions.	6/13/2000	8/3/2001, 66 FR 40616.	
Rules Applicable to Sources Required to Have Air Contaminant Discharge Permits (ACDP)				
34–090	Purpose and Applicability	6/13/2000	8/3/2001, 66 FR 40616.	
34–100	Permit Categories	6/13/2000	8/3/2001, 66 FR 40616.	
34–110	Permit Required	6/13/2000	8/3/2001, 66 FR 40616.	
34–120	Synthetic Minor Sources	6/13/2000	8/3/2001, 66 FR 40616.	
34–130	General Procedures for Obtaining ACDP Permits.	6/13/2000	8/3/2001, 66 FR 40616.	
34–140	Permit Duration	6/13/2000	8/3/2001, 66 FR 40616.	
34–150	ACDP Fees	6/13/2000	8/3/2001, 66 FR 40616.	
Table A Part I Part II	Air Contaminant Sources and Associated Fee Schedule.	6/13/2000	8/3/2001, 66 FR 40616.	
Title 38—New Source Review				
38–001	General Applicability	2/13/1990	9/9/1993, 58 FR 47385.	

TABLE 4—EPA APPROVED LANE REGIONAL AIR PROTECTION AGENCY (LRAPA) RULES FOR OREGON—Continued

LRAPA citation	Title/subject	State effective date	EPA approval date	Explanations
38–005	Definitions	2/13/1990	9/9/1993, 58 FR 47385.	
38–010	General Requirements for Major Sources and Major Modifications.	2/13/1990	9/9/1993, 58 FR 47385.	
38–015	Additional Requirements for Major Sources or Major Modifications Located in Nonattainment Areas.	2/13/1990	9/9/1993, 58 FR 47385.	
38–020	Additional Requirements for Major Sources or Major Modifications in Attainment or Unclassified Areas (Prevention of Significant Deterioration).	2/13/1990	9/9/1993, 58 FR 47385.	
38–025	Exemptions for Major Sources and Major Modifications.	2/13/1990	9/9/1993, 58 FR 47385.	
38–030	Baseline for Determining Credits for Offsets.	2/13/1990	9/9/1993, 58 FR 47385.	
38–035	Requirements for Net Air Quality Benefit for Major Sources and Major Modifications.	2/13/1990	9/9/1993, 58 FR 47385.	
38–040	Emission Reduction Credit Banking.	2/13/1990	9/9/1993, 58 FR 47385.	
38–045	Requirements for Non-Major Sources and Non-Major Modifications.	2/13/1990	9/9/1993, 58 FR 47385.	
38–050	Stack Height and Dispersion Techniques.	2/13/1990	9/9/1993, 58 FR 47385.	
Title 39—Contingency for PM_{10} Sources in Eugene-Springfield Non-Attainment Area				
39–001	Purpose	11/13/1991	8/24/1994, 59 FR 43483.	
39–005	Relation to Other Rules	11/13/1991	8/24/1994, 59 FR 43483.	
39–010	Applicability	11/13/1991	8/24/1994, 59 FR 43483.	
39–015	Definitions	11/13/1991	8/24/1994, 59 FR 43483.	
39–020	Compliance Schedule for Existing Sources.	11/13/1991	8/24/1994, 59 FR 43483.	
39–025	Wood-Waste Boilers	11/13/1991	8/24/1994, 59 FR 43483.	
39–030	Veneer Dryers	11/13/1991	8/24/1994, 59 FR 43483.	
39–035	Particleboard Plants and Wood Particle Dryers.	11/13/1991	8/24/1994, 59 FR 43483.	
39–040	Kraft Pulp Mills	11/13/1991	8/24/1994, 59 FR 43483.	
39–050	Air Conveying Systems	11/13/1991	8/24/1994, 59 FR 43483.	
39–055	Fugitive Dust	11/13/1991	8/24/1994, 59 FR 43483.	
39–060	Open Burning	11/13/1991	8/24/1994, 59 FR 43483.	
Title 47—Rules for Open Outdoor Burning				
47–001	General Policy	8/14/84	9/9/1993, 58 FR 47385.	
47–005	Statutory Exemptions from These Rules.	8/14/84	9/9/1993, 58 FR 47385.	
47–010	Definitions	1/1/1993	1/11/1995, 60 FR 2690.	
47–015	Open Burning Requirements.	1/1/1993	1/11/1995, 60 FR 2690.	
47–020	Letter Permits	1/1/1993	1/11/1995, 60 FR 2690.	
47–030	Summary of Seasons, Areas, and Permit Requirements for Open Burning.	1/1/1993	1/11/1995, 60 FR 2690.	
Title 50—Ambient Air Standards				
50–005	General	7/12/1988	9/9/1993, 58 FR 47385.	
50–015	Suspended Particulate Matter.	7/12/1988	9/9/1993, 58 FR 47385.	
50–025	Sulfur Dioxide	7/12/1988	9/9/1993, 58 FR 47385.	
50–030	Carbon Monoxide	7/12/1988	9/9/1993, 58 FR 47385.	
50–035	Ozone	7/12/1988	9/9/1993, 58 FR 47385.	
50–040	Nitrogen Dioxide	7/12/1988	9/9/1993, 58 FR 47385.	

TABLE 4—EPA APPROVED LANE REGIONAL AIR PROTECTION AGENCY (LRAPA) RULES FOR OREGON—Continued

LRAPA citation	Title/subject	State effective date	EPA approval date	Explanations
50–045	Lead	7/12/1988	9/9/1993, 58 FR 47385.	
	Title 51—Air Pollution Emergencies			
51–005	Introduction	7/12/1988	9/9/1993, 58 FR 47385.	
51–010	Episode Criteria	7/12/1988	9/9/1993, 58 FR 47385.	
51–015	Emission Reduction Plans	7/12/1988	9/9/1993, 58 FR 47385.	
51–020	Preplanned Abatement Strategies.	7/12/1988	9/9/1993, 58 FR 47385.	
51–025	Implementation	7/12/1988	9/9/1993, 58 FR 47385.	
Table I	Air Pollution Episode, Alert Condition.	7/12/1988	9/9/1993, 58 FR 47385.	
Table II	Air Pollution Episode, Warning Conditions.	7/12/1988	9/9/1993, 58 FR 47385.	
Table III	Air Pollution Episode, Emergency Conditions.	7/12/1988	9/9/1993, 58 FR 47385.	

(d) EPA approved State Source-specific requirements.

Name of source	Permit No.	State effective date	EPA approval date	Explanation
Industrial Laundry & Dry Cleaners.	26–3025	12/9/1980	8/27/1981, 46 FR 43142.	Air Contaminant Discharge Permit Expiration Date: 11/1/1987.
VANPLY, Inc.& Spalding Pulp & Paper Co.	Stipulation and Consent Final Order.	12/30/1980	8/27/1981, 46 FR 43142.	Transfer by VANPLY, INC. of a VOC Offset to Spalding Pulp & Paper Co.
Weyerhaeuser Company.	18–0037	2/3/1981	11/6/1981, 46 FR 55101.	Conditions 5 and 6—Air Contaminant Discharge Permit Exp. Date: 5/1/1986.
Spaulding Pulp and Paper Co..	36–6041	12/11/1980	8/27/1981, 46 FR 43142.	Air Contaminant Discharge Permit Expiration Date: 10/1/1984.
Dura Industries	26–3112	9/14/1995	3/31/1998, 63 FR 15293.	Air Contaminant Discharge Permit Expiration Date 9/1/1997.
Cascade General (Port of Portland).	26–3224	10/4/1995	3/7/1997, 62 FR 10455.	Air Contaminant Discharge Permit Expiration Date 5/1/1997.
White Consolidated Inc.	34–2060	8/1/1995	3/7/1997, 62 FR 10455.	Air Contaminant Discharge Permit Expiration Date 8/1/1997.
Intel Corporation	34–2681	9/24/1993 (State effective date of Title V Program).	7/18/1996, 61 FR 37393.	Oregon Title-V Operating Permit Expiration Date: 10/31/1999.
PCC Structurals, Inc	26–1867	4/4/1997	6/20/1997, 62 FR 33548.	Conditions 19, 20 and 21 in Addendum No. 2 Air Contaminant Discharge Permit Expiration Date: 4/1/2000.
Ostrander Construction Company Fremont Sawmill.	ACDP No. 19–0002	4/29/1998	9/21/1999, 64 FR 51051.	Air Contaminant Discharge Permit Expiration Date 11/1/2002.

(e) EPA Approved Nonregulatory provisions and Quasi-Regulatory Measures.

EPA APPROVED OREGON STATE STATUTES

State citation	Title/subject	State effective date	EPA approval date	Explanations
ORS Chapter 468	General Administration, Enforcement, Pollution Control Facilities Tax Credit.	11/4/1993	7/19/1995, 60 FR 37013.	
ORS Chapter 468A	Air Pollution Control, Regional Air Quality Control Authorities, Motor Vehicle Pollution Control, Field Burning and Propane.	11/4/1993	7/19/1995, 60 FR 37013	Except 468A.075.
ORS Chapter 468A.330	Small Business Stationary Source Technical and Environmental Compliance Assistance Program.	11/4/1993	9/5/1995, 60 FR 46025.	

STATE OF OREGON AIR QUALITY CONTROL PROGRAM

SIP citation	Title/subject	State effective date	EPA Approval Date	Explanation
Section 1	Introduction	4/25/1986	7/30/1991, 56 FR 36006.	
Section 2	General Administration	Section 2, 4/25/1986	Section 2, 7/30/1991, 56 FR 36006.	
		2.1, 4/25/1986	2.1, 7/30/1991, 56 FR 36006.	2.1 Agency Organization.
		2.2, 7/29/1992	2.2, 7/19/1995, 60 FR 37013.	2.2 Legal Authority.
		2.3, 4/25/1986	2.3, 7/30/1991, 56 FR 36006.	2.3 Resources.
		2.4, 4/25/1986	2.4, 7/30/1991, 56 FR 36006.	2.4 Intergovernmental cooperation.
		2.5, 4/25/1986	2.5, 7/30/1991, 56 FR 36006.	2.5 Miscellaneous Provisions.
		2.6, 11/16/1992	2.6, 9/5/1995, 60 FR 46025.	2.6 Small Business Assistance Program.
Section 3	Statewide Regulatory Provisions.	4/25/1986	7/30/1991, 56 FR 36006	Refer to table (c) for approved regulations.
Section 4	Control Strategies for Nonattainment Areas.	4, 4/25/1986	4, 7/30/1991, 56 FR 36006	
		4.1, 12/19/1980	4.1, 4/12/1982, 47 FR 15587.	4.1 Portland-Vancouver TSP Attainment Plan.
		4.2, 7/16/1982	4.2, 10/7/1982, 47 FR 44261.	4.2 Portland-Vancouver CO Attainment Plan.
		4.3, 7/16/1982	4.3, 10/7/1982, 47 FR 44261.	4.3 Portland-Vancouver Ozone Attainment Plan.
		4.4, 6/20/1979	4.4, 6/24/1980, 45 FR 42265.	4.4 Salem CO Attainment Plan.
		4.5, 9/19/1980	4.5, 4/12/1982, 47 FR 15587.	4.5 Salem Ozone Attainment Plan.
		4.6, 1/30/1981	4.6, 4/12/1982, 47 FR 15587.	4.6 Eugene-Springfield TSP Attainment Plan.
		4.7, 6/20/1979	4.7, 6/24/1980, 45 FR 42265.	4.7 Eugene-Springfield CO Attainment Plan.
		12/9/1988	12/6/1993, 58 FR 64161	Eugene-Springfield CO Maintenance Plan.
		4.8, 1/25/85	4.8, 6/4/1986, 51 FR 20285.	4.8 Medford-Ashland Ozone, Maintenance Plan.
		4.9, 10/15/1982	4.9, 2/13/1987, 52 FR 4620.	4.9 Medford-Ashland CO Attainment Plan.
		4.10, 4/1983	4.10, 8/15/1984, 49 FR 32574.	4.10 Medford-Ashland TSP, Attainment Plan.
		4.11, 10/24/1986	4.11, 1/15/1988, 53 FR 1020.	4.11 Grants Pass CO, Attainment Plan.
		4.12, 8/18/1995	4.12, 4/14/1997, 62 FR 18047.	4.12 Klamath Falls PM–10 Attainment Plan.
		4.13, 11/13/1991	4.13, 12/17/1993, 58 FR 65934.	4.13 Grants Pass PM–10 Attainment Plan.
		4.14, 9/9/2005	4.14, 6/19/2006, 71 FR 35163.	4.14 Medford PM–10 Attainment and Maintenance Plan.
		4.15, 11/8/1991	4.15, 2/15/1995, 60 FR 8563.	4.15 La Grande PM–10 Attainment Plan.
		4.16, 1/31/1991	4.16, 8/24/1994, 59 FR 43483.	4.16 Eugene-Springfield PM–10 Attainment Plan.
		4.17, 11/20/2000, (submittal date).	4.17, 9/20/2001, 66 FR 48340.	4.17 Klamath Falls CO Maintenance Plan.
		4.18, 11/4/1996	4.18, 3/15/1999, 64 FR 12751.	4.18 Oakridge PM–10 Attainment Plan.
		4.19, 6/1/1995, (submittal date).	4.19, 9/21/1999, 64 FR 51051.	4.19 Lakeview PM–10 Attainment Plan.
		4.50, 8/14/1996	4.50, 5/19/1997, 62 FR 27204.	4.50 Portland/Vancouver Ozone Maintenance Plan.
		4/12/2007	12/19/2011, 76 FR 78571.	Portland-Vancouver AQMA (Oregon portion) & Salem Kaizer Area 8-hour Ozone (110(a)(1) Maintenance Plan.
		4.51, 7/12/1996	4.51, 9/2/1997, 62 FR 46208.	4.51 Portland CO Maintenance Plan.

STATE OF OREGON AIR QUALITY CONTROL PROGRAM—Continued

SIP citation	Title/subject	State effective date	EPA Approval Date	Explanation
		4.52, 3/9/2001	4.52, 7/24/2002, 67 FR 48388.	4.52 Medford CO Maintenance Plan.
		4.53, 9/10/1999	4.53, 8/31/2000, 65 FR 52932.	4.53 Grants Pass CO Maintenance Plan.
		4.55, 10/4/2002	4.55, 10/27/2003, 68 FR 61111.	4.55 Grants Pass PM–10 Maintenance Plan.
		4.56, 10/4/2002	4.56, 10/21/2003, 68 FR 60036.	4.56 Klamath Falls PM–10 Maintenance Plan.
		4.57, 6/28/2007	4.57, 12/30/2008, 73 FR 79655.	4.57 Salem-Keizer Area CO, Limited Maintenance Plan.
		4.58, 12/15/2004	4.58, 1/24/2006, 71 FR 3768.	4.58 Portland Area CO Maintenance Plan 2nd 10-year.
		4.59, 9/9/2005	4.59, 6/19/2006, 71 FR 35161.	4.59 La Grande PM10 Maintenance Plan.
		4.60, 9/9/2005	4.60, 6/19/2006, 71 FR 35159.	4.60 Lakeview PM10 Maintenance Plan.
		4.61, 9/26/2011	4.61, 4/11/2013, 78 FR 21547.	4.61 Eugene-Springfield PM10 Limited Maintenance Plan.
Section 5	Control Strategies for Attainment and Nonattainment Areas.	5, 4/25/1986	5, 7/30/1991, 56 FR 36006	
		5.1, 1/14/1983	5.1, 5/18/1983, 48 FR 22298.	5.1 Statewide Control Strategies for Lead.
		5.2, 5/3/2002	5.2, 3/15/2005, 70 FR 12587.	5.2 Visibility Protection Plan.
		5.3, 4/25/1986	5.3, 7/30/1991, 56 FR 36006.	5.3 Prevention of Significant Deterioration.
		5.4, 10/24/2003	5.4, 11/27/2004, 69 FR 67819.	5.4 Motor Vehicle Inspection and Maintenance.
		12/9/2010	7/5/2011, 76 FR 38997	Oregon Regional Haze Plan—Section 308.
Section 6	Ambient Air Quality Monitoring Program.	1/1986	7/30/1991, 56 FR 36006	6.1 Air Monitoring Network. 6.2 Data Handling and Analysis Procedures. 6.3 Episode Monitoring.
Section 7	Emergency Action Plan	1/1986	7/30/1991, 56 FR 36006.	
Section 8	Public Involvement	1/1986	7/30/1991, 56 FR 36006.	
Section 9	Plan Revisions and Reporting.	1/1986	7/30/1991, 56 FR 36006.	

OREGON ADMINISTRATIVE RULES, APPROVED BUT NOT INCORPORATED BY REFERENCE

State citation	Title/subject	State effective date	EPA approval date	Explanations
Division 11—Rules of General Applicability and Organization				
011–0005	Definitions	3/20/2008	4/25/2013, 78 FR 24347.	
011–0009	Incorporation of Attorney General's Uniform and Model Rules.	3/20/2008	4/25/2013, 78 FR 24347.	
011–0510	Agency Representation by Environmental Law Specialist.	3/20/2008	4/25/2013, 78 FR 24347.	
011–0515	Authorized Representative of Respondent other than a Natural Person in a Contested Case Hearing.	3/20/2008	4/25/2013, 78 FR 24347.	
011–0573	Proposed Orders in Contested Cases.	3/20/2008	4/25/2013, 78 FR 24347.	
011–0575	Review of Proposed Orders in Contested Cases.	3/20/2008	4/25/2013, 78 FR 24347.	
Division 12—Enforcement Procedure and Civil Penalties				
012–0026	Policy	5/13/2005	4/25/2013, 78 FR 24347.	
012–0027	Rule Effective Date	3/26/2006	4/25/2013, 78 FR 24347.	

OREGON ADMINISTRATIVE RULES, APPROVED BUT NOT INCORPORATED BY REFERENCE—Continued

State citation	Title/subject	State effective date	EPA approval date	Explanations
012–0028	Scope of Applicability	5/13/2005	4/25/2013, 78 FR 24347.	
012–0030	Definitions	11/10/2008	6/20/2013, 78 FR 37124.	
012–0038	Warning Letters, Pre-Enforcement Notices and Notices of Permit Violation.	11/10/2008	6/20/2013, 78 FR 37124.	
012–0041	Formal Enforcement Action.	5/13/2005	4/25/2013, 78 FR 24347.	
012–0042	Determination of Base Penalty.	5/13/2005	4/25/2013, 78 FR 24347.	
012–0045	Civil Penalty Determination Procedure.	5/13/2005	4/25/2013, 78 FR 24347.	
012–0145	Determination of Aggravating or Mitigating Factors.	5/13/2005	4/25/2013, 78 FR 24347.	
012–0150	Determination of Economic Benefit.	5/13/2005	4/25/2013, 78 FR 24347.	
012–0053	Violations that Apply to all Programs.	3/26/2006	4/25/2013, 78 FR 24347.	
012–0054	Air Quality Classification of Violations.	3/15/2011	6/20/2013, 78 FR 37124.	
012–0073	Environmental Cleanup Classification of Violation.	3/26/2006	4/25/2013, 78 FR 24347.	
012–0082	Contingency Planning Classification of Violations.	3/26/2006	4/25/2013, 78 FR 24347.	
012–0130	Determination of Violation Magnitude.	3/26/2006	4/25/2013, 78 FR 24347.	
012–0135	Selected Magnitude Categories.	3/26/2006	4/25/2013, 78 FR 24347.	
012–0140	Determination of Base Penalty.	3/15/2011	6/20/2013, 78 FR 37124.	
012–0155	Additional or Alternate Civil Penalties.	11/10/2008	6/20/2013, 78 FR 37124.	
012–0160	Department Discretion Regarding Penalty Assessment.	3/13/2005	4/25/2013, 78 FR 24347.	
012–0162	Inability to Pay the Penalty	3/13/2005	4/25/2013, 78 FR 24347.	
012–0165	Stipulated Penalties	3/13/2005	4/25/2013, 78 FR 24347.	
012–0170	Compromise or Settlement of Civil Penalty by Department.	11/10/2008	6/20/2013, 78 FR 37124.	
Division 200—General Air Pollution Procedures and Definitions.				
	Conflicts of Interest			
200–0100	Conflicts of Interest	7/1/2001	1/22/2003, 68 FR 2891.	
200–0110	Conflicts of Interest	7/1/2001	1/22/2003, 68 FR 2891.	
200–0120	Conflicts of Interest	7/1/2001	1/22/2003, 68 FR 2891.	
Division 262—Heat Smart Program for, Residential Woodstoves and Other Solid Fuel Heating Devices.				
262–0050	Residential Woodheating—Civil Penalties.	10/14/1999	1/22/2003, 68 FR 2891.	

CITY AND COUNTY ORDINANCES

Agency and ordinance	Title or subject	Date	EPA approval date	Explanation
Codified Ordinances of Jackson County.	1810.09	12/20/1989	6/19/2006, 71 FR 35163.	
Codified Ordinances of Jackson County.	1810.99	10.29.2003	6/19/2006, 71 FR 35163.	
Code of the City of Medford, Oregon.	7.226	11/20/1989	6/19/2006, 71 FR 35163.	
Code of the City of Medford, Oregon.	7.300	4/6/2000	6/19/2006, 71 FR 35163.	
City of Central Point Municipal Code.	8.04.100	1966	6/19/2006, 71 FR 35163.	

CITY AND COUNTY ORDINANCES—Continued

Agency and ordinance	Title or subject	Date	EPA approval date	Explanation
City of Central Point Municipal Code.	8.04.110	1966	6/19/2006, 71 FR 35163.	
City of Central Point Municipal Code.	8.04.120	1966	6/19/2006, 71 FR 35163.	
City of Central Point Municipal Code.	8.04.130	1966	6/19/2006, 71 FR 35163.	
City of Central Point Municipal Code.	8.04.140	1966	6/19/2006, 71 FR 35163.	
City of Central Point Municipal Code.	8.04.150	1995	6/19/2006, 71 FR 35163.	
City of Ashland Municipal Code.	10.30.050	1993	6/19/2006, 71 FR 35163.	
City of Ashland Municipal Code.	9.24.060	1998	6/19/2006, 71 FR 35163.	

LANE COUNTY REGIONAL AIR POLLUTION AUTHORITY REGULATIONS, APPROVED BUT NOT INCORPORATED BY REFERENCE

LRAPA citation	Title/subject	State effective date	EPA approval date	Explanations
Title 15	Enforcement Procedure and Civil Penalties.	6/13/1995	8/22/2001, 66 FR 40616.	

EPA APPROVED OREGON STATE DIRECTIVE

State citation	Title/subject	State effective date	EPA approval date	Explanations
Directive 1–4–1–601	Operational Guidance for the Oregon Smoke Management Program.	10/23/1992	11/1/2001, 66 FR 55142.	

EPA APPROVED MANUALS

Name	Adoption date	State effective date	EPA approval date	Explanations
Sampling Manual	1/23/1992	1/23/1992	6/4/1993, 58 FR 31654	Volumes 1 and 2, Adopted by Oregon Environmental Quality Commission.
Continuous Monitoring Manual.	1/23/1992	2/4/1992	6/4/1993, 58 FR 31654	Adopted by Oregon Environmental Quality Commission.

SUPPLEMENTARY DOCUMENTS

State citation	Title/subject	State effective date	EPA approval date	Explanations
Oregon SIP Volume 2, Section 5.4.	Test Procedures and Standards.	10/24/2003	11/22/2004, 69 FR 67819.	

■ 4. Amend the newly designated § 52.1974 by revising the section heading and paragraph (a) to read as follows::

§ 52.1974 Original identification of plan section.

(a) This section identified the original "State of Oregon Clean Air Act Implementation Plan" and all revisions submitted by Oregon that were federally approved prior to September 1, 2013.

* * * * *

[FR Doc. 2013–29195 Filed 12–9–13; 8:45 am]

BILLING CODE 6560–50–P

Proposed Rules

Federal Register
Vol. 78, No. 237
Tuesday, December 10, 2013

This section of the FEDERAL REGISTER contains notices to the public of the proposed issuance of rules and regulations. The purpose of these notices is to give interested persons an opportunity to participate in the rule making prior to the adoption of the final rules.

FEDERAL RESERVE SYSTEM

12 CFR Part 210

[Regulation J; Docket No. R–1473]

RIN 7100–AE06

Collection of Checks and Other Items by Federal Reserve Banks and Funds Transfers through Fedwire; Time of Settlement by a Paying Bank for an Item Received from a Reserve Bank

AGENCY: Board of Governors of the Federal Reserve System.

ACTION: Notice of proposed rulemaking; request for public comment.

SUMMARY: The Board of Governors (Board) is requesting comment on proposed amendments to subpart A of its Regulation J, *Collection of Checks and Other Items by Federal Reserve Banks and Funds Transfers through Fedwire*. The proposed rule would permit the Federal Reserve Banks (Reserve Banks) to require paying banks that receive presentment of checks from the Reserve Banks to make the proceeds of settlement for those checks available to the Reserve Banks as soon as one half-hour after receipt of the checks. The proposed rule would also permit the Reserve Banks to obtain settlement from paying banks by as early as 8:30 a.m. Eastern time for checks that the Reserve Banks present. These proposed amendments to Regulation J are necessary to implement the proposed method for posting debits and credits to banks' Federal Reserve accounts to measure daylight overdrafts under the Federal Reserve Policy on Payment System Risk (PSR policy), as proposed in Docket No. OP–1472, elsewhere in the **Federal Register**.

DATES: Comments must be submitted by February 10, 2014.

ADDRESSES: You may submit comments, identified by Docket No. R–1473, by any of the following methods:

- Agency Web site: *http://www.federalreserve.gov*. Follow the instructions for submitting comments at *http://www.federalreserve.gov/apps/foia/proposedregs.aspx*.
- Federal eRulemaking Portal: *http://www.regulations.gov*. Follow the instructions for submitting comments.
- Email: *regs.comments@federalreserve.gov*. Include docket number in the subject line of the message.
- FAX: (202) 452–3819 or (202) 452–3102.
- Mail: Robert deV. Frierson, Secretary, Board of Governors of the Federal Reserve System, 20th Street and Constitution Avenue NW., Washington, DC 20551.

All public comments are available from the Board's Web site at *http://www.federalreserve.gov/apps/foia/proposedregs.aspx* as submitted, except as necessary for technical reasons. Accordingly, your comments will not be edited to remove any identifying or contact information. Public comments may also be viewed electronically or in paper in Room MP–500 of the Board's Martin Building (20th and C Streets NW.,) between 9:00 a.m. and 5:00 p.m. on weekdays.

FOR FURTHER INFORMATION CONTACT: Susan V. Foley, Senior Associate Director (202) 452–3596, Samantha J. Pelosi, Manager (202) 530–6292, Edith Collis, Senior Financial Services Analyst (202) 453–3638, Division of Reserve Bank Operations and Payment Systems; or Kara Handzlik, Counsel (202) 452–3852, Legal Division; for users of Telecommunication Devices for the Deaf (TDD) only, contact (202) 263–4869.

SUPPLEMENTARY INFORMATION:

I. Background

Subpart A of Regulation J, *Collection of Checks and Other Items by Federal Reserve Banks*, governs the collection of checks by the Reserve Banks and applies to all parties interested in an item handled by any Reserve Bank. Among other things, the subpart specifies the time and manner in which paying banks must settle for items presented to them by the Reserve Banks. The subpart is supplemented by the Reserve Banks' Operating Circular 3, *Collection of Cash Items and Returned Checks*, which provides more specific terms and conditions under which Reserve Banks will handle checks and other cash items and noncash items.[1] The Board's Regulation CC, *Availability of Funds and Collection of Checks*, also governs the collection, presentment, and return of checks, as do the provisions of the Uniform Commercial Code (UCC), as adopted in a state, to the extent those provisions are not inconsistent with Regulation J.[2] Under the UCC, a paying bank generally will be accountable for the amount of a check if the paying bank does not settle for or return the check (or send notice of dishonor) before midnight of the banking day on which the paying bank received the check.[3] A paying bank that has settled for a check before midnight of the banking day on which it received the check, nonetheless, may avoid accountability for the check by returning the check (or sending notice of dishonor) before midnight of the next banking day (the "midnight deadline").[4]

Regulation J adopts similar rules for checks presented by Reserve Banks. Under § 210.9(b)(1), a paying bank must, on the day it receives the check, settle for the check by the close of Fedwire Funds Service on that day, or return the check by the later of the close of its banking day or the close of Fedwire (both of which are earlier than the UCC deadline) in order to avail itself of the ability to return the check and revoke settlement within the midnight deadline under the UCC.[5] If a paying bank settles with a Reserve Bank for a check on the day that the Reserve Bank presents the

[1] Operating Circular 3 is available at *www.frbservices.org/regulations/operating_circulars.html*.

[2] 12 CFR part 229.

Article 4 of the UCC, as adopted by each state, governs the check collection process.

[3] UCC § 4–302(a). Under the UCC, a "banking day" is the part of a day that a depository institution is open to the public for carrying on substantially all of its banking functions. UCC § 4–104. An institution may treat items received after a cutoff hour of 2:00 p.m. local time or later as being received on the next banking day. UCC § 4–108. For example, if a paying bank establishes a cutoff hour of 2:00 p.m. local time and a presenting bank, including a Reserve Bank, presents an item to the paying bank at 3:00 p.m. local time Monday, the paying bank may consider an item to be received on its Tuesday banking day.

[4] UCC § 4–301(a). Section 229.30(c) of the Board's Regulation CC extends the UCC midnight deadline (and Regulation J return deadline) to the time of dispatch of the return or notice for expeditious means of delivery (generally those that would result in receiving institution's receipt of the return or notice before the cutoff hour on the receiving institution's next banking day after the otherwise applicable midnight deadline). 12 CFR 229.30(c).

[5] 12 CFR 210.9(b)(1).

check to the paying bank, the paying bank may revoke settlement of a check if it returns the check by midnight of the next banking day. For purposes of determining whether a paying bank will be subject to any applicable overdraft charges under the PSR policy, § 210.9(b)(2)(i) of Regulation J states that the proceeds of the paying bank's settlement must be made available to its administrative Reserve Bank by the latest of (A) the next clock hour that is at least one hour after the paying bank receives the item; (B) 9:30 a.m.; or (C) such later time as provided in the Reserve Banks' operating circulars.[6] Under this provision, 9:30 a.m. is the earliest possible time of day by which the paying bank would be required to settle for an item in order to avoid overdraft charges, and there must be at least one hour between the time the item is presented to the paying bank and the time the paying bank settles for the item. For example, if a Reserve Bank presents an item by 8:00 a.m., then the paying bank would be required to settle for the item at 9:30 a.m., unless a later settlement time were called for in the Reserve Banks' operating circulars. (Section 210.12(i) of Regulation J provides that recipients of returned checks must settle with Reserve Banks in the same manner and by the same time as checks presented for payment.)

In accordance with § 210.9(b), section 12.2 of the Reserve Banks' Operating Circular 3 sets forth 11:00 a.m. as the earliest settlement time (later than the 9:30 a.m. set forth in Regulation J). Under section 12.2, the proceeds of the paying bank's settlement must be available to its administrative Reserve Bank by the later of 11:00 a.m. or the next clock hour that is at least one hour after the paying bank receives the item, but no later than 3:00 p.m. local time of the paying bank.

II. Proposed Amendments

Separately from this notice, the Board is proposing changes to the PSR policy.[7] The proposed changes relate to the Board's procedures for posting debit and credit entries to depository institutions' Federal Reserve accounts for automated clearing house (ACH) debit and commercial check transactions. Therefore, the Board is proposing changes to § 210.9(b) of Regulation J to conform to the portions of the proposed changes to the PSR policy that relate to the Reserve Banks' posting practices for debits to paying banks' accounts for check presentments. Specifically, the Board proposes to permit the Reserve Banks to require a paying bank to settle for an item presented by a Reserve Bank as soon as one half-hour after it receives the item from the Reserve Bank and by as early as 8:30 a.m., in order to avoid overdraft charges. The settlement timeframe to preserve the right to return the check (close of Fedwire) would not be affected.

The Board proposes that § 210.9(b)(2)(i) be revised to state that the paying bank shall settle for an item by the latest of (A) the next clock hour or clock half-hour that is at least one half-hour after the paying bank receives the item; (B) 8:30 a.m.; or (C) such later time as provided in the Reserve Banks' operating circulars.[8] For example, if the Reserve Banks present an item by 8:00 a.m., then the paying bank would be required to settle for the item at 8:30 a.m. to avoid overdraft charges, unless a later settlement time were provided for in the Reserve Banks' operating circular. The Board proposes similar changes in §§ 210.9(b)(3)(i) and (b)(4)(i).

A. Half-Hour Window Between Presentment and Settlement

The Board adopted the current one-hour window between presentment and settlement in 1992.[9] At that time, the Board reasoned that decreasing to one hour the amount of time a paying bank has to examine the checks on the day of presentment and decide whether to settle for or return them would not affect the cash letter (batches of checks) verification processes of most institutions. The Board noted that, prior to the amendments, paying banks had to settle for or return the checks by the close of business, which permitted only limited verification of the cash letters. For example, a paying bank could verify that a cash letter had been received, but likely could not examine individual checks prior to settling for the cash letter by the close of business. Paying banks generally did not examine checks individually until after the close of business on the day of presentment or during the following day. Therefore the Board determined that the one-hour period between the paying bank's receipt of and settlement for the checks was sufficient.[10]

When the Board adopted the one-hour window between presentment and settlement in 1992, depository institutions handled most checks in paper form. The Board believes that several technological and operational developments since that time justify requiring paying institutions to settle as soon as one half-hour after presentment. In the wake of the Check Clearing for the 21st Century Act of 2003 (Check 21 Act), banks now handle most checks electronically.[11] The Reserve Banks now present virtually all (over 99.9 percent) checks to paying banks electronically. Electronic delivery of checks between Reserve Banks and paying banks, and computerized handling of those checks within institutions, should facilitate paying banks' ability to verify the receipt of cash letters sooner than when presentment of checks was done predominantly in paper form, such that one half-hour between an institution's receipt of checks from the Reserve Banks and the institution's settlement with the Reserve Banks for the checks should be sufficient.

The Board requests comment on whether one half-hour between receipt of checks by a paying bank and the paying bank's settlement is a sufficient amount of time for a paying bank to perform a limited verification of cash letters and determine whether to settle for or return the cash letter. Alternatively, the Board requests comment on whether a shorter period of time between presentment and settlement would be appropriate (for example, fifteen minutes).

The Board also proposes to define "clock half-hour" as a new term in § 210.2(p)(2) to mean a time that is on the half-hour (e.g., 1:30 or 2:30). Section 210.2(p), which the Board proposes to redesignate as § 210.2(p)(1), currently defines the term "clock hour" as a time that is on the hour (e.g., 1:00 or 2:00).

B. Earliest Settlement Time at 8:30 a.m.

In 1997, the Board revised § 210.9(b) to explicitly refer to 9:30 a.m. (rather than one hour after the opening of Fedwire) as the earliest time a paying bank could be required to settle for an item. This revision to § 210.9(b) was intended to ensure the earliest settlement time for checks remained unchanged when the scheduled opening of Fedwire moved from 8:30 a.m.[12]

[6] Section 210.9(b)(3)(i) sets forth similar times of day if the paying bank closes voluntarily on a Reserve Bank banking day. Section 210.9(b)(4)(i) sets forth analogous times if the paying bank receives an item on a banking day on which the Reserve Bank is closed, i.e., a business day that is not a banking day for the Reserve Bank. All times are stated in Eastern time, unless otherwise specified.

[7] The Board's current policy on payment system risk is available at *www.federalreserve.gov/paymentsystems/psr_policy.htm*.

[8] The Reserve Banks would modify paragraph 12.2 of Operating Circular 3 to eliminate 11:00 a.m. as the earliest posting time.

[9] See 57 FR 46950 (Oct. 14, 1992).

[10] *Id.* at 46951.

[11] Public Law 108–100, 117 Stat. 1177 (codified at 12 U.S.C. 5001–5018) (2003). The act went into effect on October 28, 2004.

[12] 62 FR 48166, 48169 (Sept. 15, 1997). Today, the Reserve Banks' Fedwire opening hour for a given

Depository institutions will need to have funding available by 8:30 a.m. to settle for checks presented under the proposal. Institutions may fund their accounts by holding sufficient balances overnight, arranging for funding before the settlement time, or incurring daylight overdrafts in their Federal Reserve accounts (if eligible). The Reserve Banks now pay interest on institutions' Federal Reserve account balances, thereby reducing institutions' opportunity cost (i.e., loss of interest) associated with holding higher Federal Reserve account balances overnight.[13] Although an institution cannot know the exact value of check presentments it will receive on a given day, it should, based on past trends, be able to predict within a reasonable margin of error an approximate amount it expects to receive and to hold balances sufficient to cover that amount. In addition, the current PSR policy, implemented in 2011, allows eligible institutions to collateralize their daylight overdrafts, which would reduce or eliminate any daylight overdraft fees associated with the proposed posting rule change. For each two-week reserve maintenance period, eligible depository institutions also receive a $150 fee waiver, reducing the burden on institutions that might incur small amounts of uncollateralized daylight overdrafts resulting from the proposed posting rule change.[14]

The posting rules were last updated in 2002, well before the Reserve Banks' check processing became almost 100 percent electronic. Thus the proposed change better aligns with today's electronic check-processing environment in which about 90 percent of checks, on average, are available to be presented by 8:00 a.m. and prompt settlement is possible for the majority of the value of check activity.

The Board requests comment on whether the Reserve Banks should be permitted to obtain settlement from a paying bank for a check by as early as 8:30 a.m. The Board also requests comment on the feasibility of settlement before 8:30 a.m., given the current electronic check-processing environment, and whether an earlier posting time would even better align presentment to settlement.

C. Effective Date

The effective date for these proposed changes would correspond to the effective date of the changes the Board is proposing to the PSR policy, the final versions of which the Board would expect to announce contemporaneously. The Board proposes that the changes to the PSR policy, and thus these conforming changes to Regulation J, would become effective six months after publication of the final changes in the **Federal Register**. The Board requests comment on whether six months between publication of the Regulation J final rule and the rule's effective date provides paying banks with sufficient time to make any necessary operational changes. Alternatively, the Board also requests comment on whether a shorter period, such as three months, would be sufficient time.

III. Competitive Impact Analysis

The Board conducts a competitive impact analysis when it considers a rule or policy change that may have a substantial effect on payment system participants, such as that being proposed for the posting of ACH debit and commercial check transactions. Specifically, the Board determines whether there would be a direct or material adverse effect on the ability of other service providers to compete with the Federal Reserve due to differing legal powers or due to the Federal Reserve's dominant market position deriving such legal differences.[15] The Board believes that there are no adverse effects resulting from the proposed changes due to legal differences.

Under Regulation J, the Reserve Banks have the legal and operational ability to debit paying banks for paper presentments of checks earlier in the day than private-sector collecting banks and, in turn, can pass credits for deposited checks earlier in the day without incurring significant intraday float. To obtain settlement from paying banks for paper checks presented, Regulation J permits the Reserve Banks to debit directly the account of the paying bank or its designated correspondent.[16] In contrast, a paying bank settles for checks presented by a private-sector bank for same-day settlement by sending a Fedwire Funds transaction to the presenting bank or by another agreed upon method.[17] In addition, the Reserve Banks have the right to debit the account of the paying bank for settlement of checks on the next clock hour that is at least one hour after presentment, whereas a private-sector collecting bank may not receive settlement until the close of Fedwire on the day of presentment.[18]

In March 1998, the Board requested comment on whether these legal differences between the Reserve Banks and the private sector provided the Reserve Banks with a competitive advantage. Most commenters acknowledged that the regulation governing the timing and settlement favor Reserve Banks over private-sector collecting banks. None of the commenters, however, suggested an alternative that eliminated the disparity while maintaining a balance between the needs of both the paying bank and collecting banks to control some part of the settlement process.[19]

Additionally, under Regulation J, Reserve Banks can obtain same-day settlement for checks presented to a paying bank before the paying bank's cutoff hour, generally 2:00 p.m. local time or later.[20] The same-day settlement rule for private-sector banks, however, requires that they make their presentments by 8:00 a.m. local time to ensure that they receive same-day settlement by Fedwire without being assessed presentment fees. In March 1998, the Board also requested comment on the effect of the difference in presentment deadlines for Reserve Banks and private-sector banks. Most commenters did not believe that the six-hour difference in presentment deadlines was a significant impediment to the ability of private-sector banks to compete with the Reserve Banks.

Based on the analysis of the comments received, the Board concluded then and continues to believe that these legal disparities do not materially affect the efficiency of or competition in the check collection

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Reserve Bank banking day is even earlier than it was in 1997; in 2004 it moved to 9:00 p.m. on the preceding calendar day. For example, for the Reserve Banks' banking day of Tuesday, Fedwire opens at 9:00 p.m. on Monday. See *www.newyorkfed.org/banking/circulars/11589.html.*

[13] 12 CFR 204.10. The Board notes that Federal Home Loan Banks (FHLBs) are not eligible to earn interest on balances in Federal Reserve accounts, but can act as pass-through correspondents. Per section 204.10 of Regulation D, in cases of balances maintained by pass-through correspondents that are not interest-eligible institutions, Reserve Banks shall pay interest only on the balances maintained to satisfy a reserve balance requirement of one or more respondents, and the correspondents shall pass back to its respondents interest paid on balances in the correspondent's account (12 CFR 204.10).

[14] The Board notes that voluntary collateralization of daylight overdrafts and the $150 fee waiver are not available to Edge and agreement corporations, bankers' banks that have not waived their exemption from reserve requirements, limited-purpose trust companies, and government-sponsored enterprises (including FHLBs) and international organizations. These types of institutions do not have regular access to the discount window and, therefore, are expected not to incur daylight overdrafts in their Federal Reserve accounts.

[15] Federal Reserve Regulatory Service, 7–145.2.

[16] 12 CFR 210.9(b)(5).

[17] 12 CFR 229.36(f)(2).

[18] 12 CFR 210.9(b)(2); 12 CFR 229.36(f)(2).

[19] The request for comment and the subsequent notice of the Board's decision can be found, respectively, at 63 FR 12700 (March 16, 1998) and 63 FR 68701 (December 14, 1998).

[20] 12 CFR 210.9(b)(1).

system. The costs to paying banks and their customers associated with reducing any remaining legal disparities would outweigh any payment system efficiency gains.

In addition, the Check 21 Act facilitated the transformation of the nation's check collection system from one that was largely paper-based to one that is virtually all electronic, based on agreements between the parties. Institutions may determine, as part of the agreements, the presentment and settlement deadlines. Thus, private-sector presenting banks may be able to obtain settlement times equivalent to the Federal Reserve's check posting rule through clearinghouse rules or individual agreements with paying banks. Furthermore, for depositary and paying banks that opt to use a check clearinghouse rather than directly exchange paper or electronic checks, private-sector clearinghouses have the option to use the Reserve Banks' National Settlement Service (NSS) to effect settlement of checks or may settle by directing their members to initiate funds transfers over the Reserve Banks' Fedwire Funds Service.[21] NSS's operating hours extend from 8:30 a.m. to 5:00 p.m., while Fedwire Funds operating hours begin at 9:00 p.m. the previous calendar day and end at 6:30 p.m. The Reserve Banks today settle current check transactions (including corrections and adjustments associated with check-processing) from 11:00 a.m. to 6:30 p.m. within the Fedwire Funds operating day.

Under the proposed posting rules, the bulk of the Reserve Banks' postings of credits to senders and debits to paying banks for commercial check transactions may shift to earlier in the day. Depending on the number of checks an institution sends to the Reserve Banks and that it receives from the Reserve Banks, the institution may receive either a "net credit" or a "net debit" earlier in the day. As a result, the earlier posting of commercial check transactions may be viewed as more or less attractive, depending on changes to balances.

Given the factors discussed above, the Board does not believe that the proposed changes to Regulation J would have any direct adverse effect on other service providers to compete effectively with Reserve Banks in providing similar services.

[21] NSS is a multilateral settlement service owned and operated by the Reserve Banks. The service is offered to depository institutions that settle for participants in clearinghouses, financial exchanges, and other clearing and settlement groups. Settlement agents, acting on behalf of those depository institutions in a settlement arrangement, electronically submit settlement files to the Reserve Banks. Files are processed upon receipt, and entries are automatically posted to the depository institutions' Federal Reserve accounts.

IV. Initial Regulatory Flexibility Analysis

The Regulatory Flexibility Act (RFA) (5 U.S.C. 601 *et seq.*) requires agencies either to provide an initial regulatory flexibility analysis with a proposed rule or to certify that the proposed rule will not have a significant economic impact on a substantial number of small entities. In accordance with section 3(a) of the RFA, the Board has reviewed the proposed regulation. In this case, the proposed rule would apply to all depository institutions that receive presentment or return of checks from the Reserve Banks. Based on current information, the Board believes that the proposed rule would not have a significant economic impact on a substantial number of small entities (5 U.S.C. 605(b)). Nonetheless, an initial regulatory flexibility analysis has been prepared in accordance with 5 U.S.C. 603 in order for the Board to solicit comment. The Board will, if necessary, conduct a final regulatory flexibility analysis after consideration of comments received during the public comment period.

1. Statement of the Need for, Objectives of, and Legal Basis for, the Proposed Rule

These proposed amendments to Regulation J are necessary to conform the required settlement times for checks presented by Reserve Banks to the proposed method for posting debits and credits to institutions' Federal Reserve accounts to measure daylight overdrafts under the PSR policy, as proposed in Docket No. OP–1472, elsewhere in the **Federal Register**. The Board believes that the proposed posting rules better align the settlement for checks with actual deposit and presentment times, reflecting the industry's almost complete shift from paper to electronic check-processing.

The proposal would permit the Reserve Banks to require a paying bank to settle for an item by as early as 8:30 a.m. (one hour earlier than under the current rule) and would require a paying bank to settle for an item as soon as one half-hour after it receives the item from the Reserve Banks (currently, paying banks are required to settle for an item as soon as one hour after they receive the item). Subpart A of Regulation J is issued by the Board pursuant to the following sections of the Federal Reserve Act: Sections 11(i) and (j), which grant the Board general supervisory and rulemaking authority over Reserve Bank activities; section 13, which authorizes the Reserve Banks to engage in check collection on behalf of depository institutions; and section 16(14), which authorizes the Board to make regulations concerning the transfer of funds among Reserve Banks and to require Reserve Banks to exercise the functions of a clearinghouse for depository institutions.[22]

2. Small Entities Affected by the Proposed Rule

The proposed rule would affect all institutions that receive checks or returned checks handled by the Reserve Banks. The Board believes that virtually all depository institutions receive checks or returned checks handled by the Reserve Banks on at least an occasional basis. Pursuant to regulations issued by the Small Business Administration (SBA) (13 CFR 121.201), a "small banking organization" includes a depository institution with $500 million or less in total assets. Based on data reported as of June 30, 2013, the Board believes that there are approximately 12,164 small depository institutions.

3. Projected Reporting, Recordkeeping, and Other Compliance Requirements

The proposed rule would permit the Reserve Banks to require a paying bank to settle for an item by as early as 8:30 a.m., instead of 9:30 a.m., and as soon as one half-hour, instead of one hour, after it receives the item from the Reserve Banks. Paying banks may choose to maintain sufficient overnight Federal Reserve account balances to fund checks debited at 8:30 a.m. The Reserve Banks' payment of interest on institutions' Federal Reserve account balances reduces paying banks' opportunity cost associated with doing so. In addition, the PSR policy allows eligible institutions to collateralize their daylight overdrafts, which would reduce or eliminate any daylight overdraft fees that may occur from the earlier settlement. Eligible institutions also receive a $150 fee waiver for each two-week reserve maintenance period, which reduces the burden particularly for smaller institutions if small amounts of uncollateralized daylight overdrafts occur.[23] As noted earlier, under the proposed posting rules, the bulk of the Reserve Banks' postings of debits to paying institutions for commercial check transactions may shift to earlier in the day, allowing Reserve Banks to provide credits to depositing

[22] 12 U.S.C. 248(i) and (j); 12 U.S.C. 342; 12 U.S.C. 248–1.

[23] As previously noted, the Board recognizes that these cost-mitigating options are not available to all institutions.

institutions earlier, thus mitigating adverse effects on depository institutions.

The Board seeks information and comment on any costs that would arise from the application of the proposed rule.

4. Identification of Duplicative, Overlapping, or Conflicting Federal Rules

Subpart C of the Board's Regulation CC (12 CFR part 229) sets forth conditions under which a paying bank must settle with a presenting bank for a check on the same day the check is presented to the paying bank in order for the paying bank to avail itself of its ability to return the check on its next banking day under the UCC. Settlement for checks presented by Reserve Banks is governed by the provisions of subpart A of Regulation J, and the same-day settlement provisions of Regulation CC do not supersede or limit the rules in Regulation J.[24]

5. Significant Alternatives to the Proposed Rule

As noted above, the proposed rule would permit the Reserve Banks to require a paying bank to settle for an item by as early as 8:30 a.m., instead of 9:30 a.m., and as soon as one half-hour, instead of one hour, after it receives the item from the Reserve Banks. In connection with the proposed changes, the Board recognizes that an alternative to the proposed rule would be a rule that permits the Reserve Banks to require a paying bank to settle for an item at a time earlier than 8:30 a.m. The Board believes the proposed time of 8:30 a.m. achieves the Board's goal of better aligning presentment to settlement while imposing minimal costs on paying banks. The Board is seeking comment, however, on the feasibility of settlement before 8:30 a.m. and whether an earlier posting time would even better align presentment to settlement. (*See* discussion above in section II.B.) In addition, in lieu of proposing to permit the Reserve Banks to require a paying bank to settle as soon as one half-hour after it receives the item from the Reserve Banks, the Board could have proposed a shorter period of time, such as fifteen minutes. The Board believes the proposed time period of one half-hour promotes the Board's objective of minimizing the window between presentment and settlement to reflect technological and operational developments while continuing to provide paying banks with sufficient time to perform a limited verification of cash letters. The Board is seeking comment on whether one half-hour between presentment and settlement is appropriate or if a shorter window would be sufficient. (*See* discussion above in section II.A.)

[24] See 12 CFR 210.3(f).

V. Paperwork Reduction Act Analysis

In accordance with the Paperwork Reduction Act (PRA) of 1995 (44 U.S.C. 3506; 5 CFR part 1320 appendix A.1), the Board reviewed the proposed rule under the authority delegated to the Board by the Office of Management and Budget (OMB). No collections of information pursuant to the PRA are contained in the proposed rule.

List of Subjects in 12 CFR Part 210

Banks, banking, Federal Reserve System.

Authority and Issuance

For the reasons set forth in the preamble, the Board proposes to amend Regulation J, 12 CFR part 210, as follows:

PART 210—COLLECTION OF CHECKS AND OTHER ITEMS BY FEDERAL RESERVE BANKS AND FUNDS TRANSFERS THROUGH FEDWIRE (REGULATION J)

■ 1. The authority citation for part 210 is revised to read as follows:

Authority: 12 U.S.C. 248(i), (j), and 248–1, 342, 360, 464, 4001–4010, and 5001–5018.

■ 2. In § 210.2, revise paragraph (p) to read as follows:

§ 210.2 Definitions.

* * * * *

(p) *Clock hour and clock half-hour.*

(1) Clock hour means a time that is on the hour, such as 1:00, 2:00, etc.

(2) Clock half-hour means a time that is on the half-hour, such as 1:30, 2:30, etc.

■ 3. In § 210.9, revise paragraphs (b)(2), (b)(3), and (b)(4) to read as follows:

§ 210.9 Settlement and Payment.

* * * * *

(b) * * *

(2) *Time of settlement.* (i) On the day a paying bank receives a cash item from a Reserve Bank, it shall settle for the item so that the proceeds of the settlement are available to its administrative Reserve Bank, or return the item, by the latest of—

(A) the next clock hour or clock half-hour that is at least one half-hour after the paying bank receives the item;

(B) 8:30 a.m. Eastern Time; or

(C) such later time as provided in the Reserve Banks' operating circulars.

(ii) If the paying bank fails to settle for or return a cash item in accordance with paragraph (b)(2)(i) of this section, it shall be subject to any applicable overdraft charges. Settlement under paragraph (b)(2)(i) of this section satisfies the settlement requirements of paragraph (b)(1) of this section.

(3) *Paying bank closes voluntarily.* (i) If a paying bank closes voluntarily so that it does not receive a cash item on a day that is a banking day for a Reserve Bank, and the Reserve Bank makes a cash item available to the paying bank on that day, the paying bank shall either—

(A) on that day, settle for the item so that the proceeds of the settlement are available to its administrative Reserve Bank, or return the item, by the latest of the next clock hour or clock half-hour that is at least one half-hour after it ordinarily would have received the item, 8:30 a.m. Eastern Time, or such later time as provided in the Reserve Banks' operating circulars; or

(B) on the next day that is a banking day for both the paying bank and the Reserve Bank, settle for the item so that the proceeds of the settlement are available to its administrative Reserve Bank by 8:30 a.m. Eastern Time on that day or such later time as provided in the Reserve Banks' operating circulars; and compensate the Reserve Bank for the value of the float associated with the item in accordance with procedures provided in the Reserve Bank's operating circular.

(ii) If a paying bank closes voluntarily so that it does not receive a cash item on a day that is a banking day for a Reserve Bank, and the Reserve Bank makes a cash item available to the paying bank on that day, the paying bank is not considered to have received the item until its next banking day, but it shall be subject to any applicable overdraft charges if it fails to settle for or return the item in accordance with paragraph (b)(3)(i) of this section. The settlement requirements of paragraphs (b)(1) and (b)(2) of this section do not apply to a paying bank that settles in accordance with paragraph (b)(3)(i) of this section.

(4) *Reserve Bank closed.* (i) If a paying bank receives a cash item from a Reserve Bank on a banking day that is not a banking day for the Reserve Bank, the paying bank shall—

(A) settle for the item so that the proceeds of the settlement are available to its administrative Reserve Bank by the close of Fedwire on the Reserve Bank's next banking day, or return the item by midnight of the day it receives the item (if the paying bank fails to settle for or return a cash item in accordance with this paragraph (b)(4)(i)(A), it shall become accountable

for the amount of the item as of the close of its banking day on the day it receives the item); and

(B) settle for the item so that the proceeds of the settlement are available to its administrative Reserve Bank by 8:30 a.m. Eastern Time on the Reserve Bank's next banking day or such later time as provided in the Reserve Bank's operating circular, or return the item by midnight of the day it receives the item. If the paying bank fails to settle for or return a cash item in accordance with this paragraph (b)(4)(i)(B), it shall be subject to any applicable overdraft charges. Settlement under this paragraph (b)(4)(i)(B) satisfies the settlement requirements of paragraph (b)(4)(i)(A) of this section.

* * * * *

By order of the Board of Governors of the Federal Reserve System, November 25, 2013.

Robert deV. Frierson,

Secretary of the Board.

[FR Doc. 2013–28747 Filed 12–9–13; 8:45 am]

BILLING CODE P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

15 CFR Part 922

[Docket No. 130813710–3710–01]

RIN 0648–BD60

Gray's Reef National Marine Sanctuary Regulations and Management Plan

AGENCY: Office of National Marine Sanctuaries (ONMS), National Ocean Service (NOS), National Oceanic and Atmospheric Administration (NOAA), Department of Commerce (DOC).

ACTION: Proposed rule.

SUMMARY: NOAA is proposing to update the regulations and management plan for Gray's Reef National Marine Sanctuary (GRNMS or Sanctuary). The regulations would be revised to clarify the prohibition on anchoring and add an exemption to allow the use of weighted marker buoys that are continuously tended and used during otherwise lawful fishing or diving activities and that are not attached to a vessel and not capable of holding a boat at anchor. A draft environmental assessment has been prepared that includes analysis of the consequences of this proposed action. A draft management plan outlining management priorities for GRNMS for the next 5–10 years has also been prepared. NOAA is soliciting public comment on the proposed rule, draft environmental assessment, and draft management plan.

DATES: Comments will be considered if received by February 10, 2014. A Public hearing will be held as detailed below:

(1) January 7, 2014, 5:30–7:30 p.m., Pooler Public Library, 216 S. Rogers St., Pooler, Georgia

(2) January 8, 2014, 5:30–7:30 p.m., Statesboro Regional Library, 124 S. Main St., Statesboro, Georgia

(3) January 9, 2014, 5:30–7:30 p.m., Marshes of Glynn Library, 208 Gloucester St., Brunswick, Georgia

ADDRESSES: You may submit comments on this document, identified by NOAA–NOS–2013–0160, by any of the following methods:

- *Electronic Submission:* Submit all electronic public comments via the Federal e-Rulemaking Portal. Go to *www.regulations.gov/#!docketDetail;D=NOAA-NOS-2013-0160*, click the "Comment Now!" icon, complete the required fields, and enter or attach your comments.
- *Mail:* Gray's Reef National Marine Sanctuary, 10 Ocean Science Circle, Savannah, GA 31411, Attn: Greg McFall, Superintendent.

Instructions: Comments sent by any other method, to any other address or individual, or received after the end of the comment period, may not be considered by NOAA. All comments received are a part of the public record and will generally be posted for public viewing on *www.regulations.gov* without change. All personal identifying information (e.g., name, address, etc.), confidential business information, or otherwise sensitive information submitted voluntarily by the sender will be publicly accessible. NOAA will accept anonymous comments (enter "N/A" in the required fields if you wish to remain anonymous). Attachments to electronic comments will be accepted in Microsoft Word, Excel, or Adobe PDF file formats only.

FOR FURTHER INFORMATION CONTACT: Becky Shortland at (912) 598–2381.

Copies of the proposed rule, draft environmental assessment, and draft management plan can be downloaded or viewed on the internet at *www.regulations.gov* (search for docket # NOAA–NOS–2013–0160) or at *http://graysreef.noaa.gov*. Copies can also be obtained by contacting Resource Protection Coordinator Becky Shortland, Gray's Reef National Marine Sanctuary, 10 Ocean Science Circle, Savannah, Georgia; or, *becky.shortland@noaa.gov*.

SUPPLEMENTARY INFORMATION:

I. Background

A. Gray's Reef National Marine Sanctuary

NOAA designated GRNMS as the nation's fourth national marine sanctuary in 1981 for the purposes of: Protecting the quality of this unique and fragile ecological community; promoting scientific understanding of this live bottom ecosystem; and enhancing public awareness and wise use of this significant regional resource. GRNMS protects 22 square miles of open ocean and submerged lands of particularly dense and nearshore patches of productive live bottom habitat. The sanctuary is influenced by complex ocean currents and serves as a mixing zone for temperate (colder water) and sub-tropical species. The series of rock ledges and sand expanses has produced a complex habitat of caves, burrows, troughs, and overhangs that provide a solid base upon which temperate and tropical marine flora and fauna attach and flourish.

B. Need for Action

The National Marine Sanctuaries Act of 1972 (NMSA; 16 U.S.C. 1431 *et seq.*) section 304(e) requires that NOAA review and evaluate, among other things, the site-specific management techniques and strategies to ensure that each sanctuary continues to fulfill the purposes and policies of the NMSA. Emerging issues, such as the effects of invasive lionfish on sanctuary resources, for example, are not adequately addressed in the 2006 plan. The new draft management plan reflects some of these emerging issues and presents management priorities for GRNMS for the next 5–10 years. These proposed regulatory changes would, in the case of the anchoring prohibition, clarify that attempting to anchor is also prohibited because deployment of anchors, even if the anchors do not set on the bottom, can result in impacts to the submerged lands. In the case of the weighted marker buoys, these proposed regulatory changes would allow the placement of weighted marker buoys used during otherwise lawful fishing or diving activities. The purpose of deployment of a weight on the bottom is for safety or convenience while conducting diving and recreational fishing activities, since anchoring is not allowed.

II. Summary of the Proposed Revisions to GRNMS Regulations

The proposed regulatory action would clarify a prohibition and add an exemption.

(a) Clarification of anchoring prohibition:

NOAA is proposing to clarify the prohibition on anchoring in the sanctuary (15 CFR 922.92 (a)(10)) by adding ". . . or attempting to anchor" to GRNMS's existing anchoring regulation. This would facilitate law enforcement efforts and protect sanctuary resources by allowing authorized officers to enforce the anchoring prohibition even when an anchor had not yet been set in the submerged lands of the sanctuary. Enforcement officials have experienced occasions where sanctuary users were "attempting" to anchor in GRNMS despite the prohibition, but because the anchor had not yet been "set", the prohibition did not apply. This amendment would better align the regulation with its original intent to minimize disturbance to the submerged lands, which can occur during deployment of the anchor even if it has not been set on the bottom.

(b) Exemption for marker buoys:

Current GRNMS regulations prohibit placing any material on the submerged lands of the sanctuary, including weights for marker buoys that sit on the seafloor to mark locations during recreational diving or fishing (15 CFR 922.92 (a)(2)). NOAA is proposing to add an exemption to this regulation for bottom placement of weighted marker buoys that are continuously tended and used during otherwise lawful fishing or diving activities and that are not attached to a vessel and not capable of holding a boat at anchor. Weights used with a marker buoy would not have a combined weight of more than 10 pounds, would be attached with not greater than one-fourth inch (¼") line and would be removed from the sanctuary within twelve (12) hours of deployment. Any weighted marker buoy that is not continuously tended could be removed by the Assistant Administrator or designee or an authorized officer, without notice. By "continuously tended", NOAA means that the buoy is in use by fishers or divers at the time it is observed and that the fishers' or divers' boat is in some proximity to the buoy.

The weighted marker buoys would be used for diving safety (markers provide a stationary point for divers to more accurately locate a site and for boat operators to find divers on their ascent), and to assist recreational fishers for marking and relocating a fishing spot as their boat drifts. Because anchoring in GRNMS is currently prohibited, recreational diving must be conducted by "live-boat" (non-anchored vessels), and recreational fishing by trolling or drifting with a vessel. Public comment and Sanctuary Advisory Council discussion during scoping for the management plan review indicated strong support for regulatory exemption of weighted marker buoys. Because the use of marker buoys for recreational fishing is more a matter of convenience than safety, the benefit of this action to recreational fishing would be minimal; however, the impact of weighted marker buoys from diving or fishing on sanctuary resources is negligible and essentially identical and therefore, NOAA is proposing to allow this practice for both of these activities.

III. Classification

A. National Environmental Policy Act

NOAA has prepared a draft environmental assessment to evaluate the impacts of the proposed rulemaking. Copies are available at the address and Web site listed in the **ADDRESSES** section of this proposed rule.

B. Executive Order 12866: Regulatory Impact

This proposed rule has been determined to be not significant as that term is defined in Executive Order 12866.

C. Executive Order 13132: Federalism Assessment

NOAA has concluded this regulatory action does not have federalism implications sufficient to warrant preparation of a federalism assessment under Executive Order 13132.

D. Regulatory Flexibility Act

The Chief Counsel for Regulation of the Department of Commerce certified to the Chief Counsel for Advocacy of the Small Business Administration (SBA) that this proposed rule, if adopted, would not have a significant economic impact on a substantial number of small entities.

NOAA expects the proposed regulatory exemption on the use of small, weighted marker buoys in the sanctuary to result in beneficial effects for recreational users of GRNMS by: (a) Enhancing dive opportunities at the Sanctuary and, (b) enhancing bottom fishing opportunities within the for-hire charter boat fishing and private recreational boating industries.

It is estimated that there are currently one or two diving operators occasionally taking people out to the sanctuary. A 2008 survey (Ehler 2010) identified 15 charter boats that utilize GRNMS as one of their fishing locations. The survey found that approximately 40 percent of their fishing activity took place in the sanctuary. In 2012, NOAA estimated that 245 people participated in bottom-fishing from private household boats in the sanctuary accounting for a little over 3,000 person-days of bottom-fishing. An additional 36 people participated in diving activities in the sanctuary via access from private household boats and accounted for a little over 300 person-days of activity (Leeworthy 2013). NOAA expects this rule to slightly increase the number of bottom-fishing trips from private household boats in the sanctuary with small positive benefits to the current participants and some additional small economic benefits to recreational fishing related economies based on increased activity and spending. All spending by the recreational sector would benefit small businesses that provide goods and services to recreational participants.

E. Paperwork Reduction Act

This proposed rule would not require any additional collection of information, and therefore no paperwork reduction act action is required. Notwithstanding any other provision of the law, no person is required to respond to, nor shall any person be subject to a penalty for failure to comply with, a collection of information subject to the requirements of the PRA, unless that collection of information displays a currently valid OMB Control Number.

IV. Request for Comments

NOAA requests comments on this proposed rule for 60 days after publication of this notice.

V. References

A complete list of all references cited herein is available upon request (see **ADDRESSES** section).

List of Subjects in 15 CFR Part 922

Administrative practice and procedure, Coastal zone, Fishing gear, Marine resources, Natural resources, Penalties, Recreation and recreation areas, Wildlife.

(Federal Domestic Assistance Catalog Number 11.429 Marine Sanctuary Program).

Dated: November 29, 2013.

Holly A. Bamford,

Assistant Administrator, National Ocean Service, National Oceanic and Atmospheric Administration.

Accordingly, for the reasons set forth above, NOAA proposes amending part 922, title 15 of the Code of Federal Regulations as follows:

PART 922—NATIONAL MARINE SANCTUARY PROGRAM REGULATIONS

■ 1. The authority citation for part 922 continues to read as follows:

Authority: 16 U.S.C. 1431 et seq.

■ 2. In § 922.92, revise paragraphs (a)(2) and (a)(10) to read as follows:

§ 922.92 Prohibited or otherwise regulated activities—Sanctuary-wide.

(a) * * *

(2) Constructing any structure other than a navigation aid, or constructing, placing, or abandoning any structure, material, or other matter on the submerged lands of the Sanctuary except weighted marker buoys that are continuously tended and used during otherwise lawful fishing or diving activities and that are not attached to a vessel and not capable of holding a boat at anchor. Weights used with a marker buoy shall not have a combined weight of more than 10 pounds, shall be attached with not greater than one-fourth inch (¼″) line and shall be removed from the Sanctuary within twelve (12) hours of deployment. Any weighted marker buoy that is not continuously tended may be removed by the Assistant Administrator or designee or an authorized officer, without notice.

* * * * *

(10) Anchoring, or attempting to anchor, any vessel in the Sanctuary, except as provided in paragraph (d) of this section when responding to an emergency threatening life, property, or the environment.

* * * * *

[FR Doc. 2013–29290 Filed 12–9–13; 8:45 am]

BILLING CODE 3510–NK–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 165

[Docket No. USCG–2013–0362]

RIN 1625–AA00

Eleventh Coast Guard District Annual Fireworks Events

AGENCY: Coast Guard, DHS.

ACTION: Notice of proposed rulemaking.

SUMMARY: The Coast Guard proposes to amend several permanent safety zones located in the Eleventh Coast Guard District that are established to protect public safety during annual firework displays. These amendments will standardize the safety zone language, update listed events, delete events that are no longer occurring, add new annual fireworks events, and establish a standardized format using a table to list these recurring annual fireworks events. When these safety zones are activated, and thus subject to enforcement, this rule would limit the movement of vessels within the established firework display area.

DATES: Comments and related material must be received by the Coast Guard on or before January 9, 2014. Requests for public meetings must be received by the Coast Guard on or before December 24, 2013.

ADDRESSES: You may submit comments identified by docket number USCG–2013–0362 using any one of the following methods:

(1) *Federal eRulemaking Portal: http://www.regulations.gov.*

(2) *Fax:* 202–493–2251.

(3) *Mail or Delivery:* Docket Management Facility (M–30), U.S. Department of Transportation, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE., Washington, DC 20590–0001. Deliveries accepted between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The telephone number is 202–366–9329. To avoid duplication, please use only one of these three methods.

See the "Public Participation and Request for Comments" portion of the **SUPPLEMENTARY INFORMATION** section below for instructions on submitting comments.

FOR FURTHER INFORMATION CONTACT: If you have questions on this proposed rule, call or email LTJG Blake Morris, Eleventh Coast Guard District Prevention Division, Waterways Management Branch, U.S. Coast Guard; telephone 510–437–3801, email *Blake.J.Morris@uscg.mil.* If you have questions on viewing or submitting material to the docket, call Barbara Hairston, Program Manager, Docket Operations, telephone 202–366–9826.

SUPPLEMENTARY INFORMATION:

A. Public Participation and Request for Comments

We encourage you to participate in this rulemaking by submitting comments and related materials. All comments received will be posted without change to *http://www.regulations.gov* and will include any personal information you have provided.

1. Submitting Comments

If you submit a comment, please include the docket number for this rulemaking (USCG–2013–0362), indicate the specific section of this document to which each comment applies, and provide a reason for each suggestion or recommendation. You may submit your comments and material online at *http://www.regulations.gov*, or by fax, mail, or hand delivery, but please use only one of these means. If you submit a comment online, it will be considered received by the Coast Guard when you successfully transmit the comment. If you fax, hand deliver, or mail your comment, it will be considered as having been received by the Coast Guard when it is received at the Docket Management Facility. We recommend that you include your name and a mailing address, an email address, or a telephone number in the body of your document so that we can contact you if we have questions regarding your submission.

To submit your comment online, go to *http://www.regulations.gov*, type the docket number "USCG–2013–0362" in the "SEARCH" box and click "SEARCH." Click on "Submit a Comment" on the line associated with this rulemaking.

If you submit your comments by mail or hand delivery, submit them in an unbound format, no larger than 8½ by 11 inches, suitable for copying and electronic filing. If you submit comments by mail and would like to know that they reached the Facility, please enclose a stamped, self-addressed postcard or envelope. We will consider all comments and material received during the comment period and may change the rule based on your comments.

2. Viewing Comments and Documents

To view comments, as well as documents mentioned in this preamble as being available in the docket, go to *http://www.regulations.gov;* type the docket number "USCG–2013–0362" in the "SEARCH" box and click "SEARCH." You may also visit the Docket Management Facility in Room W12–140 on the ground floor of the Department of Transportation West Building, 1200 New Jersey Avenue SE., Washington, DC 20590, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

3. Privacy Act

Anyone can search the electronic form of comments received into any of our dockets by the name of the individual submitting the comment (or signing the comment, if submitted on behalf of an association, business, labor union, etc.). You may review a Privacy

Act notice regarding our public dockets in the January 17, 2008, issue of the **Federal Register** (73 FR 3316).

4. Public Meeting

We do not now plan to hold a public meeting. But you may submit a request for one using one of the four methods specified under **ADDRESSES**. In your request, please explain why you believe a public meeting would be beneficial. If we determine that a public meeting would aid this rulemaking, we will hold one at a time and place announced by a later notice in the **Federal Register**.

B. Basis and Purpose

The Coast Guard is conducting this rulemaking under the authority of 33 U.S.C. 1231.

Fireworks displays are held annually on a recurring basis on the navigable waters within the Eleventh Coast Guard District. Many of the annual fireworks events that require safety zones do not currently reflect some of the required information pertinent to the events such as the dates of the events and other required information that is described below. These safety zones are necessary to provide for the safety of the crew, spectators, participants of the event, participating vessels, and other users and vessels of the waterway from the hazards associated with firework displays. This proposed rule will also provide the public current information on safety zone locations, size, and length of time the zones will be active.

The effect of these proposed safety zones will be to restrict general navigation in the vicinity of the events, from the start of each event until the conclusion of that event. Except for persons or vessels authorized by the Coast Guard Patrol Commander, no person or vessel may enter or remain in the regulated area. These regulations are needed to keep spectators and vessels a safe distance away from the fireworks displays to ensure the safety of participants, spectators, and transiting vessels.

C. Discussion of Proposed Rule

The Coast Guard has reviewed 33 CFR 165 sections 1123, 1124, and 1191 for accuracy. The Coast Guard is proposing to amend Table 1 in sections 1123, 1124, and 1191 of Title 33 CFR as follows: Existing events are being updated with current information; unlisted events are being added; and listed events that the Coast Guard has been unable to verify as still in existence are being deleted.

The Coast Guard proposes to update the annual fireworks events for the San Diego Captain of the Port zone listed in 33 CFR 165 section 1123 as follows: 4 Events require updating to reflect current sponsor information and event location. These events are the "San Diego CA POPS Fireworks Display", "Fourth of July Fireworks, Mission Bay", "Coronado Glorietta Bay Fourth of July Fireworks", and "San Diego Parade of Lights Fireworks Display." Through this rulemaking, three new safety zones are being proposed for the following events. The first proposed safety zone is for the "Big Bay Boom Fourth of July Fireworks" event occurring one evening during the first week of July in San Diego Bay. This event requires four 1,000 foot radius safety zones around barges located at Shelter Island, Harbor Island, Embarcadero, and Seaport Village. The second proposed safety zone is for the "MIDWAY Fireworks" event occurring on various evenings throughout the year on the USS MIDWAY in San Diego Bay. The proposed safety zone will be 800 feet in radius around a barge located immediately to the west of the USS MIDWAY at approximately 32°42′46″ N, 11°10′47″ W. The third proposed safety zone is for the "Sea World Fireworks" event in Mission Bay occurring nightly between Memorial Day and Labor Day, and on approximately 10 evenings between Labor Day and Memorial Day. The safety zone at Sea World, Mission Bay, will be 800 feet in radius around a barge located at approximately 32°46′03″ N, 117°13′11″ W. Sea World Fireworks events will also be scheduled between Thanksgiving and New Year's Day as conditions allow.

The Coast Guard also proposes to update the annual fireworks events listed in 33 CFR 165 section 1124 within the San Diego Captain of the Port zone for the Colorado River, between Davis Dam (Bullhead City, AZ) and Headgate Dam (Parker, AZ) as follows: 4 Events require updating with current sponsor information and event locations. These events are the "Avi Resort & Casino Memorial Day Fireworks", "Laughlin/Bullhead City Rockets Over the River Fireworks", "Avi Resort & Casino Independence Day Fireworks", and the "Avi Resort & Casino Labor Day Fireworks." Through this rulemaking, two new safety zones are proposed for the following events. The first proposed safety zone is for the "Colorado Belle & Edgewater Hotel/Casino Thanksgiving Fireworks" event occurring in the lower Colorado River at Laughlin, NV. The proposed safety zone will encompass the following coordinates: 35°09′51″ N, 114°34′08″ W; 35°09′53″ N, 114°34′15″ W along the shoreline to 35°09′31″ N, 114°34′17″ W; 35°09′33″ N, 114°34′08″ W along the shoreline to 35°09′51″ N, 114°34′08″ W. The second proposed safety zone is for the "Colorado Belle & Edgewater Hotel/Casino New Years Eve Fireworks" event occurring on the lower Colorado River at Laughlin, NV. The proposed safety zone will encompass the following coordinates: 35°09′51″ N, 114°34′08″ W; 35°09′53″ N, 114°34′15″ W along the shoreline to 35°09′31″ N, 114°34′18″ W; 35°09′33″ N, 114°347′08″ W along the shoreline to 35°09′51″ N, 114°34′08″ W.

The Coast Guard also proposes to update the annual fireworks events listed in 33 CFR 165 section 1191 within the San Francisco Captain of the Port zone for the Northern California and Lake Tahoe Area as follows: 14 events require updating to reflect current sponsor information and event location. The Coast Guard proposes to update the following 14 numerically listed events in Table 1 of this section: (1), (4), (5), (6), (7), (9), (11), (13), (14), (15), (16), (20), (24), (25). Through this rulemaking, two new safety zones are proposed for the following events. The first proposed safety zone is for the "Jameson Beach Fourth of July Fireworks" event, occurring at South Lake Tahoe near Jameson Beach. This proposed safety zone will be 560 feet in radius around the fireworks barge. The second proposed safety zone is for the "Feast of Lanterns Fireworks" event, occurring on the last Saturday in July near Lovers Point Park in Pacific Grove. This proposed safety zone will be 490 feet in radius around the launch platform located on the beach at approximately 36°37′26″ N, 121°54′54″ W. Finally, the Coast Guard is proposing to delete three safety zones for events that no longer take place within the San Francisco Captain of the Port zone. Those three events are: the "Fourth of July Fireworks, City of Monterey", the "Jack London Square Fourth of July Fireworks", and the "Independence Day Celebration, City of Stockton."

D. Regulatory Analyses

We developed this proposed rule after considering numerous statutes and executive orders related to rulemaking. Below we summarize our analyses based on a number of these statutes or executive orders.

1. Regulatory Planning and Review

This proposed rule is not a significant regulatory action under section 3(f) of Executive Order 12866, Regulatory Planning and Review, as supplemented by Executive Order 13563, Improving Regulation and Regulatory Review, and does not require an assessment of potential costs and benefits under

section 6(a)(3) of Executive Order 12866 or under section 1 of Executive Order 13563. The Office of Management and Budget has not reviewed it under those Orders. Since the proposed safety zones are limited and temporary in nature, they do not constitute a significant regulatory action.

2. Impact on Small Entities

The Regulatory Flexibility Act of 1980 (RFA), 5 U.S.C. 601–612, as amended, requires federal agencies to consider the potential impact of regulations on small entities during rulemaking. The term "small entities" comprises small businesses, not-for-profit organizations that are independently owned and operated and are not dominant in their fields, and governmental jurisdictions with populations of less than 50,000. The Coast Guard certifies under 5 U.S.C. 605(b) that this proposed rule would not have a significant economic impact on a substantial number of small entities.

We expect this proposed rule may affect owners and operators of vessels, some of which may be small entities, intending to fish, sightsee, transit, or anchor in the waters affected by these proposed safety zones. This proposed rule will not have a significant economic impact on a substantial number of small entities for several reasons: Small vessel traffic will be able to pass safely around the area and vessels engaged in event activities, sightseeing and commercial fishing have ample space outside of the area governed by the proposed safety zones to engage in these activities. Small entities and the maritime public will be advised of the activation of the proposed safety zones via public notice to mariners or notice of implementation published in the **Federal Register**.

If you think that your business, organization, or governmental jurisdiction qualifies as a small entity and that this rule would have a significant economic impact on it, please submit a comment (see **ADDRESSES**) explaining why you think it qualifies and how and to what degree this rulemaking would economically affect it.

3. Assistance for Small Entities

Under section 213(a) of the Small Business Regulatory Enforcement Fairness Act of 1996 (Pub. L. 104–121), we want to assist small entities in understanding this proposed rule. If the rule would affect your small business, organization, or governmental jurisdiction and you have questions concerning its provisions or options for compliance, please contact the person listed in the **FOR FURTHER INFORMATION CONTACT**, above. The Coast Guard will not retaliate against small entities that question or complain about this proposed rule or any policy or action of the Coast Guard.

4. Collection of Information

This proposed rule will not call for a new collection of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3520.).

5. Federalism

A rule has implications for federalism under Executive Order 13132, Federalism, if it has a substantial direct effect 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. We have analyzed this proposed rule under that Order and determined that this rulemaking does not have implications for federalism.

6. Protest Activities

The Coast Guard respects the First Amendment rights of protesters. Protesters are asked to contact the person listed in the **FOR FURTHER INFORMATION CONTACT** section to coordinate protest activities so that your message can be received without jeopardizing the safety or security of people, places or vessels.

7. Unfunded Mandates Reform Act

The Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1531–1538) requires Federal agencies to assess the effects of their discretionary regulatory actions. In particular, the Act addresses actions that may result in the expenditure by a State, local, or tribal government, in the aggregate, or by the private sector of $100,000,000 (adjusted for inflation) or more in any one year. Though this proposed rule would not result in such an expenditure, we do discuss the effects of this rulemaking elsewhere in this preamble.

8. Taking of Private Property

This proposed rule would not cause a taking of private property or otherwise have taking implications under Executive Order 12630, Governmental Actions and Interference with Constitutionally Protected Property Rights.

9. Civil Justice Reform

This proposed rule meets applicable standards in sections 3(a) and 3(b)(2) of Executive Order 12988, Civil Justice Reform, to minimize litigation, eliminate ambiguity, and reduce burden.

10. Protection of Children From Environmental Health Risks

We have analyzed this proposed rule under Executive Order 13045, Protection of Children from Environmental Health Risks and Safety Risks. This rulemaking would not be an economically significant rule and would not create an environmental risk to health or risk to safety that might disproportionately affect children.

11. Indian Tribal Governments

This proposed rule does not have tribal implications under Executive Order 13175, Consultation and Coordination with Indian Tribal Governments, because it would not have a substantial direct effect on one or more Indian tribes, on the relationship between the Federal Government and Indian tribes, or on the distribution of power and responsibilities between the Federal Government and Indian tribes.

12. Energy Effects

This proposed rule is not a "significant energy action" under Executive Order 13211, Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use.

13. Technical Standards

This proposed rule does not use technical standards. Therefore, we did not consider the use of voluntary consensus standards.

14. Environment

We have analyzed this proposed rule under Department of Homeland Security Management Directive 023–01 and Commandant Instruction M16475.lD, which guide the Coast Guard in complying with the National Environmental Policy Act of 1969 (NEPA) (42 U.S.C. 4321–4370f), and have made a preliminary determination that this action is one of a category of actions that do not individually or cumulatively have a significant effect on the human environment. This proposed rule involves establishing, updating, or removing temporary safety zones for fireworks displays. The fireworks are launched from navigable waters of the United States and may have potential for negative impact on the safety or other interest of waterway users and near shore activities in the event area. The activites include fireworks launched from barges near the shoreline that generally rely on the use of navigable waters as a safety buffer to protect the public from fireworks fallouts and premature detonations. This rulemaking is categorically excluded from further review under

paragraph 34(g) of Figure 2–1 of the Commandant Instruction. A preliminary environmental analysis checklist supporting this determination is available in the docket where indicated under **ADDRESSES**. We seek any comments or information that may lead to the discovery of a significant environmental impact from this proposed rule.

List of Subjects in 33 CFR Part 165

Harbors, Marine safety, Navigation (water), Reporting and recordkeeping requirements, Security measures, Waterways.

For the reasons discussed in the preamble, the Coast Guard proposes to amend 33 CFR part 165 as follows:

PART 165—REGULATED NAVIGATION AREAS AND LIMITED ACCESS AREAS

■ 1. The authority citation for part 165 continues to read as follows:

Authority: 33 U.S.C. 1231; 46 U.S.C. Chapter 701, 3306, 3703; 50 U.S.C. 191, 195; 33 CFR 1.05–1, 6.04–1, 6.04–6, and 160.5; Pub. L. 107–295, 116 Stat. 2064; Department of Homeland Security Delegation No. 0170.1.

■ 2. Revise Table 1 to § 165.1123 to read as follows:

§ 165.1123 Southern California Annual Firework Events for the San Diego Captain of the Port Zone.

* * * * *

[All coordinates referenced use datum NAD 83.]

1. San Diego, CA POPS Fireworks Display	
Sponsor	San Diego Symphony
Event Description	Fireworks Display.
Date	Friday/Saturday/Sunday last weekend of June through first weekend of September.
Location	San Diego Bay South Embarcadero, San Diego, CA.
Regulated Area	800-foot radius safety zone around tug/barge combination located at approximately: 32°42′16″ N, 117°09′59″ W.
2. Fourth of July Fireworks, Mission Bay	
Sponsor	Mission Bay Yacht Club
Event Description	Fireworks Display.
Date	One evening; the first week in July.
Location	Mission Bay, San Diego, CA.
Regulated Area	800-foot radius safety zone around tug/barge combination located at approximately 32°47′00″ N, 117°14′45″ W.
3. Coronado Glorietta Bay Fourth of July Fireworks	
Sponsor	Coronado, CA.
Event Description	Fireworks Display.
Date	One evening; the first week in July.
Location	Glorietta Bay, CA.
Regulated Area	800-foot radius safety zone around a tug/barge combination located at approximately: 32°40′43″ N, 117°10′14″ W.
4. San Diego Parade of Lights Fireworks Display	
Sponsor	Greater Shelter Island Association.
Event Description	Boat Parade/Fireworks display.
Date	Two evenings in December.
Location	San Diego Harbor, San Diego, CA.
Regulated Area	800-foot radius safety zone around a tug/barge combination in the northern portion of the San Diego Main Ship Channel off of Harbor Island located at approximately: 32°43′25″ N, 117°11′50″ W. (Note: see also 33 CFR 100.1101, Table 1, for related marine event).
5. Big Bay Boom Fourth of July Fireworks	
Sponsor	Port of San Diego.
Event Description	Fireworks Display.
Date	One evening; first week in July.
Location	San Diego Bay, San Diego, CA.
Regulated Area	1000-foot radius safety zone around four tug/barge combinations located at approximately: Shelter Island Barge: 32°42′48″ N, 117°13′12″ W. Harbor Island Barge: 32°43′00″ N, 117°12′00″ W. Embarcadero Barge: 32°42′45″ N, 117°10′47″ W. Seaport Village Barge: 32°42′02″ N, 117°10′00″ W.
6. MIDWAY Fireworks	
Sponsor	USS MIDWAY Association.
Event Description	Fireworks Display.
Date	Evening shows throughout the year.
Location	San Diego Bay off the USS MIDWAY, San Diego, CA.
Regulated Area	800-foot radius safety zone around either the tug/barge combination immediately to the west of the USS MIDWAY located at approximately: 32°42′46″ N, 117°10′47″ W or off of the western end of the flight deck of the USS MIDWAY.
7. Sea World Fireworks	
Sponsor	Sea World.
Event Description	Fireworks Display.

[All coordinates referenced use datum NAD 83.]

Date	Nightly; between Memorial Day and Labor Day. Approximately 10 evening shows between Labor Day and Memorial Day, primarily on weekend evenings. Between Thanksgiving and New Year's Day as conditions allow.
Location	Mission Bay/Fiesta Island, San Diego, CA.
Regulated Area	800-foot radius safety zone around a tug/barge combination located at approximately: 32°46′03″ N, 117°13′11″ W.

■ 3. Revise Table 1 to § 165:1124 to read as follows:

§ 165.1124 Annual Firework Events on the Colorado River, between Davis Dam (Bullhead City, Arizona) and Headgate Dam (Parker, Arizona).

* * * * *

[All coordinates referenced use datum NAD 83.]

1. Avi Resort & Casino Memorial Day Fireworks

Sponsor	Avi Resort & Casino.
Event Description	Fireworks Display.
Date	Sunday before Memorial Day.
Location	Laughlin, NV.
Regulated Area	River closure from 8 p.m.–10 p.m. The safety zone includes all navigable waters of the lower Colorado River at Laughlin, NV encompassed by the following coordinates: 35°01′05″ N, 114°38′20″ W; 35°01′05″ N, 114°38′15″ W; along the shoreline to 35°00′50″ N, 114°38′13″ W; 35°00′49″ N, 114°38′18″ W; along the shoreline to 35°01′05″ N, 114°38′20″ W.

2. Laughlin/Bullhead City Rockets Over the River Fireworks

Sponsor	Laughlin Tourism Committee.
Event Description	Fireworks Display. Two events over the 4th of July Weekend. One will be on the 4th and the other will be on a weekend evening closest to the 4th of July.
Date	First week in July.
Location	Laughlin, NV./Bullhead City, AZ.
Regulated Area	The temporary safety zone is specifically defined as all navigable waters of the lower Colorado River at Laughlin, NV encompassed by the following coordinates: 35°09′53″ N, 114°34′15″ W; 35°09′53″ N, 114°34′07″ W; along the shoreline to 35°09′25″ N, 114°34′09″ W; 35°09′06″ N, 114°34′17″ W; along the shoreline to 35°09′53″ N, 114°34′15″ W.

3. Avi Resort & Casino Independence Day Fireworks

Sponsor	Avi Resort & Casino.
Event Description	Fireworks Display.
Date	First week in July.
Location	Laughlin, NV.
Regulated Area	River closure from 8 p.m.–10 p.m. The safety zone includes all navigable waters of the lower Colorado River at Laughlin, NV encompassed by the following coordinates: 35°01′05″ N, 114°38′20″ W; 35°01′05″ N, 114°38′14″ W; along the shoreline to 35°00′50″ N, 114°38′13″ W; 35°00′49″ N, 114°38′18″ W; along the shoreline to 35°01′05″ N, 114°38′20″ W.

4. Avi Resort & Casino Labor Day Fireworks

Sponsor	Avi Resort & Casino.
Event Description	Fireworks Display.
Date	Sunday before Labor Day.
Location	Laughlin, NV.
Regulated Area	River closure from 8 p.m.–10 p.m. The safety zone includes all navigable waters of the lower Colorado River at Laughlin, NV encompassed by the following coordinates: 35°01′05″ N, 114°38′20″ W; 35°01′05″ N, 114°38′15″ W; along the shoreline to 35°00′20″ N, 114°38′13″ W; 35°00′49″ N, 114°38′18″ W; along the shoreline to 35°01′05″ N, 114°38′20″ W.

5. Colorado Belle & Edgewater Hotel/Casino Thanksgiving Fireworks

Sponsor	Edgewater Hotel & Casino.
Event Description	Fireworks Display.
Date	One evening during Thanksgiving week.
Location	Laughlin, NV.
Regulated Area	The temporary safety zone is specifically defined as all navigable waters of the lower Colorado River at Laughlin, NV, from 10 p.m.–12:30 a.m., encompassed by the following coordinates: 35°09′51″ N, 114°34′08″ W; 35°09′53″ N, 114°34′15″ W, along the shoreline to 35°09′31″ N, 114°34′17″ W; 35°09′33″ N, 114°34′08″ W along the shoreline to 35°09′51″ N, 114°34′08″ W.

6. Colorado Belle & Edgewater Hotel/Casino New Years Eve Fireworks

Sponsor	Edgewater Hotel & Casino.
Event Description	Fireworks Display.
Date	New Years Eve.
Location	Laughlin, NV.

[All coordinates referenced use datum NAD 83.]

Regulated Area	The temporary safety zone is specifically defined as all navigable waters of the lower Colorado River at Laughlin, NV, from 10 p.m.–12:30 a.m., encompassed by the following coordinates: 35°09′51″ N, 114°34′08″ W; 35°09′53″ N, 114°34′15″ W along the shoreline to 35°09′31″ N, 114°34′18″ W; 35°09′33″ N, 114°34′08″ W along the shoreline to 35°09′51″ N, 114°34′08″ W.

■ 4. Revise Table 1 to § 165.1191 to read as follows:

§ 165.1191 Northern California and Lake Tahoe Area Annual Fireworks Events.

* * * * *

[All coordinates referenced use datum NAD 83.]

1. San Francisco Giants Fireworks

Sponsor	San Francisco Giants Baseball Team.
Event Description	Fireworks display in conjunction with baseball season home games.
Date	All season home games at AT&T Park.
Location	700 feet off of Pier 48, San Francisco, CA
Regulated Area	100-foot radius around the fireworks launch barge during the loading of pyrotechnics aboard the fireworks barge and during the transit of the fireworks barge from the loading location to the display location. Increases to a 700-foot radius upon commencement of the fireworks display.

2. KFOG KaBoom

Sponsor	KFOG Radio, San Francisco, CA.
Event Description	Fireworks Display.
Date	Second or Third Saturday in May.
Location	1,200 feet off Candlestick Point, San Francisco, CA.
Regulated Area	100-foot radius around the fireworks launch barge during the loading of pyrotechnics aboard the fireworks barge and during the transit of the fireworks barge from the loading location to the display location. Increases to a 1,000-foot radius upon commencement of the fireworks display.

3. Fourth of July Fireworks, City of Eureka

Sponsor	City of Eureka, CA.
Event Description	Fireworks Display.
Date	July 4th.
Location	Humboldt Bay, CA.
Regulated Area	100-foot radius around the fireworks launch barge during the loading of pyrotechnics aboard the fireworks barge and during the transit of the fireworks barge from the loading location to the display location. Increases to a 1,000-foot radius upon commencement of the fireworks display.

4. Fourth of July Fireworks, Crescent City

Sponsor	Crescent City, CA.
Event Description	Fireworks Display.
Date	July 4th.
Location	Crescent City Harbor, Crescent City, CA.
Regulated Area	Crescent City Harbor in the navigable waters within a 700-foot radius of the launch platform located on the West Jetty.

5. Pillar Point Harbor Fireworks

Sponsor	Various sponsors.
Event Description	Fireworks Display.
Date	July 4th.
Location	Half Moon Bay, CA.
Regulated Area	Pillar Point Harbor Beach.

6. Fourth of July Fireworks, Redwood City

Sponsor	Various Sponsors.
Event Description	Fireworks Display.
Date	July 4th.
Location	Redwood City, CA.
Regulated Area	600-foot radius around the fireworks launch platform located on the pier at the Port of Redwood City.

7. San Francisco Independence Day Fireworks

Sponsor	The City of San Francisco.
Event Description	Fireworks Display.
Date	July 4th.
Location 1	A barge located approximately 1000 feet off San Francisco Pier 39 at approximately 37°48′49″ N, 122°24′46″ W.
Location 2	Land based launch at the end of the San Francisco Municipal Pier at Aquatic Park at approximately 37°48′38″ N, 122°25′28″ W.

[All coordinates referenced use datum NAD 83:]

Regulated Area 1	1. 100-foot radius around the fireworks barge during the loading, transit, setup, and until the commencement of the scheduled display. Increases to a 1,000-foot radius upon commencement of the fireworks display.
Regulated Area 2	2. The area of navigable waters within a 1,000-foot radius of the launch platform located on the Municipal Pier.

8. Fourth of July Fireworks, Berkeley Marina

Sponsor	Berkeley Marina.
Event Description	Fireworks Display.
Date	July 4th.
Location	Berkeley Pier, Berkeley, CA.
Regulated Area	The area of navigable waters within a 1,000-foot radius of the launch platform located on the Berkeley Pier.

9. Fourth of July Fireworks, City of Richmond

Sponsor	City of Richmond.
Event Description	Fireworks Display.
Date	Week of July 4th.
Location	Richmond Harbor, Richmond, CA.
Regulated Area	The area of navigable waters within a 560-foot radius of the launch platform located at Lucretia Edwards Park.

10. Fourth of July Fireworks, City of Sausalito

Sponsor	City of Sausalito.
Event Description	Fireworks Display.
Date	July 4th.
Location	1,000 feet off-shore from Sausalito, CA waterfront, north of Spinnaker Restaurant.
Regulated Area	100-foot radius around the fireworks launch barge during the loading of pyrotechnics aboard the fireworks barge and during the transit of the fireworks barge from the loading location to the display location. Increases to a 1,000-foot radius upon commencement of the fireworks display.

11. Fourth of July Fireworks, City of Martinez

Sponsor	City of Martinez.
Event Description	Fireworks Display.
Date	July 4th.
Location	Carquinez Strait, CA.
Regulated Area	The area of navigable waters within a 560-foot radius of the launch platform located near Waterfront Park.

12. Fourth of July Fireworks, City of Antioch

Sponsor	City of Anticch.
Event Description	Fireworks Display.
Date	July 4th.
Location	San Joaquin River, CA.
Regulated Area	100-foot radius around the fireworks launch barge during the loading of pyrotechnics aboard the fireworks barge and during the transit of the fireworks barge from the loading location to the display location. Increases to a 1,000-foot radius upon commencement of the moving fireworks display.

13. Fourth of July Fireworks, City of Pittsburg

Sponsor	City of Pittsburg.
Event Description	Fireworks Display.
Date	July 4th.
Location	Suisun Bay, CA.
Regulated Area	The area of navigable waters within a 560-foot radius of the launch platform located on a Pittsburg Marina Pier.

14. Delta Independence Day Celebration Fireworks

Sponsor	Various Sponsors.
Event Description	Fireworks Display.
Date	Week of July 4th.
Location	San Joaquin River, near Mandeville Island, CA.
Regulated Area	100-foot radius around the fireworks launch barge during the loading of pyrotechnics aboard the fireworks barge and during the transit of the fireworks barge from the loading location to the display location. Increases to a 1,000-foot radius upon commencement of the fireworks display.

15. Fourth of July Fireworks, Tahoe City, CA

Sponsor	Various Sponsors.
Event Description	Fireworks Display.
Date	July 4th.
Location	Off-shore from Common Beach, Tahoe City, CA.
Regulated Area	100-foot radius around the fireworks launch barge during the loading of pyrotechnics aboard the fireworks barge and during the transit of the fireworks barge from the loading location to the display location. Increases to a 1,000-foot radius upon commencement of the fireworks display.

[All coordinates referenced use datum NAD 83.]

16. Fourth of July Fireworks, Glenbrook NV

Sponsor	Various Sponsors.
Event Description	Fireworks Display.
Date	July 4th.
Location	Off-shore Glenbrook Beach, NV.
Regulated Area	100-foot radius around the fireworks launch barge during the loading of pyrotechnics aboard the fireworks barge and during the transit of the fireworks barge from the loading location to the display location. Increases to a 1,000-foot radius upon commencement of the fireworks display.

17. Independence Day Fireworks, Kings Beach, CA

Sponsor	North Tahoe Business Association.
Event Description	Fireworks Display.
Date	Week of July 4th.
Location	Off-shore from Kings Beach, CA.
Regulated Area	100-foot radius around the fireworks launch barge during the loading of pyrotechnics aboard the fireworks barge and during the transit of the fireworks barge from the loading location to the display location. Increases to a 1,000-foot radius upon commencement of the fireworks display.

18. Lights on the Lake Fourth of July Fireworks, South Lake Tahoe, CA

Sponsor	Various Sponsors.
Event Description	Fireworks Display.
Date	Week of July 4th.
Location	Off South Lake Tahoe, CA near the NV Border.
Regulated Area	100-foot radius around the fireworks launch barge during the loading of pyrotechnics aboard the fireworks barge and during the transit of the fireworks barge from the loading location to the display location. Increases to a 1,000-foot radius upon commencement of the fireworks display.

19. Red, White, and Tahoe Blue Fireworks, Incline Village, NV

Sponsor	Various Sponsors.
Event Description	Fireworks Display.
Date	Week of July 4th.
Location	500–1,000 feet off Incline Village, NV in Crystal Bay.
Regulated Area	100-foot radius around the fireworks launch barge during the loading of pyrotechnics aboard the fireworks barge and during the transit of the fireworks barge from the loading location to the display location. Increases to a 1,000-foot radius upon commencement of the fireworks display.

20. Labor Day Fireworks, South Lake Tahoe, CA

Sponsor	Various Sponsors.
Event Description	Fireworks Display.
Date	Labor Day.
Location	Off South Lake Tahoe, California near the Nevada Border.
Regulated Area	100-foot radius around the fireworks launch barge during the loading of pyrotechnics aboard the fireworks barge and during the transit of the fireworks barge from the loading location to the display location. Increases to a 1,000-foot radius upon commencement of the fireworks display.

21. Fleet Week Fireworks

Sponsor	Various Sponsors.
Event Description	Fireworks Display.
Date	Second Friday and Saturday in October.
Location	1,000 feet off Pier 3, San Francisco, CA.
Regulated Area	100-foot radius around the fireworks launch barge during the loading of pyrotechnics aboard the fireworks barge and during the transit of the fireworks barge from the loading location to the display location. Increases to a 1,000-foot radius upon commencement of the fireworks display.

22. Monte Foundation Fireworks

Sponsor	Monte Foundation Fireworks.
Event Description	Fireworks Display.
Date	Second Saturday in October.
Location	Sea Cliff State Beach Pier in Aptos, CA.
Regulated Area	1,000-foot safety zone around the navigable waters of the Sea Cliff State Beach Pier.

23. Rio Vista Bass Derby Fireworks

Sponsor	Rio Vista Chamber of Commerce.
Event Description	Fireworks Display.
Date	Second Saturday in October.
Location	500 feet off Rio Vista, CA waterfront.

[All coordinates referenced use datum NAD 83.]

Regulated Area	100-foot radius around the fireworks launch barge during the loading of pyrotechnics aboard the fireworks barge and during the transit of the fireworks barge from the loading location to the display location. Increases to a 1,000-foot radius upon commencement of the fireworks display.

24. San Francisco New Years Eve Fireworks

Sponsor	City of San Francisco.
Event Description	Fireworks Display.
Date	New Years Eve, December 31st.
Location	1,000 feet off the Embarcadero near the Ferry Plaza, San Francisco, CA.
Regulated Area	100-foot radius around the fireworks launch barge during the loading of pyrotechnics aboard the fireworks barge and during the transit of the fireworks barge from the loading location to the display location. Increases to a 1,000-foot radius upon commencement of the fireworks display.

25. Sacramento New Years Eve Fireworks

Sponsor	Various Sponsors.
Event Description	Fireworks Display.
Date	New Years Eve, December 31st.
Location	Near Tower Bridge, Sacramento River.
Regulated Area	The navigable waters of the Sacramento River within 700 feet of the two shore-based launch locations in approximate positions 38°34′48″ N, 121°30′38″ W and 38°34′49″ N, 121°30′29″ W.

26. Jameson Beach Fourth of July Fireworks

Sponsor	Various Sponsors
Event Description	Fireworks Display.
Date	Week of July 4th.
Location	South Lake Tahoe near Jameson Beach.
Regulated Area	100-foot radius around the fireworks barge during the loading, transit, setup, and until the commencement of the scheduled display. Increases to a 560-foot radius upon commencement of the fireworks display.

27. Feast of Lanterns Fireworks

Sponsor	Feast of Lanterns, Inc.
Event Description	Fireworks Display.
Date	Last Saturday of July.
Location	Near Lover's Point Park in Pacific Grove, CA.
Regulated Area	The area of navigable waters within a 490-foot radius of the launch platform located on the beach near Lover's Point Park in approximate position 36°37′26″ N, 121°54′54″ W.

Dated: September 6, 2013.

K.L. Schultz,

Rear Admiral, U.S. Coast Guard, Commander, Eleventh Coast Guard District.

[FR Doc. 2013–29367 Filed 12–9–13; 8:45 am]

BILLING CODE 9110–04–P

ARCHITECTURAL AND TRANSPORTATION BARRIERS COMPLIANCE BOARD

36 CFR Part 1192

[Docket No. ATBCB–2013–0001]

RIN 3014–AA42

Rail Vehicles Access Advisory Committee

AGENCY: Architectural and Transportation Barriers Compliance Board.

ACTION: Notice of advisory committee meeting.

SUMMARY: On May 23, 2013, we, the Architectural and Transportation Barriers Compliance Board (Access Board), established the Rail Vehicle Access Advisory Committee (Committee) to advise us on revising and updating our accessibility guidelines issued pursuant to the Americans with Disabilities Act for transportation vehicles that operate on fixed guideway systems (e.g., rapid rail, light rail, commuter rail, intercity rail, and high speed rail). The Committee will hold its second meeting on the following dates and times.

DATES: The Committee will meet on January 9, 2014, from 10:00 a.m. to 5:00 p.m. and on January 10, 2014, from 9:00 a.m. to 3:00 p.m.

ADDRESSES: The meeting will be held at the Access Board Conference Room, 1331 F Street NW., Suite 800, Washington, DC 20004–1111. Call-in information and a communication access real-time translation (CART) web streaming link will be posted on the Access Board's Rail Vehicles Access Advisory Committee Web site page at *www.access-board.gov/rvaac* prior to the meeting.

FOR FURTHER INFORMATION CONTACT: Paul Beatty, Office of Technical and Information Services, Access Board, 1331 F Street NW., Suite 1000, Washington, DC 20004–1111. Telephone number (202) 272–0012 (Voice); (202) 272–0072 (TTY). Electronic mail address: *rvaac@access-board.gov*.

SUPPLEMENTARY INFORMATION: On May 23, 2013, we published a notice establishing a Rail Vehicles Access Advisory Committee (Committee) to make recommendations to us on matters associated with revising and updating our accessibility guidelines issued pursuant to the Americans with Disabilities Act for transportation vehicles that operate on fixed guideway systems (e.g., rapid rail, light rail, commuter rail, intercity rail, and high speed rail). See 78 FR 30828 (May 23, 2013).

The Committee will hold its second meeting on January 9, 2014, from 10:00 a.m. to 5:00 p.m. and on January 10, 2014, from 9:00 a.m. to 3:00 p.m. The agenda for the January meeting includes: Educational presentations; deliberation of committee member concerns pertaining to the accessibility

of rail vehicles; and the consideration of process-related matters. The preliminary meeting agenda, along with information about the Committee, is available on our Web site (*www.access-board.gov/rvaac*).

Committee meetings will be open to the public and interested persons can attend the meetings and communicate their views. Members of the public will have opportunities to address the Committee on issues of interest to them during public comment periods scheduled on each day of the meeting. Members of groups or individuals who are not members of the Committee may also have the opportunity to participate in subcommittees if subcommittees are formed.

The meetings will be accessible to persons with disabilities. An assistive listening system, communication access real-time translation (CART), and sign language interpreters will be provided. Persons attending the meetings are requested to refrain from using perfume, cologne, and other fragrances for the comfort of other participants (see *www.access-board.gov/the-board/policies/fragrance-free-environment* for more information).

Persons wishing to provide handouts or other written information to the Committee are requested to provide electronic formats to Paul Beatty via email at least five business days prior to the meetings so that alternate formats can be distributed to Committee members.

David M. Capozzi,

Executive Director.

[FR Doc. 2013–29457 Filed 12–9–13; 8:45 am]

BILLING CODE 8150–01–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[EPA–R09–OAR–2013–0778; FRL–9904–00–Region 9]

Disapproval of State Implementation Plan Revisions; Clark County, Nevada

AGENCY: Environmental Protection Agency (EPA).

ACTION: Proposed rule.

SUMMARY: The EPA is proposing to disapprove revisions to the Clark County portion of the Nevada State Implementation Plan (SIP). The SIP contains state and local regulations necessary to meet requirements of the Clean Air Act (CAA or the Act). We are proposing to disapprove a submission that would revise the SIP to include affirmative defense provisions applicable to violations related to excess emissions during equipment startup, shutdown and malfunction (SSM) events. We are taking comments on this proposal and plan to follow with a final action.

DATES: Any comments must arrive by January 9, 2014.

ADDRESSES: Submit comments, identified by docket number EPA–R09–OAR–2013–0778, by one of the following methods:

1. *Federal eRulemaking Portal: www.regulations.gov.* Follow the on-line instructions.
2. *Email: steckel.andrew@epa.gov.*
3. *Mail or deliver:* Andrew Steckel (Air-4), U.S. Environmental Protection Agency Region IX, 75 Hawthorne Street, San Francisco, CA 94105–3901.

Instructions: All comments will be included in the public docket without change and may be made available online at *www.regulations.gov,* including any personal information provided, unless the comment includes Confidential Business Information (CBI) or other information whose disclosure is restricted by statute. Information that you consider CBI or otherwise protected should be clearly identified as such and should not be submitted through *www.regulations.gov* or email. *www.regulations.gov* is an "anonymous access" system, and EPA will not know your identity or contact information unless you provide it in the body of your comment. If you send email directly to EPA, your email address will be automatically captured and included as part of the public comment. If EPA cannot read your comment due to technical difficulties and cannot contact you for clarification, EPA may not be able to consider your comment. Electronic files should avoid the use of special characters, any form of encryption, and be free of any defects or viruses.

Docket: Generally, documents in the docket for this action are available electronically at *www.regulations.gov* and in hard copy at EPA Region IX, 75 Hawthorne Street, San Francisco, California. While all documents in the docket are listed at *www.regulations.gov*, some information may be publicly available only at the hard copy location (e.g., copyrighted material, large maps), and some may not be publicly available in either location (e.g., CBI). To inspect the hard copy materials, please schedule an appointment during normal business hours with the contact listed in the **FOR FURTHER INFORMATION CONTACT** section.

FOR FURTHER INFORMATION CONTACT: Idalia Perez, EPA Region IX, (415) 972–3248, *perez.idalia@epa.gov.*

SUPPLEMENTARY INFORMATION: Throughout this document "we," "us," and "our" refer to EPA.

Outline

I. The State's Submittal

A. What regulation did the State submit?

Table 1 identifies the section of the Clark County Air Quality Regulations (CCAQR) proposed for disapproval, with the dates that it was amended by the Clark County Board of Commissioners (CCBC) and submitted to EPA on behalf of the Clark County Department of Air Quality and Environmental Management (DAQEM) by the State of Nevada Division of Environmental Protection (NDEP).

TABLE 1—SUBMITTED REGULATION

Local agency	Regulation number and title	Amended	Submitted
DAQEM	Section 25: Affirmative Defense for Excess Emissions Due to Malfunctions, Startups, and Shutdown.	May 18, 2010	September 1, 2010.

On March 1, 2011, NDEP's September 1, 2010 submission was deemed complete by operation of law, pursuant to CAA section 110(k)(1).

The CCBC also decided to adopt or amend other sections of the CCAQR, primarily addressing air pollution permit procedures, at the same May 18, 2010 CCBC hearing, and included these revisions in the same September 1, 2010 SIP submission. EPA has already taken action upon the other revisions in the September 1, 2010 SIP submission. EPA proposed a limited approval and limited disapproval of these other revisions on July 24, 2012 (77 FR 43206) and finalized the limited approval and limited disapproval on October 18, 2012 (77 FR 6403). EPA did not address the revisions to CCAQR Section 25 in the July 24, 2012 proposal or October 18, 2012 final action. Today's action addresses the remaining portion of NDEP's September 1, 2010 submission, specifically CCAQR Section 25.

B. Are there other versions of the submitted regulation?

We are not certain when CCBC originally adopted Section 25, but CCBC has amended it at the local level many times, most recently on May 18, 2010.[1] EPA has not previously approved a version of Section 25 into the Nevada SIP.[2] Therefore, the May 18, 2010 version of Section 25 is a new submittal to the SIP and is not replacing or amending pre-existing requirements already approved into the SIP. EPA is today reviewing only the May 18, 2010 version of Section 25 and the relevant materials associated with it that were included in NDEP's September 1, 2010 SIP submittal.

C. What is the purpose of the submitted regulation?

Section 25 and the other CCAQR sections submitted on September 1, 2010 are part of DAQEM's overall program intended to control the health and environmental impacts of air pollution. Specifically, CCAQR Section 25 describes the procedures by which air pollution sources may assert an affirmative defense for violations that result from excess emissions due to SSM events. CAA Section 110 describes procedures for States to develop and submit various air pollution regulations to EPA as part of SIP revisions. EPA interprets the CAA to authorize a state to elect to create narrowly drawn affirmative defense provisions applicable to malfunctions, consistent with EPA guidance. Accordingly, the Section 25 provision submitted by Clark County is not required by the CAA, but may be submitted to EPA under CAA section 110(a).

D. What does the submitted regulation provide?

CCAQR Section 25 establishes affirmative defenses applicable to violations that result from excess emissions. Section 25.1 states that affirmative defenses for certain excess emissions are available in the case of violations of all emission standards and limitations, except those specifically listed in Section 25.1.1(a) through (d), which are primarily emission limits or standards related to federal requirements under the CAA. For example, EPA interprets the exceptions from 25.1.1(a) to provide that Section 25 does not operate to create any affirmative defense applicable to violations of any EPA standards promulgated pursuant to CAA section 111.

Section 25.2 states that emissions in excess of emission limits that were caused by equipment malfunction constitute a violation. However, a source is provided an affirmative defense from civil and administrative enforcement (except injunctive relief) for these violations if it meets the reporting requirements in Section 25.6 and demonstrates compliance with Sections 25.2.1(a) through (j), which require that: (a) The excess emissions resulted from a sudden and unavoidable equipment breakdown beyond reasonable control; (b) equipment was well maintained and operated; (c) equipment was repaired expeditiously; (d) excess emissions were minimized; (e) excess emission impacts were minimized; (f) there was no recurring pattern of excess emissions; (g) ambient air quality standards were not exceeded; (h) the excess emissions could not have been foreseen or avoided; (i) emission monitoring systems were operated if practicable; and (j) the response to the excess emissions was documented by contemporaneous records.

Section 25.3 similarly states that emissions in excess of emission limits that were caused by equipment startup and shutdown constitute a violation. However, a source is provided an affirmative defense from civil and administrative enforcement (except injunctive relief) for these violations if it meets the reporting requirements in Section 25.6 and demonstrates compliance with Sections 25.3.1(a) through (h), which require that: (a) The excess emissions could not have been prevented through prudent planning and design; (b) if the excess emissions resulted from a bypass of control equipment, the bypass was unavoidable to prevent loss of life, personal injury or severe property damage; (c) equipment was well maintained and operated; (d) excess emissions were minimized; (e) excess emission impacts were minimized; (f) ambient air quality standards were not exceeded; (g) emission monitoring systems were operated if practicable; and (h) the response to the excess emissions was documented by contemporaneous records. Section 25.3.2 notes that if excess emissions occur during scheduled startup and shutdown, then those instances shall be treated as other malfunctions subject to Section 25.2.

Section 25.4 states that if excess emissions occur due to a malfunction during scheduled maintenance, then that exceedance will be treated the same as other malfunctions subject to 25.2.

To obtain an affirmative defense, Section 25.5 requires sources to demonstrate, through information required by Section 25.6, that all reasonable measures were implemented to prevent the excess emissions.

Section 25.6 requires air pollution sources to report to DAQEM regarding emissions in excess of permit limits by: (a) a notification within 24 hours of learning of the excess emissions; and (b) a report containing the information required by Section 25.6.3 within 72 hours of the initial notification. Section 25.6.2 accelerates these reporting deadlines where emissions pose imminent and substantial danger. Section 25.6.3 specifies that the report must describe the emissions including: (a) location; (b) magnitude; (c) time and duration; (d) type of equipment; (e) cause; (f) steps taken to remedy and prevent future malfunction; (g) steps taken to limit emissions; and (h) steps taken to comply with applicable permit procedures. In the case of continuing or recurring excess emissions, Section 25.6.4 states that the notification requirements in Sections 25.6.1 and 25.6.2 will be satisfied if the source provides notification after excess emissions are first detected and includes in the notification an estimate of the time the excess emissions will continue.

[1] "CCAQR Section 25: Affirmative Defense for Excess Emissions Due to Malfunctions, Startups, and Shudown," as adopted by CCBC on May 18, 2010, page 25–4.

[2] CCBC previously submitted a version of Section 25, which EPA disapproved on March 20, 1984. See 49 FR 10259, March 20, 1984 (previous disapproval of Clark Section 25). See also 69 FR 54006 at 54007 and 54018, September 7, 2004 (partial approval/disapproval of Clark New Source Review program); 77 FR 14862 at 14884, March 13, 2012 (revised format for Nevada SIP incorporation by reference); and 40 CFR 52.1483.

II. EPA's Evaluation Criteria

A. General Framework for State Submittal and EPA Review of SIP Revisions

Under the principle of cooperative federalism, both states and EPA have authorities and responsibilities under the CAA with respect to SIPs. Pursuant to CAA section 109, 42 U.S.C. 7409, EPA promulgates National Ambient Air Quality Standards (NAAQS) for criteria pollutants, the attainment and maintenance of which are considered requisite to protect the public health and welfare. CAA section 107(a) assigns states the primary responsibility for assuring that the NAAQS are attained and maintained, and CAA section 110(a)(1), 42 U.S.C. 7410(a)(1), requires states to develop and submit to EPA, SIPs which provide for NAAQS implementation, maintenance, and enforcement. CAA section 110(a)(2), 42 U.S.C. 7410(a)(2), requires each SIP to meet the requirements listed in section 110(a)(2)(A) through (M).

In developing SIPs, states have broad authority to develop the mix of emission limitations they deem best suited for the particular situation, but this discretion is not unbridled. Under CAA section 110(k), EPA is required to determine whether or not SIP submissions in fact meet all applicable requirements of the Act. EPA is authorized to approve, disapprove, partially approve and partially disapprove, or conditionally approve each SIP submission, as appropriate. When a SIP submission does not meet the applicable requirements of the CAA, EPA is obligated to disapprove it, in whole or in part, as appropriate.

CAA sections 110(l) and 193 impose additional requirements upon EPA when reviewing a state's proposed SIP revision. CAA section 110(l), 42 U.S.C. 7410(l), provides that EPA may not approve a SIP revision if it "would interfere with any applicable requirement concerning attainment and reasonable further progress, or any other applicable requirement of this chapter." In addition, CAA section 193 prohibits SIP revisions that would affect control measures in effect prior to the 1990 CAA amendments in any area that is designated nonattainment for any NAAQS, unless the modification insures equivalent to greater emission reductions of such air pollutant.

B. Specific Framework for Evaluating SIP Provisions Regarding Excess Emissions

The general framework summarized above underlies EPA's evaluation of SIP submissions as they relate to provisions related to excess emissions. EPA has a longstanding interpretation of the CAA with respect to the treatment in SIPs of excess emissions during SSM events. Central to EPA's interpretation are the definitions of "emission limitation" and "emission standard" contained in CAA section 302(k), 42 U.S.C. 7602(k), which are defined as limitations that must be met on a continuous basis. Under CAA section 110(a)(2)(A), 42 U.S.C. 7410(a)(2)(A), each SIP must include enforceable emission limitations and other control measures as may be necessary or appropriate to meet applicable CAA requirements. In addition, under CAA section 110(a)(2)(C), 42 U.S.C. 7410(a)(2)(C), each SIP must provide for the enforcement of the measures described in CAA section 110(a)(2)(A) and provide for the regulation of sources as necessary to ensure the attainment and maintenance of the NAAQS and protection of Prevention of Significant Deterioration (PSD) increments.

While the CAA requires that emission limitations in a SIP must be met on a "continuous" basis, practical realities or circumstances may create difficulties in meeting a legally required emission limit continuously 100% of the time. Case law holding that technology-based standards should account for the practical realities of technology supports EPA's view that an enforcement program under a SIP that incorporates some level of flexibility is reasonable and consistent with the overall intent of the CAA.[3] While EPA views all excess emissions as violations of emission limitations or emission standards, we recognize that, in certain situations, imposition of a civil penalty for sudden and unavoidable malfunctions caused by circumstances entirely beyond a source's control may not be appropriate.

In addressing excess emissions due to sudden and unavoidable malfunctions, EPA has provided guidance on three approaches states may elect to use: (1) Traditional enforcement discretion; (2) SIP provisions that address the exercise of enforcement discretion by state personnel; and (3) SIP provisions that provide a narrowly tailored affirmative defense to civil penalties. Under the first approach, the State (or another entity, such as EPA, seeking to enforce a violation of the SIP) may consider the circumstances surrounding the event in determining whether to pursue enforcement. Under the second approach, states may elect to create SIP provisions that provide parameters for the exercise of enforcement discretion by state personnel, so long as they do not adversely affect enforcement by EPA or citizens. Under the third approach, states may elect to create SIP provisions that establish an affirmative defense that may be raised by the defendant in the context of an enforcement proceeding for civil penalties (not injunctive relief), if the defendant has proven that certain criteria have been met.

Most relevant to this action, EPA interprets the CAA to allow SIP provisions that provide an affirmative defense, so long as they are appropriately drawn. EPA has issued guidance specifically concerning affirmative defense provisions in SIPs.[4] EPA guidance recommends criteria that it considers necessary to assure that the affirmative defense is consistent with CAA requirements for SIP provisions. EPA believes that narrowly-tailored affirmative defense provisions can supply flexibility both to ensure that emission limitations are "continuous" as required by CAA section 302(k), because any violations remain subject to a claim for injunctive relief, and to provide limited relief for penalties for malfunctions that are beyond the source's control where the source has taken necessary steps to minimize the likelihood and extent of any such violation. Several courts have agreed with this approach.[5] Neither the enforcement discretion nor the affirmative defense approaches may waive reporting requirements for the violation. States are not required to employ an affirmative defense approach, but if they choose to do so,

[3] *See, e.g., Essex Chemical* v. *Ruckelshaus*, 486 F.2d 427, 433 (D.C. Cir. 1973); and *Portland Cement Association* v. *Ruckelshaus*, 486 F.2d 375 (D.C. Cir. 1973).

[4] See Memorandum dated September 20, 1999, from Steven A. Herman, Assistant Administrator for Enforcement and Compliance Assurance, and Robert Perciasepe, Assistant Administrator for Air and Radiation, entitled "State Implementation Plans: Policy Regarding Excess Emissions During Malfunctions, Startup, and Shutdown" ("1999 Policy"), pg. 3 of the Attachment. EPA notes that at the time of the 1999 SSM Policy, EPA interpreted the CAA to allow such affirmative defense provisions not only in the case of malfunctions, but also in the case of startup and shutdown. For the reasons explained later in this proposal, EPA no longer interprets the CAA to permit affirmative defense provisions for events other than malfunctions, because it believes that sources should be expected to meet applicable emission limits during normal modes of source operation or for appropriate alternative emission limits to apply during such normal modes of source operation.

[5] See, *Luminant Generation Co.* v. *EPA*, 714 F.3d 841 (5th Cir. 2013) (upholding the EPA's approval of an affirmative defense applicable during malfunctions in a SIP submission as a permissible interpretation of the statute under Chevron step 2 analysis), *cert denied*, 187 L. Ed. 2d 45 (October 7, 2013); *Mont. Sulphur & Chemical Co.* v. *EPA*, 666 F.3d 1174 (9th Cir. 2012); and *Ariz. Public Service Co.* v. *EPA*, 562 F.3d 1116, 1130 (9th Cir. 2009).

EPA will evaluate the state's SIP provisions for consistency with the Act as interpreted by our policy and guidance, including those documents listed in section II.C below.

In CCAQR Section 25 as submitted, DAQEM has elected to create an affirmative defense provision applicable to excess emissions for SSM events. EPA acknowledges that DAQEM attempted to develop these affirmative defenses in NDEP's September 1, 2010 SIP submittal consistent with EPA guidance at that time. However, EPA has reexamined its interpretation of the CAA with respect to affirmative defenses and accordingly believes that such affirmative defenses are only appropriate in the case of unplanned events like malfunctions, not in the case of planned events such as startup and shutdown for which sources should be expected to comply with applicable SIP emission limitations. Under CAA sections 110(k) and 110(l), EPA is obligated to determine whether SIP submissions in fact meet CAA requirements and our interpretation of the Act at the time EPA takes action on a SIP submission.

C. What documents did we use in our evaluation?

EPA's interpretation of the Act as it applies to SIP provisions that address excess emissions occurring during SSM periods is set forth in a series of guidance documents. These include: (1) A memorandum dated September 28, 1982, from Kathleen M. Bennett, Assistant Administrator for Air, Noise, and Radiation, entitled "Policy on Excess Emissions During Startup, Shutdown, Maintenance, and Malfunctions" (1982 Policy); (2) a memorandum dated February 15, 1983, from Kathleen M. Bennett, Assistant Administrator for Air, Noise, and Radiation, also entitled, "Policy on Excess Emissions During Startup, Shutdown, Maintenance, and Malfunctions" (1983 Policy); (3) a memorandum dated September 20, 1999, from Steven A. Herman, Assistant Administrator for Enforcement and Compliance Assurance, and Robert Perciasepe, Assistant Administrator for Air and Radiation, entitled "State Implementation Plans: Policy Regarding Excess Emissions During Malfunctions, Startup, and Shutdown" (1999 Policy); and (4) a memorandum dated December 5, 2001, from Eric Schaeffer, Director, Office of Regulatory Enforcement, Office of Enforcement and Compliance Assurance, and John S. Seitz, Director, Office of Air Quality Planning and Standards, Office of Air and Radiation, entitled, "Re-Issuance of Clarification—State Implementation Plans (SIPs): Policy Regarding Excess Emissions During Malfunctions, Startup, and Shutdown" (2001 Policy).

EPA's interpretation of the CAA with respect to SIP provisions that address excess emissions during SSM events has been applied in rulemaking, including, but not limited to: (1) EPA's "Approval and Promulgation of Implementation Plans; Texas; Excess Emissions During Startup, Shutdown, Maintenance, and Malfunction Activities," 75 FR 68989 (Nov. 10, 2010); (2) EPA's "Federal Implementation Plan for the Billings/Laurel, MT, Sulfur Dioxide Area," 73 FR 21418 (Apr. 21, 2008); and (3) EPA's "Finding of Substantial Inadequacy of Implementation Plan: Call for Utah State Implementation Plan Revision," April 18, 2011 (76 FR 21639).

In addition, EPA recently issued a proposal in response to a petition for rulemaking concerning CAA requirements for SIP provisions that address excess emissions, reiterating EPA's interpretation of the CAA with respect to such provisions.[6] In this recent action, EPA specifically addressed the CAA requirements with respect to SIP provisions that provide an affirmative defense for violations of emission limitations due to excess emissions during SSM events.

A copy of each document listed in this section is available in the docket for this rulemaking.

III. EPA's Evaluation and Action

A. Does the regulation meet the evaluation criteria?

NDEP's September 1, 2010 submission of CCAQR Section 25 fails to meet the evaluation criteria in at least two significant respects.

First, Sections 25.1 and 25.3 are inconsistent with the requirements provided in CAA section 110(a) and conflict with the fundamental enforcement structure provided in CAA sections 113 and 304, because they create an affirmative defense for violations due to excess emissions during startup and shutdown. EPA believes that providing affirmative defenses for avoidable violations, such as those resulting from excess emissions during planned events such as startups and shutdowns, that are within the source's control, is inconsistent with the requirements provided in CAA section 110(a) and the fundamental enforcement structure provided in CAA sections 113 and 304,[7] which provide for potential civil penalties for violations of SIP requirements.[8]

By contrast, SIP provisions providing affirmative defenses can be appropriate for malfunctions because, by definition and unlike planned startups and shutdowns, malfunctions are unforeseen and could not have been avoided by the source, and the source will have taken steps to prevent the violation and to minimize the effects of the violation after it occurs. In such circumstances, EPA interprets the Act to allow narrowly drawn affirmative defense provisions that may provide relief from civil penalties (but not injunctive relief) to sources, when their conduct justifies this relief.[9] Such is not the case with planned and predictable events, such as startups and shutdowns, during which sources should be expected to comply with applicable SIP emission limitations and should not be accorded relief from civil penalties if they fail to do so.[10] Providing an affirmative defense for monetary penalties for violations that result from planned events is inconsistent with the basic premise that the excess emissions were beyond the source's control, and thus is diametrically opposed to the intended purpose of such an affirmative defense to encourage better compliance even by sources for which 100% compliance is not possible.

Second, the criteria for obtaining an affirmative defense for excess emissions during malfunctions in CCAQR Section 25.2 are not fully consistent with CAA requirements. EPA has guidance making recommendations for criteria appropriate for affirmative defense provisions that would be consistent with the CAA. EPA's 1999 Policy and the February 22, 2013 Proposed SSM SIP Call lay out these criteria. These are

[6] See State Implementation Plans: Response to Petition for Rulemaking; Findings of Substantial Inadequacy; and SIP Calls To Amend Provisions Applying to Excess Emissions During Periods of Startup, Shutdown, and Malfunction, February 22, 2013 (78 FR 12460) ("February 22, 2013 Proposed SSM SIP Calls"); see also EPA's February 4, 2013 Statutory, Regulatory, and Policy Context Memorandum for the February 22, 2013 Proposed SSM SIP Calls.

[7] *See, Luminant Generation Co.* v. *EPA*, 714 F.3d 841 (5th Cir. 2013) (upholding the EPA's approval of an affirmative defense applicable during malfunctions in a SIP submission as a permissible interpretation of the statute under Chevron step 2 analysis), *cert denied*, 187 L. Ed. 2d 45 (October 7, 2013); *See also*, EPA's February 22, 2013 Proposed SIP Calls (78 FR 12460, 12480).

[8] See EPA's February 22, 2013 Proposed SIP Calls (78 FR 12460, 12480).

[9] See EPA's February 22, 2013 Proposed SIP Calls (78 FR 12460, 12478).

[10] EPA notes that a state can elect to adopt alternative emission limitations that apply to normal modes of source operation, such as startup and shutdown, so long as these provisions are consistent with CAA requirements. EPA's February 22, 2013 Proposed SSM SIP Calls provides guidance on how such SIP provisions may be developed to meet CAA requirements.

guidance recommendations and states do not need to track EPA's recommended wording verbatim, but states should have SIP provisions that are consistent with these recommendations in order to assure that the affirmative defense meets CAA requirements. The affirmative defense criteria set forth in Section 25.2.1 are not sufficiently consistent with these recommended criteria for affirmative defense provisions in SIPs for malfunctions.

Specifically, EPA's guidance notes that affirmative defenses are "not appropriate for areas and pollutants where a single source or small group of sources has the potential to cause an exceedance of the NAAQS or PSD increments." [11] CCAQR Section 25.2.1(g) states that sources with emissions in excess of an applicable emission limitation due to a malfunction have an affirmative defense if the source has demonstrated (among other things) that "During the period of excess emissions there were no exceedances of the relevant ambient air quality standards established in Section 11 that could be attributed to the emitting source." This deviates from EPA's guidance because CCAQR Section 11.2 was adopted and submitted in 2003 and lists "relevant ambient air quality standards" that do not account for all of the NAAQS promulgated since the regulation was approved into the SIP in 2004.[12] As a result, CCAQR Section 25.2 would allow an affirmative defense for an exceedance of an applicable emission limitation even if that exceedance violated a NAAQS that is not listed in CCAQR Section 11.2.[13]

In addition, Section 25.2.1(g) is not fully consistent with CAA requirements because it fails to include consideration of the impacts of excess emissions during a malfunction on the PSD increments. As noted above, Section 25.2.1(g) only mentions the relevant ambient air quality standards in Section 11, and Section 11 also does not mention the PSD increments. SIP requirements are not limited to those specific requirements for designated nonattainment areas; SIPs must also meet requirements related to PSD in attainment areas. Similarly, SIP provisions addressing affirmative defense provisions cannot be limited exclusively to impacts on nonattainment areas.

B. EPA Recommendations To Improve the Regulation

CCAQR Section 25.6 requires sources to provide information to DAQEM regarding excess emissions caused by SSM. Such reporting would enable DAQEM to review, evaluate, and utilize the information as a tool in its air quality planning and management efforts and help provide for attainment and maintenance of the NAAQS and other applicable requirements of the Act. This reporting would also facilitate effective enforcement, if appropriate. As a result, while it is not appropriate at this time for EPA to separately approve Section 25.6 as submitted in context of the overall Section 25, EPA would support a SIP revision creating such reporting requirements, independent of the problematic affirmative defense provisions elsewhere in Section 25.

As stated in Section II.B and elsewhere above, EPA interprets the CAA to allow only narrowly drawn affirmative defense provisions that are available for events that are entirely beyond a source's control. Thus, an affirmative defense may be appropriate for events like malfunctions, which are sudden and unavoidable events that cannot be foreseen or planned for. The underlying premise for an affirmative defense provision is that the source is properly designed, operated and maintained, and could not have taken action to prevent the exceedance. Because a qualifying source could not have foreseen or prevented the event, the affirmative defense is available to provide relief from monetary penalties that could result from an event beyond a source's control. Therefore, it may be possible for DAQEM to revise Section 25 to provide an affirmative defense for malfunctions consistent with CAA requirements, as recommended in EPA's SSM Policy.

The legal and factual basis supporting the concept of an affirmative defense for malfunctions does not support providing an affirmative defense for normal modes of operation like startup and shutdown. Such events are planned and predictable. Sources should be designed, operated, and maintained to comply with applicable emission limitations during normal and predictable source operation. Because startup and shutdown periods are part of a source's normal operations, the same approach to compliance with, and enforcement of, applicable emission limitations during those periods should apply as otherwise applies during a source's normal operations. If justified, the state can develop and submit to EPA for approval as part of the SIP, alternative emission limitations or control measures that apply during startup and shutdown, if a source cannot meet the otherwise applicable emission limitations in the SIP.

However, even if a source is a suitable candidate for alternative SIP emission limitations during startup and shutdown, that does not justify the creation of an affirmative defense in the case of excess emissions during such events. Because these events are planned, EPA believes that sources should be able to comply with applicable emission limitations during these periods of time. To provide an affirmative defense for violations that occur during planned and predictable events for which sources should have been expected to comply is tantamount to providing relief from civil penalties for a planned violation. Accordingly, EPA recommends that NDEP should eliminate the affirmative defense provisions in Section 25 applicable to startup and shutdown.

C. Proposed Action and Public Comment

As discussed in Section II.B and elsewhere above, affirmative defense provisions that include periods of normal source operation that are within a source's control, such as planned startup and shutdown, are inconsistent with the requirements of CAA section 110(a) and the enforcement structure provided in CAA sections 113 and 304. Therefore, the affirmative defense provision for excess emissions during startup and shutdown created in Sections 25.1, 25.3 and elsewhere in CCAQR Section 25 do not meet CAA requirements for SIPs. In addition, the affirmative defense provisions for malfunctions in Section 25.2 do not fully comply with the CAA as discussed in Section III.A above, and thus also do not meet CAA requirements.

As authorized in CAA section 110(k)(3), we are proposing to disapprove CCAQR Section 25 in NDEP's September 1, 2010 SIP submission because of the deficiencies discussed in section III.A above. Affirmative defenses for excess emissions and other elements of Section 25 are not required by the Act, and the lack of affirmative defenses for excess emissions does not make a SIP deficient. Therefore, if this disapproval is finalized as proposed, there would be no CAA sanction implications as described in CAA section 179 and 40 CFR 52.31, and no Federal

[11] See page 3 of the Attachment to EPA's 1999 Policy on SSM events.

[12] See CCAQR Section 11.2, "Ambient Air Quality Standards," adopted by CCBC on 10/7/03, submitted by NDEP to EPA on 10/23/03, and approved by EPA on 9/7/04 (69 FR 54006); 40 CFR 50.4–50,13.

[13] See, e.g. the 24-hour standard for $PM_{2.5}$ of 65 $\mu g/m^3$ in CCAQR Section 11.2, which is inconsistent with the 24-hour standard set on October 17, 2006 of 35 $\mu g/m^3$ (71 FR 61144).

Implementation Plan (FIP) implications as described in CAA section 110(c).

We will accept comments from the public on this proposed disapproval for the next 30 days.

IV. Statutory and Executive Order Reviews

A. Executive Order 12866: Regulatory Planning and Review and Executive Order 13563: Improving Regulation and Regulatory Review

This proposed action is not a "significant regulatory action" subject to review by the Office of Management and Budget (OMB) under Executive Order (EO) 12866 (58 FR 51735, October 4, 1993) and is therefore not subject to review under EO 12866 and EO 13563 (76 FR 3821, January 21, 2011).

B. Paperwork Reduction Act

This proposed action does not impose an information collection burden under the provisions of the Paperwork Reduction Act (44 U.S.C. 3501 et seq.) because this proposed action under CAA section 110 will not in and of itself create any new information collection burdens but simply disapproves certain State requirements for inclusion into the SIP. Burden is defined at 5 CFR 1320.3(b).

C. Regulatory Flexibility Act

The Regulatory Flexibility Act (RFA, 5 U.S.C. 601 et seq.) generally requires an agency to prepare a regulatory flexibility analysis of any rule subject to notice-and-comment rulemaking requirements under the Administrative Procedure Act or any other statute unless the agency certifies that the rule will not have a significant economic impact on a substantial number of small entities.[14] This proposed SIP disapproval under section 110 and subchapter I, part D of the CAA will not have a significant impact on a substantial number of small entities because it will not create any new requirements but simply disapproves certain State requirements for inclusion in the SIP. Accordingly, it affords no opportunity for EPA to fashion for small entities less burdensome compliance or reporting requirements or timetables or exemptions from all or part of the rule. Therefore, I certify that this action will not have a significant economic impact on a substantial number of small entities under the RFA. Moreover, due to the nature of the Federal-State relationship under the CAA, preparation of flexibility analysis would constitute Federal inquiry into the economic reasonableness of State action. The CAA forbids EPA to base its actions concerning SIPs on such grounds. *Union Electric Co., v. U.S. EPA*, 427 U.S. 246, 255–66 (1976); 42 U.S.C. 7410(a)(2).

D. Unfunded Mandates Reform Act

This action contains no Federal mandates under Title II of the Unfunded Mandates Reform Act of 1995 (UMRA, 2 U.S.C. 1531–1538), for State, local, or tribal governments or the private sector. EPA has determined that the proposed disapproval action does not include a Federal mandate that may result in estimated costs of $100 million or more to either State, local, or tribal governments in the aggregate, or to the private sector. This action proposes to disapprove pre-existing requirements under State or local law, and imposes no new requirements. Accordingly, no additional costs to State, local or tribal governments, or to the private sector, result from this action.

E. Executive Order 13132—Federalism

EO 13132, entitled "Federalism" (64 FR 43255, August 10, 1999), requires EPA to develop an accountable process to ensure "meaningful and timely input by State and local officials in the development of regulatory policies that have federalism implications." "Policies that have federalism implications" is defined in EO 13132 to include regulations that 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."

This proposed action does not have Federalism implications as specified in EO 13132. It will not 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, as specified in EO 13132, because it merely disapproves certain State requirements for inclusion into the SIP and does not alter the relationship or the distribution of power and responsibilities established in the CAA. Thus, EO 13132 does not apply to this action.

F. Executive Order 13175—Consultation and Coordination With Indian Tribal Governments

This action does not have tribal implications, as specified in EO 13175 (65 FR 67249, November 9, 2000). In this action, EPA is not addressing any tribal implementation plans. This action is limited to Clark County, Nevada, and the SIP provisions which are the subject of the proposed action do not apply to sources of emissions located in Indian country. Thus, EO 13175 does not apply to this action. However, EPA invites comment on this proposed rule from tribal officials.

G. Executive Order 13045—Protection of Children From Environmental Health Risks and Safety Risks

EPA interprets EO 13045 (62 FR 19885, April 23, 1997) as applying only to those regulatory actions that concern health or safety risks, such that the analysis required under section 5–501 of EO 13045 has the potential to influence the regulation. This proposed action is not subject to EO 13045 because it is not an economically significant regulatory action based on health or safety risks subject to EO 13045. This proposed action under section 110 and subchapter I, part D of the CAA will not in and of itself create any new regulations but simply disapproves certain State requirements for inclusion into the SIP.

H. Executive Order 13211—Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use

This proposed action is not a "significant energy action" as defined in EO 13211 (66 FR 28355, May 22, 2001), because it is not likely to have a significant adverse effect on the supply, distribution or use of energy. This proposed action under section 110 and subchapter I, part D of the CAA will not in and of itself create any new regulations, but simply disapproves certain State requirements for inclusion into the SIP.

I. National Technology Transfer and Advancement Act

Section 12(d) of the National Technology Transfer and Advancement Act of 1995 ("NTTAA"), Public Law 104–113, section 12(d) (15 U.S.C. 272 note) directs EPA to use voluntary consensus standards in its regulatory activities unless to do so would be inconsistent with applicable law or otherwise impractical. Voluntary consensus standards are technical standards (e.g., materials specifications, test methods, sampling procedures, and business practices) that are developed or

[14] Small entities include small businesses, small organizations, and small governmental jurisdictions. For purposes of assessing the impacts of this notice on small entities, small entity is defined as: (1) A small business that is a small industrial entity as defined in the U.S. Small Business Administration (SBA) size standards (see 13 CFR 121.201); (2) a small governmental jurisdiction that is a government of a city, county, town, school district, or special district with a population of less than 50,000; or (3) a small organization that is any not-for-profit enterprise that is independently owned and operated and is not dominant in its field.

adopted by voluntary consensus standards bodies. The NTTAA directs EPA to provide Congress, through OMB, explanations when the Agency decides not to use available and applicable voluntary consensus standards.

EPA believes that this proposed action is not subject to requirements of section 12(d) of NTTAA because application of those requirements would be inconsistent with the CAA. We also note that this proposed rulemaking does not involve technical standards. Therefore, EPA is not considering the use of any voluntary consensus standards.

J. Executive Order 12898—Federal Actions To Address Environmental Justice in Minority Populations and Low-Income Populations

EO 12898 (59 FR 7629, February 16, 1994) establishes federal executive policy on environmental justice. Its main provision directs federal agencies, to the greatest extent practicable and permitted by law, to make environmental justice part of their mission by identifying and addressing, as appropriate, disproportionately high and adverse human health or environmental effects of their programs, policies and activities on minority populations and low-income populations in the United States.

EPA lacks the discretionary authority to address environmental justice in this proposed action. In reviewing SIP submissions, EPA's role is to approve or disapprove state choices, based on the criteria of the CAA. Accordingly, this action merely proposes to disapprove certain State requirements for inclusion into the SIP under section CAA 110 and will not in and of itself create any new requirements.

List of Subjects in 40 CFR Part 52

Environmental protection, Air pollution control, Hydrocarbons, Incorporation by reference, Intergovernmental relations, Reporting and recordkeeping requirements, State implementation plan, Volatile organic compounds.

Authority: 42 U.S.C. 7401 *et seq.*

Dated: November 26, 2013.

Jared Blumenfeld,

Regional Administrator, Region IX.

[FR Doc. 2013–29450 Filed 12–9–13; 8:45 am]

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DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 679

[Docket No. 131021878–3878–01]

RIN 0648–XC927

Fisheries of the Exclusive Economic Zone Off Alaska; Bering Sea and Aleutian Islands; 2014 and 2015 Harvest Specifications for Groundfish

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

ACTION: Proposed rule; request for comments.

SUMMARY: NMFS proposes 2014 and 2015 harvest specifications, apportionments, and prohibited species catch allowances for the groundfish fisheries of the Bering Sea and Aleutian Islands (BSAI) management area. This action is necessary to establish harvest limits for groundfish during the 2014 and 2015 fishing years, and to accomplish the goals and objectives of the Fishery Management Plan for Groundfish of the Bering Sea and Aleutian Islands Management Area. The intended effect of this action is to conserve and manage the groundfish resources in the BSAI in accordance with the Magnuson-Stevens Fishery Conservation and Management Act.

DATES: Comments must be received by January 9, 2014.

ADDRESSES: You may submit comments on this document, identified by NOAA–NMFS–2013–0152, by any of the following methods:

- *Electronic Submission:* Submit all electronic public comments via the Federal e-Rulemaking Portal. Go to *www.regulations.gov/#!docketDetail;D=NOAA-NMFS-2013-0152*, click the "Comment Now!" icon, complete the required fields, and enter or attach your comments.
- *Mail:* Address written comments to Glenn Merrill, Assistant Regional Administrator, Sustainable Fisheries Division, Alaska Region NMFS, Attn: Ellen Sebastian. Mail comments to P.O. Box 21668, Juneau, AK 99802–1668.
- *Fax:* Address written comments to Glenn Merrill, Assistant Regional Administrator, Sustainable Fisheries Division, Alaska Region NMFS, Attn: Ellen Sebastian. Fax comments to 907–586–7557.

Instructions: Comments sent by any other method, to any other address or individual, or received after the end of the comment period, may not be considered by NMFS. All comments received are a part of the public record and will generally be posted for public viewing on *www.regulations.gov* without change. All personal identifying information (e.g., name, address), confidential business information, or otherwise sensitive information submitted voluntarily by the sender will be publicly accessible. NMFS will accept anonymous comments (enter "N/A" in the required fields if you wish to remain anonymous). Attachments to electronic comments will be accepted in Microsoft Word, Excel, or Adobe PDF file formats only.

Electronic copies of the Alaska Groundfish Harvest Specifications Final Environmental Impact Statement (Final EIS), Supplementary Information Report (SIR) and the Initial Regulatory Flexibility Analysis (IRFA) prepared for this action may be obtained from *http://www.regulations.gov* or from the Alaska Region Web site at *http://alaskafisheries.noaa.gov*. The final 2012 Stock Assessment and Fishery Evaluation (SAFE) report for the groundfish resources of the BSAI, dated November 2012, is available from the North Pacific Fishery Management Council (Council) at 605 West 4th Avenue, Suite 306, Anchorage, AK 99501–2252, phone 907–271–2809, or from the Council's Web site at *http://alaskafisheries.noaa.gov/npfmc*. The draft 2013 SAFE report for the BSAI will be available from the same sources in November 2013.

FOR FURTHER INFORMATION CONTACT: Steve Whitney, 907–586–7228.

SUPPLEMENTARY INFORMATION: Federal regulations at 50 CFR part 679 implement the Fishery Management Plan for Groundfish of the Bering Sea and Aleutian Islands Management Area (FMP) and govern the groundfish fisheries in the BSAI. The Council prepared the FMP and NMFS approved it under the Magnuson-Stevens Fishery Conservation and Management Act (Magnuson-Stevens Act). General regulations governing U.S. fisheries also appear at 50 CFR part 600.

The FMP and its implementing regulations require NMFS, after consultation with the Council, to specify annually the total allowable catch (TAC) for each target species category. The sum TAC for all groundfish species must be within the optimum yield (OY) range of 1.4 million to 2.0 million metric tons (mt) (see § 679.20(a)(1)(i)). Section 679.20(c)(1) further requires NMFS to publish proposed harvest specifications in the **Federal Register** and solicit public

comments on proposed annual TACs and apportionments thereof, prohibited species catch (PSC) allowances, prohibited species quota (PSQ) reserves established by § 679.21, seasonal allowances of pollock, Pacific cod, and Atka mackerel TAC, American Fisheries Act allocations, Amendment 80 allocations, and Community Development Quota (CDQ) reserve amounts established by § 679.20(b)(1)(ii). The proposed harvest specifications set forth in Tables 1 through 16 of this action satisfy these requirements.

Under § 679.20(c)(3), NMFS will publish the final harvest specifications for 2014 and 2015 after (1) considering comments received within the comment period (see DATES), (2) consulting with the Council at its December 2013 meeting, and (3) considering information presented in the Supplementary Information Report that assesses the need to prepare a Supplemental EIS (see **ADDRESSES**) and the final 2013 SAFE reports prepared for the 2014 and 2015 groundfish fisheries.

Other Actions Affecting the 2014 and 2015 Harvest Specifications

For 2014, the Board of Fisheries (BOF) for the State of Alaska (State) established a guideline harvest level (GHL) in State waters between 164 and 167 degrees west longitude in the BS subarea equal to 3 percent of the Pacific cod ABC in the BSAI. The action by the State does not require a downward adjustment of the proposed Bering Sea subarea Pacific cod TAC because the combined TAC and GHL (252,381 mt) are less than the proposed ABC of 300,390 mt.

For 2014, the BOF for the State of Alaska State established a guideline harvest level (GHL) in State waters in the Aleutian Islands subarea equal to 3 percent of the Pacific cod ABC in the BSAI. The action by the State does not require a downward adjustment of the proposed Aleutian Islands subarea Pacific cod TAC because the combined TAC and GHL (16,900 mt) equal the proposed ABC of 16,900 mt.

Accordingly, the Council will need to consider these GHLs when recommending the final 2014 and 2015 BSAI TACs. The Council is expected to set the final Bering Sea TACs less than the ABCs by amounts that account for these 2014 and 2015 GHLs. In addition, the Plan Team is reviewing the stock structure of BSAI groundfish and may recommend allocating current OFLs or ABCs by subareas or reporting areas.

Proposed ABC and TAC Harvest Specifications

At the October 2013 Council meeting, the SSC, Advisory Panel (AP), and Council reviewed the most recent biological and harvest information about the condition of the BSAI groundfish stocks. The Council's Plan Team compiled and presented this information, which was initially compiled by the Plan Team and presented in the final 2012 SAFE report for the BSAI groundfish fisheries, dated November 2012 (see **ADDRESSES**). The amounts proposed for the 2014 and 2015 harvest specifications are based on the 2012 SAFE report, and are subject to change in the final harvest specifications to be published by NMFS following the Council's December 2013 meeting. In November 2013, the Plan Team updated the 2012 SAFE report to include new information collected during 2013, such as NMFS stock surveys, revised stock assessments, and catch data. At its December 2013 meeting, the Council will consider information contained in the final 2013 SAFE report, recommendations from the November 2013 Plan Team meeting, public testimony from the December 2013 SSC and AP meetings, and relevant written comments in making its recommendations for the final 2014 and 2015 harvest specifications.

In previous years, some of the largest changes from the proposed to the final harvest specifications have been based on the most recent NMFS stock surveys, which provide updated estimates of stock biomass and spatial distribution, and changes to the models used in the stock assessments. These changes are recommended by the Plan Team in November 2013 and are included in the 2013 final SAFE report. The 2013 final SAFE report includes the most recent information, such as 2013 catch. The final harvest specification amounts for these stocks are not expected to vary greatly from the proposed specification amounts published here.

If the final 2013 SAFE report indicates that the stock biomass trend is increasing for a species, then the final 2014 and 2015 harvest specifications may reflect that increase from the proposed harvest specifications. Conversely, if the final 2013 SAFE report indicates that the stock biomass trend is decreasing for a species, then the final 2014 and 2015 harvest specifications may reflect a decrease from the proposed harvest specifications. In addition to changes driven by biomass trends, there may be changes in TACs due to the sum of ABCs exceeding 2 million mt. Since the FMP requires TACs to be set to an OY between 1.4 and 2 million mt, the Council may be required to recommend TACs that are lower than the ABCs recommended by the Plan Team, if setting TACs equal to ABC would cause TAC to exceed an OY of 2 million mt. Generally, ABCs greatly exceed 2 million mt in years with a large pollock biomass. NMFS anticipates that, both for 2014 and 2015, the sum of the ABCs will exceed 2 million mt. NMFS expects that the final total TAC for the BSAI for both 2014 and 2015 will equal 2 million mt.

The proposed ABCs and TACs are based on the best available biological and socioeconomic data, including projected biomass trends, information on assumed distribution of stock biomass, and revised methods used to calculate stock biomass. The FMP specifies a series of six tiers to define OFLs and ABCs based on the level of reliable information available to fishery scientists. Tier one represents the highest level of information quality available while tier six represents the lowest.

In October 2013, the SSC adopted the proposed 2014 and 2015 OFLs and ABCs recommended by the Plan Team for all groundfish species. The Council adopted the SSC's OFL and ABC recommendations. These amounts are unchanged from the final 2014 harvest specifications published in the **Federal Register** on March 1, 2013 (78 FR 13813) except for Pacific cod and Kamchatka flounder. For Pacific cod, separate BS and AI harvest specifications were recommended. For the eastern Bering Sea (EBS), the Plan Team used 93 percent of the combined 2014 BSAI OFL and ABC published last year. For the AI, the Plan Team used Tier 5 estimates from last year's preliminary assessment, noting that it will review a revised model in November 2013. The proposed 2014 OFL and ABC for Kamchatka flounder were obtained using results from the preliminary Tier 3 assessment that was approved for use in November by the Plan Team. The Council adopted the AP's TAC recommendations except for Pacific cod, pollock, yellowfin sole, and rock sole. The Council decreased the AI Pacific cod TAC to account for the State's AI GHL of 3 percent of the BSAI ABC, and increased by that same amount the TACs for BS Pacific cod, pollock, yellowfin sole, and rock sole. For 2014 and 2015, the Council recommended and NMFS proposes the OFLs, ABCs, and TACs listed in Table 1. The proposed ABCs reflect harvest amounts that are less than the specified overfishing amounts. The sum of the

proposed 2014 and 2015 ABCs for all assessed groundfish is 2,686,688 mt, which is higher than the final 2013 ABC total of 2,639,317 mt (78 FR 13813, March 1, 2013).

Specification and Apportionment of TAC Amounts

The Council recommended proposed TACs for 2014 and 2015 that are equal to proposed ABCs for sablefish, Kamchatka flounder, Pacific ocean perch, shortraker rockfish, rougheye rockfish, AI "other rockfish," and Eastern AI/BS Atka mackerel. The Council recommended proposed TACs for 2014 and 2015 that are less than the proposed ABCs for pollock, Pacific cod, Western and Central AI Atka mackerel, Greenland turbot, yellowfin sole, rock sole, arrowtooth flounder, flathead sole, "other flatfish," Alaska plaice, northern rockfish, BS "other rockfish," squids, sharks, skates, sculpins, and octopuses.

Section 679.20(a)(5)(iii)(B)(*1*) requires the AI pollock TAC to be set at 19,000 mt when the AI pollock ABC equals or exceeds 19,000 mt. The Bogoslof pollock TAC is set to accommodate incidental catch amounts. TACs are set so that the sum of the overall TAC does not exceed the BSAI OY.

The proposed groundfish OFLs, ABCs, and TACs are subject to change pending the completion of the final 2013 SAFE report and the Council's recommendations for final 2014 and 2015 harvest specifications during its December 2013 meeting. These proposed amounts are consistent with the biological condition of groundfish stocks as described in the 2012 SAFE report, and adjusted for other biological and socioeconomic considerations. Pursuant to section 3.2.3.4.1 of the FMP, the Council could recommend adjusting the TACs if "warranted on the basis of bycatch considerations, management uncertainty, or socioeconomic considerations, or if required in order to cause the sum of the TACs to fall within the OY range." Table 1 lists the proposed 2014 and 2015 OFL, ABC, TAC, initial TAC (ITAC), and CDQ amounts for groundfish for the BSAI. The proposed apportionment of TAC amounts among fisheries and seasons is discussed below.

TABLE 1—PROPOSED 2014 AND 2015 OVERFISHING LEVEL (OFL), ACCEPTABLE BIOLOGICAL CATCH (ABC), TOTAL ALLOWABLE CATCH (TAC), INITIAL TAC (ITAC), AND CDQ RESERVE ALLOCATION OF GROUNDFISH IN THE BSAI [1]

[Amounts are in metric tons]

Species	Area	Proposed 2014 and 2015				
		OFL	ABC	TAC	ITAC [2]	CDQ [3 4 5]
Pollock	BS	2,730,000	1,430,000	1,252,500	1,127,250	125,250
	AI	48,600	39,800	19,000	17,100	1,900
	Bogoslof	13,400	10,100	100	100	0
Pacific cod	BS	352,470	300,390	245,000	218,785	26,215
	AI	22,500	16,900	7,381	6,591	790
Sablefish	BS	1,760	1,480	1,480	629	56
	AI	2,370	2,010	2,010	427	38
Yellowfin sole	BSAI	219,000	206,000	200,000	178,600	21,400
Greenland turbot	BSAI	3,270	2,650	2,060	1,751	0
	BS	n/a	2,070	1,610	1,369	172
	AI	n/a	580	450	383	0
Arrowtooth flounder	BSAI	186,000	152,000	25,000	21,250	2,675
Kamchatka flounder	BSAI	8,300	7,100	7,100	6,035	0
Northern rock sole [6]	BSAI	229,000	204,000	94,569	80,384	10,119
Flathead sole [7]	BSAI	80,100	66,700	22,699	19,294	2,429
Alaska plaice	BSAI	60,200	55,800	23,700	20,145	0
Other flatfish [8]	BSAI	17,800	13,300	3,500	2,975	0
Pacific Ocean perch	BSAI	39,500	33,100	33,100	28,135	2,720
	BS	n/a	7,680	7,680	6,528	0
	EAI	n/a	9,240	9,240	7,854	989
	CAI	n/a	6,590	6,590	5,602	705
	WAI	n/a	9,590	9,590	8,152	1,026
Northern rockfish	BSAI	12,000	9,320	3,000	2,550	0
Blackspotted/Rougheye rockfish [9]	BSAI	524	429	429	365	0
	EBS/EAI	n/a	189	189	161	0
	CAI/WAI	n/a	240	240	204	0
Shortraker rockfish	BSAI	493	370	370	315	0
Other rockfish	BSAI	1,540	1,159	873	742	0
	BS	n/a	686	400	340	0
	AI	n/a	473	473	402	0
Atka mackerel	BSAI	56,500	48,900	25,379	21,572	2,716
	EAI/BS	n/a	16,500	16,500	14,025	1,766
	CAI	n/a	15,700	7,379	6,272	790
	WAI	n/a	16,700	1,500	1,275	161
Skates	BSAI	44,100	37,300	24,000	20,400	0
Sculpins	BSAI	56,400	42,300	5,600	4,760	0
Sharks	BSAI	1,360	1,020	150	128	0
Squids	BSAI	2,620	1,970	500	425	0
Octopuses	BSAI	3,450	2,590	500	425	0
Total		4,193,257	2,686,688	2,000,000	1,781,132	196,306

[1] These amounts apply to the entire BSAI management area unless otherwise specified. With the exception of pollock, and for the purpose of these harvest specifications, the Bering Sea (BS) subarea includes the Bogoslof District.

[2] Except for pollock, the portion of the sablefish TAC allocated to hook-and-line and pot gear, and Amendment 80 species (Atka mackerel, Aleutian Islands Pacific ocean perch, yellowfin sole, rock sole, flathead sole, and Pacific cod), 15 percent of each TAC is put into a reserve. The ITAC for these species is the remainder of the TAC after the subtraction of these reserves.

[3] Under § 679.20(a)(5)(i)(A)(*1*), the annual Bering Sea subarea pollock TAC, after subtracting first for the CDQ directed fishing allowance (10 percent) and second for the incidental catch allowance (3.4 percent), is further allocated by sector for a directed pollock fishery as follows: inshore—50 percent; catcher/processor—40 percent; and motherships—10 percent. Under § 679.20(a)(5)(iii)(B)(*2*)(*i*) and (*ii*), the annual Aleutian Islands subarea pollock TAC, after subtracting first for the CDQ directed fishing allowance (10 percent) and second for the incidental catch allowance (1,600 mt), is allocated to the Aleut Corporation for a directed pollock fishery.

[4] The Pacific cod TAC is reduced by 3 percent from the ABC to account for the State of Alaska guideline harvest level in state waters of the Aleutian Islands subarea.

[5] For the Amendment 80 species (Atka mackerel, Aleutian Islands Pacific ocean perch, yellowfin sole, rock sole, flathead sole, and Pacific cod), 10.7 percent of the TAC is reserved for use by CDQ participants (see §§ 679.20(b)(1)(ii)(C) and 679.31). Twenty percent of the sablefish TAC allocated to hook-and-line gear or pot gear, 7.5 percent of the sablefish TAC allocated to trawl gear. The 2014 hook-and-line and pot gear portion of the sablefish ITAC and CDQ reserve will not be specified until the fall of 2013. 10.7 percent of the TACs for Bering Sea Greenland turbot and arrowtooth flounder are reserved for use by CDQ participants (see § 679.20(b)(1)(ii)(B) and (D)). Aleutian Islands Greenland turbot, "other flatfish," Alaska plaice, Bering Sea Pacific ocean perch, Kamchatka flounder, northern rockfish, shortraker rockfish, rougheye rockfish, "other rockfish," squids, octopuses, skates, sculpins, and sharks are not allocated to the CDQ program.

[6] "Rock sole" includes *Lepidopsetta polyxystra* (Northern rock sole) and *Lepidopsetta bilineata* (Southern rock sole).

[7] "Flathead sole" includes *Hippoglossoides elassodon* (flathead sole) and *Hippoglossoides robustus* (Bering flounder).

[8] "Other flatfish" includes all flatfish species, except for halibut (a prohibited species), flathead sole, Greenland turbot, rock sole, yellowfin sole, arrowtooth flounder, Kamchatka flounder, and Alaska plaice.

[9] "Rougheye rockfish" includes *Sebastes aleutianus* (rougheye) and *Sebastes melanostictus* (blackspotted).

[10] "Other rockfish" includes all *Sebastes* and *Sebastolobus* species except for Pacific ocean perch, northern, shortraker, and rougheye rockfish.

Groundfish Reserves and the Incidental Catch Allowance (ICA) for Pollock, Atka Mackerel, Flathead Sole, Rock Sole, Yellowfin Sole, and AI Pacific Ocean Perch

Section 679.20(b)(1)(i) requires NMFS to reserve 15 percent of the TAC for each target species category, except for pollock, hook-and-line or pot gear allocation of sablefish, and Amendment 80 species, in a non-specified reserve. Section 679.20(b)(1)(ii)(B) requires NMFS to allocate 20 percent of the hook-and-line or pot gear allocation of sablefish to the fixed gear sablefish CDQ reserve. Section 679.20(b)(1)(ii)(D) requires NMFS to allocate 7.5 percent of the trawl gear allocation of sablefish and 10.7 percent of Bering Sea Greenland turbot and arrowtooth flounder to the respective CDQ reserves. Section 679.20(b)(1)(ii)(C) requires NMFS to allocate 10.7 percent of the TACs for Atka mackerel, AI Pacific ocean perch, yellowfin sole, rock sole, flathead sole, and Pacific cod to the CDQ reserves. Sections 679.20(a)(5)(i)(A) and 679.31(a) also require allocation of 10 percent of the BSAI pollock TACs to the pollock CDQ directed fishing allowance (DFA). The entire Bogoslof District pollock TAC is allocated as an ICA (see § 679.20(a)(5)(ii)). With the exception of the hook-and-line and pot gear sablefish CDQ reserve, the regulations do not further apportion the CDQ reserves by gear.

Pursuant to § 679.20(a)(5)(i)(A)(*1*), NMFS proposes a pollock ICA of 3.4 percent of the Bering Sea subarea pollock TAC after subtracting the 10 percent CDQ reserve. This allowance is based on NMFS' examination of the pollock incidentally retained and discarded catch, including the incidental catch by CDQ vessels, in target fisheries other than pollock from 1999 through 2013. During this 15-year period, the pollock incidental catch ranged from a low of 2.3 percent in 2012 to a high of 5 percent in 1999, with a 15-year average of 3.4 percent. Pursuant to § 679.20(a)(5)(iii)(B)(*2*)(*i*) and (*ii*), NMFS proposes a pollock ICA of 2,000 mt for the AI subarea after subtracting the 10 percent CDQ DFA. This allowance is based on NMFS' examination of the pollock incidental catch, including the incidental catch by CDQ vessels, in target fisheries other than pollock from 2003 through 2013. During this 11-year period, the incidental catch of pollock ranged from a low of 5 percent in 2006 to a high of 17 percent in 2013, with an 11-year average of 8 percent.

Pursuant to § 679.20(a)(8) and (10), NMFS proposes ICAs of 5,000 mt of flathead sole, 10,000 mt of rock sole, 2,400 mt of yellowfin sole, 10 mt of Western Aleutian District Pacific ocean perch, 75 mt of Central Aleutian District Pacific ocean perch, 200 mt of Eastern Aleutian District Pacific ocean perch, 40 mt for Western Aleutian District Atka mackerel, 75 mt for Central Aleutian District Atka mackerel, and 1,000 mt of Eastern Aleutian District and Bering Sea subarea Atka mackerel after subtracting the 10.7 percent CDQ reserve. These ICAs are based on NMFS' examination of the average incidental retained and discarded catch in other target fisheries from 2003 through 2013.

The regulations do not designate the remainder of the non-specified reserve by species or species group. Any amount of the reserve may be apportioned to a target species that contributed to the non-specified reserve, provided that such apportionments do not result in overfishing (see § 679.20(b)(1)(i)).

Allocations of Pollock TAC Under the American Fisheries Act (AFA)

Section 679.20(a)(5)(i)(A) requires that Bering Sea pollock TAC be apportioned after subtracting 10 percent for the CDQ program and 3.4 percent for the ICA as a DFA as follows: 50 percent to the inshore sector, 40 percent to the catcher/processor sector, and 10 percent to the mothership sector. In the Bering Sea subarea, 40 percent of the DFA is allocated to the A season (January 20 to June 10) and 60 percent of the DFA is allocated to the B season (June 10 to November 1) (§ 679.20(a)(5)(i)(B)). The AI directed pollock fishery allocation to the Aleut Corporation is the amount of pollock remaining in the AI subarea after subtracting 1,900 mt for the CDQ DFA (10 percent), and 2,000 mt for the ICA (§ 679.20(a)(5)(iii)(B)(*2*)(*ii*)). In the AI subarea, the A season pollock TAC may equal up to 40 percent of the ABC and the remainder of the pollock TAC is allocated to the B season. Table 2 lists these proposed 2014 and 2015 amounts.

Section 679.20(a)(5)(i)(A)(*4*) also includes several specific requirements regarding Bering Sea subarea pollock allocations. First, 8.5 percent of the pollock allocated to the catcher/processor sector will be available for harvest by AFA catcher vessels with catcher/processor sector endorsements, unless the Regional Administrator receives a cooperative contract entered into by listed AFA C/Ps and all AFA catcher vessels with C/P sector endorsements, and the Regional Administrator determines the contract provides for the distribution of harvest among AFA catcher/processors and AFA catcher vessels in a manner agreed to by all members. Second, AFA catcher/processors not listed in the AFA are limited to harvesting not more than 0.5 percent of the pollock allocated to

the catcher/processor sector. Table 2 lists the proposed 2014 and 2015 allocations of pollock TAC. Tables 13 through 16 list the AFA catcher/processor and catcher vessel harvesting sideboard limits. In past years, the proposed harvest specifications included text and tables describing pollock allocations to the Bering Sea subarea inshore pollock cooperatives and open access sector. These allocations are based on the submission of AFA inshore cooperative applications due to NMFS on December 1 of each calendar year. Because AFA inshore cooperative applications for 2014 have not been submitted to NMFS, thereby preventing NMFS from calculating 2014 allocations, NMFS has not included inshore cooperative text and tables in these proposed harvest specifications. NMFS will post 2014 AFA inshore cooperative allocations on the Alaska Region Web site at *http://alaskafisheries.noaa.gov* when they become available in December 2013.

Table 2 also lists proposed seasonal apportionments of pollock and harvest limits within the Steller Sea Lion Conservation Area (SCA). The harvest of pollock within the SCA, as defined at § 679.22(a)(7)(vii), is limited to no more than 28 percent of the DFA until before April 1, as provided in § 679.20(a)(5)(i)(C). The remaining 12 percent of the 40 percent annual DFA allocated to the A season may be taken outside the SCA before noon, April 1, or inside the SCA after noon, April 1. The A season pollock SCA harvest limit will be apportioned to each sector in proportion to each sector's allocated percentage of the DFA. Table 2 lists these proposed 2014 and 2015 amounts by sector.

TABLE 2—PROPOSED 2014 AND 2015 ALLOCATIONS OF POLLOCK TACS TO THE DIRECTED POLLOCK FISHERIES AND TO THE CDQ DIRECTED FISHING ALLOWANCES (DFA) [1]

[Amounts are in metric tons]

Area and sector	2014 and 2015 allocations	A season [1]		B season [1]
		A season DFA	SCA harvest limit [2]	B season DFA
Bering Sea subarea TAC	1,252,500	N/A	N/A	N/A
CDQ DFA	125,250	50,100	35,070	75,150
ICA [1]	38,327	N/A	N/A	N/A
AFA Inshore	544,462	217,785	152,449	326,677
AFA Catcher/Processors [3]	435,569	174,228	121,959	261,342
Catch by C/Ps	398,546	159,418	N/A	239,128
Catch by C/Vs [3]	37,023	14,809	N/A	22,214
Unlisted C/P Limit [4]	2,178	871	N/A	1,307
AFA Motherships	108,892	43,557	30,490	65,335
Excessive Harvesting Limit [5]	190,562	N/A	N/A	N/A
Excessive Processing Limit [6]	326,677	N/A	N/A	N/A
Total Bering Sea DFA (non-CDQ)	1,088,924	435,569	304,899	653,354
Aleutian Islands subarea TAC	19,000	N/A	N/A	N/A
CDQ DFA	1,900	760	N/A	1,140
ICA	2,000	1,000	N/A	1,000
Aleut Corporation	15,100	14,160	N/A	940
Bogoslof District ICA [7]	100	N/A	N/A	N/A

[1] Pursuant to § 679.20(a)(5)(i)(A), the annual Bering Sea subarea pollock TAC, after subtracting the CDQ DFA (10 percent) and the ICA (3.4 percent), is allocated as a DFA as follows: Inshore sector 50 percent, catcher/processor sector 40 percent, and mothership sector 10 percent. In the Bering Sea subarea, 40 percent of the DFA is allocated to the A season (January 20–June 10) and 60 percent of the DFA is allocated to the B season (June 10–November 1). Pursuant to § 679.20(a)(5)(iii)(B)(*2*)(*i*) and (*ii*), the annual AI pollock TAC, after subtracting first for the CDQ DFA (10 percent) and second the ICA (2,000 mt), is allocated to the Aleut Corporation for a directed pollock fishery. In the AI subarea, the A season is allocated 40 percent of the ABC and the B season is allocated the remainder of the directed pollock fishery.

[2] In the Bering Sea subarea, no more than 28 percent of each sector's annual DFA may be taken from the SCA before April 1. The remaining 12 percent of the annual DFA allocated to the A season may be taken outside of the SCA before April 1 or inside the SCA after April 1. If 28 percent of the annual DFA is not taken inside the SCA before April 1, the remainder is available to be taken inside the SCA after April 1.

[3] Pursuant to § 679.20(a)(5)(i)(A)(*4*), not less than 8.5 percent of the DFA allocated to listed catcher/processors (C/Ps) shall be available for harvest only by eligible catcher vessels (CVs) delivering to listed catcher/processors.

[4] Pursuant to § 679.20(a)(5)(i)(A)(*4*)(*iii*), the AFA unlisted catcher/processors are limited to harvesting not more than 0.5 percent of the catcher/processor sector's allocation of pollock.

[5] Pursuant to § 679.20(a)(5)(i)(A)(*6*), NMFS establishes an excessive harvesting share limit equal to 17.5 percent of the sum of the pollock DFAs not including CDQ.

[6] Pursuant to § 679.20(a)(5)(i)(A)(*7*), NMFS establishes an excessive processing share limit equal to 30.0 percent of the sum of the pollock DFAs not including CDQ.

[7] The Regional Administrator proposes closing the Bogoslof pollock fishery for directed fishing under the final 2014 and 2015 harvest specifications for the BSAI. The amounts specified are for incidental catch only and are not apportioned by season or sector.

Allocation of the Atka Mackerel TACs

Section 679.20(a)(8) allocates the Atka mackerel TACs to the Amendment 80 and BSAI trawl limited access sectors, after subtracting the CDQ reserves, jig gear allocation, and ICAs for the BSAI trawl limited access sector and non-trawl gear (Table 3). The percentage of the ITAC for Atka mackerel allocated to the Amendment 80 and BSAI trawl limited access sectors is listed in Table 33 to part 679 and in § 679.91. Pursuant to § 679.20(a)(8)(i), up to 2 percent of the Eastern Aleutian District and Bering Sea subarea Atka mackerel ITAC may be allocated to jig gear. The percent of this allocation is recommended annually by the Council based on several criteria, including the anticipated harvest capacity of the jig gear fleet. The Council recommended and NMFS proposes a 0.5 percent allocation of the Atka mackerel ITAC in the Eastern Aleutian District and Bering Sea subarea to jig gear in 2014 and 2015. This percentage is applied to the TAC after subtracting the CDQ reserve and the ICA. Section 679.20(a)(8)(ii)(C)(*3*) limits the annual TAC for Area 542 to no more than 47 percent of the Area 542 ABC. Section 679.7(a)(19) prohibits retaining Atka mackerel in Area 543, and the

proposed TAC is set to account for discards in other fisheries.

Section 679.20(a)(8)(ii)(A) apportions the Atka mackerel TAC (including the CDQ reserve) into two equal seasonal allowances. Section 679.23(e)(3) sets the first seasonal allowance for directed fishing with trawl gear from January 20 to June 10 (A season), and the second seasonal allowance from June 10 to November 1 (B season). Section 679.23(e)(4)(iii) applies Atka mackerel seasons to CDQ Atka mackerel fishing. The jig gear and ICA allocations are not apportioned by season.

Sections 679.20(a)(8)(ii)(C)(*1*)(*i*) and (*ii*) require the Amendment 80 cooperatives and CDQ groups to limit harvest to 10 percent of their Central Aleutian District Atka mackerel allocation equally divided between the A and B seasons within waters 10 nautical miles (nm) to 20 nm of Gramp Rock and Tag Island, as described on Table 12 to part 679. Vessels not fishing under the authority of an Amendment 80 cooperative quota or CDQ allocation are prohibited from conducting directed fishing for Atka mackerel inside Steller sea lion critical habitat in the Central Aleutian District.

Two Amendment 80 cooperatives have formed for the 2014 fishing year. Because all Amendment 80 vessels are part of a cooperative, no allocation to the Amendment 80 limited access sector is required. NMFS will post 2014 Amendment 80 cooperative allocations on the Alaska Region Web site at *http://alaskafisheries.noaa.gov* prior to the start of the fishing year on January 1, 2014, based on the harvest specifications effective on that date.

Table 3 lists these 2014 and 2015 Atka mackerel season allowances, area allowances, and the sector allocations. The 2015 allocations for Amendment 80 species between Amendment 80 cooperatives and the Amendment 80 limited access sector will not be known until eligible participants apply for participation in the program by November 1, 2014. NMFS will post 2015 Amendment 80 cooperatives and Amendment 80 limited access allocations on the Alaska Region Web site at *http://alaskafisheries.noaa.gov* when they become available in December 2014.

TABLE 3—PROPOSED 2014 AND 2015 SEASONAL AND SPATIAL ALLOWANCES, GEAR SHARES, CDQ RESERVE, INCIDENTAL CATCH ALLOWANCE, AND AMENDMENT 80 ALLOCATIONS OF THE BSAI ATKA MACKEREL TAC

[Amounts are in metric tons]

Sector [1]	Season [2 3 4]	Allocation by area		
		Eastern Aleutian District/ Bering Sea	Central Aleutian District	Western Aleutian District
TAC	n/a	16,500	7,379	1,500
CDQ reserve	Total	1,766	790	161
	A	883	395	80
	Critical habitat [5]	n/a	39	n/a
	B	883	395	80
	Critical habitat [5]	n/a	39	n/a
ICA	Total	1,000	75	40
Jig [6]	Total	69	0	0
BSAI trawl limited access	Total	1,367	651	0
	A	683	326	0
	B	683	326	0
Amendment 80 [7]	Total	12,299	5,863	1,300
Alaska Groundfish Cooperative for 2014	Total	7,082	3,495	767
	A	3,541	1,748	384
	Critical habitat [5]	n/a	175	n/a
	B	3,541	1,748	384
	Critical habitat [5]	n/a	175	n/a
Alaska Seafood Cooperative for 2014	Total	5,217	2,368	532
	A	2,609	1,184	266
	Critical habitat [5]	n/a	118	n/a
	B	2,609	1,184	266
	Critical habitat [5]	n/a	118	n/a

[1] Section 679.20(a)(8)(ii) allocates the Atka mackerel TACs, after subtracting the CDQ reserves, ICAs, and the jig gear allocation, to the Amendment 80 and BSAI trawl limited access sectors. The allocation of the ITAC for Atka mackerel to the Amendment 80 and BSAI trawl limited access sectors is established in Table 33 to part 679 and § 679.91. The CDQ reserve is 10.7 percent of the TAC for use by CDQ participants (see §§ 679.20(b)(1)(ii)(C) and 679.31).

[2] Sections 679.20(a)(8)(ii)(A) and 679.22(a) establish temporal and spatial limitations for the Atka mackerel fishery.

[3] The seasonal allowances of Atka mackerel are 50 percent in the A season and 50 percent in the B season.

[4] Section 679.23(e)(3) authorizes directed fishing for Atka mackerel with trawl gear during the A season from January 20 to June 10, and the B season from June 10 to November 1.

[5] Section 679.20(a)(8)(ii)(C) requires the TAC in area 542 shall be no more than 47 percent of ABC, and Atka mackerel harvests for Amendment 80 cooperatives and CDQ groups within waters 10 nm to 20 nm of Gramp Rock and Tag Island, as described in Table 12 to part 679, in Area 542 are limited to no more than 10 percent of the Amendment 80 cooperative Atka mackerel allocation or 10 percent of the CDQ Atka mackerel allocation.

[6] Section 679.20(a)(8)(i) requires that up to 2 percent of the Eastern Aleutian District and Bering Sea subarea TAC be allocated to jig gear after subtraction of the CDQ reserve and ICA. The amount of this allocation is 0.5 percent. The jig gear allocation is not apportioned by season.

[7] The 2015 allocations for Amendment 80 species between Amendment 80 cooperatives and the Amendment 80 limited access sector will not be known until eligible participants apply for participation in the program by November 1, 2014.

Allocation of the Pacific Cod TAC

The Council recommended and NMFS proposes separate BS and AI subarea OFLs, ABCs, and TACs for Pacific cod. Section 679.20(b)(1)(ii)(C) allocates 10.7 percent of the BS TAC and AI TAC to the CDQ program. After CDQ allocations have been deducted from the respective BS and AI Pacific

cod TACs, the remaining BS and AI Pacific cod TACs will be combined for calculating further BSAI Pacific cod sector allocations. However, if the non-CDQ Pacific cod TAC is or will be reached in either the BS or AI subareas, NMFS will prohibit non-CDQ directed fishing for Pacific cod in that subarea as provided in § 679.20(d)(1)(iii).

Sections 679.20(a)(7)(i) and (ii) allocate the Pacific cod TAC in the combined BSAI TAC, after subtracting 10.7 percent for the CDQ program, as follows: 1.4 Percent to vessels using jig gear, 2.0 percent to hook-and-line and pot catcher vessels less than 60 ft (18.3 m) length overall (LOA), 0.2 percent to hook-and-line catcher vessels greater than or equal to 60 ft (18.3 m) LOA, 48.7 percent to hook-and-line catcher/processors, 8.4 percent to pot catcher vessels greater than or equal to 60 ft (18.3 m) LOA, 1.5 percent to pot catcher/processors, 2.3 percent to AFA trawl catcher/processors, 13.4 percent to non-AFA trawl catcher/processors, and 22.1 percent to trawl catcher vessels. The BSAI ICA for the hook-and-line and pot sectors will be deducted from the aggregate portion of BSAI Pacific cod TAC allocated to the hook-and-line and pot sectors. For 2014 and 2015, the Regional Administrator proposes a BSAI ICA of 500 mt, based on anticipated incidental catch in these fisheries.

The allocation of the BSAI ITAC for Pacific cod to the Amendment 80 sector is established in Table 33 to part 679 and § 679.91. Two Amendment 80 cooperatives have formed for the 2014 fishing year. Because all Amendment 80 vessels are part of a cooperative, no allocation to the Amendment 80 limited access sector is required. NMFS will post 2014 Amendment 80 cooperative allocations on the Alaska Region Web site at *http://alaskafisheries.noaa.gov* prior to the start of the fishing year on January 1, 2014, based on the harvest specifications effective on that date.

The 2015 allocations for Amendment 80 species between Amendment 80 cooperatives and the Amendment 80 limited access sector will not be known until eligible participants apply for participation in the program by November 1, 2014. NMFS will post 2015 Amendment 80 cooperatives and Amendment 80 limited access allocations on the Alaska Region Web site at *http://alaskafisheries.noaa.gov* when they become available in December 2014.

The Pacific cod ITAC is apportioned into seasonal allowances to disperse the Pacific cod fisheries over the fishing year (see §§ 679.20(a)(7) and 679.23(e)(5)). In accordance with § 679.20(a)(7)(iv)(B) and (C), any unused portion of a seasonal Pacific cod allowance will become available at the beginning of the next seasonal allowance.

The CDQ and non-CDQ season allowances by gear based on the proposed 2014 and 2015 Pacific cod TACs are listed in Table 4 based on the sector allocation percentages of Pacific cod set forth at §§ 679.20(a)(7)(i)(B) and 679.20(a)(7)(iv)(A); and the seasonal allowances of Pacific cod set forth at § 679.23(e)(5).

Section 679.7(a)(19) prohibits retaining Pacific cod in Area 543 and § 679.7(a)(23) prohibits directed fishing for Pacific cod with hook-and-line, pot, or jig gear in the AI subarea November 1 through December 31.

TABLE 4—PROPOSED 2014 AND 2015 GEAR SHARES AND SEASONAL ALLOWANCES OF THE BSAI [1] PACIFIC COD TAC

[Amounts are in metric tons]

Gear sector	Percent	2014 and 2015 share of gear sector total	2014 and 2015 share of sector total	2014 and 2015 seasonal apportionment	
				Season	Amount
BS TAC		245,000	n/a	n/a	n/a
BS CDQ		26,215	n/a	See § 679.20(a)(7)(i)(B)	n/a
AI TAC		7,381	n/a	n/a	n/a
AI CDQ		790	n/a	See § 679.20(a)(7)(i)(B)	n/a
Total BSAI non-CDQ TAC [1]	100	225,376	n/a	n/a	n/a
Total hook-and-line/pot gear	60.8	137,029	n/a	n/a	n/a
Hook-and-line/pot ICA [2]	n/a	n/a	500	n/a	n/a
Hook-and-line/pot sub-total	n/a	136,529	n/a	n/a	n/a
Hook-and-line catcher/processors	48.7	n/a	109,358	Jan 1–Jun 10	55,772
				Jun 10–Dec 31	53,585
Hook-and-line catcher vessels ≥60 ft LOA.	0.2	n/a	449	Jan 1–Jun 10	229
				Jun 10–Dec 31	220
Pot catcher/processors	1.5	n/a	3,368	Jan 1–Jun 10	1,718.
				Sept 1–Dec 31	1,650
Pot catcher vessels ≥60 ft LOA	8.4	n/a	18,863	Jan 1–Jun 10	9,620
				Sept 1–Dec 31	9,243
Catcher vessels <60 ft LOA using hook-and-line or pot gear.	2	n/a	4,491	n/a	n/a
Trawl catcher vessels	22.1	49,808	n/a	Jan 20–Apr 1	36,858
				Apr 1–Jun 10	5,479
				Jun 10–Nov 1	7,471
AFA trawl catcher/processors	2.3	5,184	n/a	Jan 20–Apr 1	3,888
				Apr 1–Jun 10	1,296
				Jun 10–Nov 1	0
Amendment 80	13.4	30,200	n/a	Jan 20–Apr 1	22,650
				Apr 1–Jun 10	7,550
				Jun 10–Nov 1	0
Alaska Groundfish Cooperative for 2014 [3].	n/a	5,624	n/a	Jan 20–Apr 1	4,218
				Apr 1–Jun 10	1,406
				Jun 10–Nov 1	0
Alaska Seafood Cooperative for 2014 [3].	n/a	24,577	n/a	Jan 20–Apr 1	18,433

TABLE 4—PROPOSED 2014 AND 2015 GEAR SHARES AND SEASONAL ALLOWANCES OF THE BSAI [1] PACIFIC COD TAC—Continued

[Amounts are in metric tons]

Gear sector	Percent	2014 and 2015 share of gear sector total	2014 and 2015 share of sector total	2014 and 2015 seasonal apportionment	
				Season	Amount
	.....	.....	.....	Apr 1–Jun 10	6,144
	.....	.....	.....	Jun 10–Nov 1	0
Jig	1.4	3,155	n/a	Jan 1–Apr 30	1,893
	.....	.....	.....	Apr 30–Aug 31	631
	.....	.....	.....	Aug 31–Dec 31	631

[1] The gear shares and seasonal allowances for BSAI Pacific cod TAC are based on the sum of the BS and AI Pacific cod TACs. If the TAC for Pacific cod in either the AI or BS is reached, then directed fishing for Pacific cod in that subarea may be prohibited, even if a BSAI allowance remains.

[2] The ICA for the hook-and-line and pot sectors will be deducted from the aggregate portion of Pacific cod TAC allocated to the hook-and-line and pot sectors. The Regional Administrator proposes an ICA of 500 mt for 2014 and 2015 based on anticipated incidental catch in these fisheries.

[3] The 2015 allocations for Amendment 80 species between Amendment 80 cooperatives and the Amendment 80 limited access sector will not be known until eligible participants apply for participation in the program by November 1, 2014.

Sablefish Gear Allocation

Sections 679.20(a)(4)(iii) and (iv) require allocation of sablefish TACs for the Bering Sea and AI subareas between trawl gear and hook-and-line or pot gear. Gear allocations of the TACs for the Bering Sea subarea are 50 percent for trawl gear and 50 percent for hook-and-line or pot gear. Gear allocations for the AI subarea are 25 percent for trawl gear and 75 percent for hook-and-line or pot gear. Section 679.20(b)(1)(ii)(B) requires NMFS to apportion 20 percent of the hook-and-line and pot gear allocation of sablefish to the CDQ reserve. Additionally, § 679.20(b)(1)(ii)(D)(*1*) requires that 7.5 percent of the trawl gear allocation of sablefish from the nonspecified reserves, established under § 679.20(b)(1)(i), be assigned to the CDQ reserve. The Council recommended that only trawl sablefish TAC be established biennially. The harvest specifications for the hook-and-line gear and pot gear sablefish Individual Fishing Quota (IFQ) fisheries will be limited to the 2014 fishing year to ensure those fisheries are conducted concurrently with the halibut IFQ fishery. Concurrent sablefish and halibut IFQ fisheries would reduce the potential for discards of halibut and sablefish in those fisheries. The sablefish IFQ fisheries would remain closed at the beginning of each fishing year until the final harvest specifications for the sablefish IFQ fisheries are in effect. Table 5 lists the proposed 2014 and 2015 gear allocations of the sablefish TAC and CDQ reserve amounts.

TABLE 5—PROPOSED 2014 AND 2015 GEAR SHARES AND CDQ RESERVE OF BSAI SABLEFISH TACS

[Amounts are in metric tons]

Subarea gear	Percent of TAC	2014 share of TAC	2014 ITAC [1]	2014 CDQ reserve	2015 share of TAC	2015 ITAC	2015 CDQ reserve
Bearing Sea							
Trawl	50	740	629	56	740	629	56
Hook-and-line gear [2]	50	740	n/a	148	n/a	n/a	n/a
Total	100	1,480	629	204	740	629	56
Aleutian Islands							
Trawl	25	503	427	38	503	427	38
Hook-and-line gear [2]	75	1,508	n/a	302	n/a	n/a	n/a
Total	2,010	427	339	503	427	38	

[1] Except for the sablefish hook-and-line or pot gear allocation, 15 percent of TAC is apportioned to the reserve. The ITAC is the remainder of the TAC after the subtraction of these reserves.

[2] For the portion of the sablefish TAC allocated to vessels using hook-and-line or pot gear, 20 percent of the allocated TAC is reserved for use by CDQ participants. Section 679.20(b)(1) does not provide for the establishment of an ITAC for sablefish allocated to hook-and-line or pot gear.

Allocation of the Aleutian Islands Pacific Ocean Perch, and BSAI Flathead Sole, Rock Sole, and Yellowfin Sole TACs

Sections 679.20(a)(10)(i) and (ii) require that NMFS allocate AI Pacific ocean perch, and BSAI flathead sole, rock sole, and yellowfin sole TACs between the Amendment 80 and BSAI trawl limited access sectors, after subtracting 10.7 percent for the CDQ reserve and an ICA for the BSAI trawl limited access sector and vessels using non-trawl gear. The allocation of the ITAC for AI Pacific ocean perch, and BSAI flathead sole, rock sole, and yellowfin sole to the Amendment 80 sector is established in Tables 33 and 34 to part 679 and in § 679.91.

Two Amendment 80 cooperatives have formed for the 2014 fishing year. Because all Amendment 80 vessels are part of a cooperative, no allocation to the Amendment 80 limited access sector is required. NMFS will post 2014 Amendment 80 cooperative allocations

on the Alaska Region Web site at *http://alaskafisheries.noaa.gov* prior to the start of the fishing year on January 1, 2014, based on the harvest specifications effective on that date.

The 2015 allocations for Amendment 80 species between Amendment 80 cooperatives and the Amendment 80 limited access sector will not be known until eligible participants apply for participation in the program by November 1, 2014. NMFS will post 2015 Amendment 80 cooperatives and Amendment 80 limited access allocations on the Alaska Region Web site at *http://alaskafisheries.noaa.gov* when they become available in December 2014.

Table 6 lists the proposed 2014 and 2015 allocations of the AI Pacific ocean perch, and BSAI flathead sole, rock sole, and yellowfin sole TACs.

TABLE 6–PROPOSED 2014 AND 2015 COMMUNITY DEVELOPMENT QUOTA (CDQ) RESERVES, INCIDENTAL CATCH AMOUNTS (ICAS), AND AMENDMENT 80 ALLOCATIONS OF THE ALEUTIAN ISLANDS PACIFIC OCEAN PERCH, AND BSAI FLATHEAD SOLE, ROCK SOLE, AND YELLOWFIN SOLE TACS

[Amounts are in metric tons]

Sector	2014 and 2015 allocations					
	Pacific ocean perch			Flathead sole	Rock sole	Yellowfin sole
	Eastern Aleutian District	Central Aleutian District	Western Aleutian District	BSAI	BSAI	BSAI
TAC	9,240	6,590	9,590	22,699	94,569	200,000
CDQ	989	705	1,026	2,429	10,119	21,400
ICA	200	75	10	5,000	10,000	2,400
BSAI trawl limited access	805	581	171	0	0	35,422
Amendment 80	7,246	5,229	8,383	15,270	74,450	140,778
Alaska Groundfish Cooperative for 2014[1]	3,404	2,456	3,938	2,997	21,270	60,460
Alaska Seafood Cooperative for 2014[1]	3,842	2,773	4,445	12,273	53,180	80,317

[1] The 2015 allocations for Amendment 80 species between Amendment 80 cooperatives and the Amendment 80 limited access sector will not be known until eligible participants apply for participation in the program by November 1, 2014.

Allocation of PSC Limits for Halibut, Salmon, Crab, and Herring

Section 679.21(e) sets forth the BSAI PSC limits. Pursuant to § 679.21(e)(1)(iv) and (e)(2), the 2014 and 2015 BSAI halibut mortality limits are 3,675 mt for trawl fisheries, and 900 mt for the non-trawl fisheries. Sections 679.21(e)(3)(i)(A)(*2*) and (e)(4)(i)(A) allocate 326 mt of the trawl halibut mortality limit and 7.5 percent, or 67 mt, of the non-trawl halibut mortality limit as the PSQ reserve for use by the groundfish CDQ program.

Section 679.21(e)(4)(i) authorizes apportionment of the non-trawl halibut PSC limit into PSC bycatch allowances among six fishery categories. Table 9 lists the fishery bycatch allowances for the trawl fisheries, and Table 10 lists the fishery bycatch allowances for the non-trawl fisheries.

Pursuant to section 3.6 of the BSAI FMP, the Council recommends, and NMFS agrees, that certain specified non-trawl fisheries be exempt from the halibut PSC limit. As in past years after consultation with the Council, NMFS exempts pot gear, jig gear, and the sablefish IFQ hook-and-line gear fishery categories from halibut bycatch restrictions for the following reasons: (1) The pot gear fisheries have low halibut bycatch mortality; (2) NMFS estimates halibut mortality for the jig gear fleet to be negligible because of the small size of the fishery and the selectivity of the gear; and (3) the sablefish and halibut IFQ fisheries have low halibut bycatch mortality because the IFQ program requires legal-size halibut to be retained by vessels using hook-and-line gear if a halibut IFQ permit holder or a hired master is aboard and is holding unused halibut IFQ (subpart D of 50 CFR part 679). In 2013, total groundfish catch for the pot gear fishery in the BSAI was 26,433 mt, with an associated halibut bycatch mortality of 2 mt.

The 2013 jig gear fishery harvested about 11 mt of groundfish. Most vessels in the jig gear fleet are exempt from observer coverage requirements. As a result, observer data are not available on halibut bycatch in the jig gear fishery. However, as mentioned above, NMFS estimates a negligible amount of halibut bycatch mortality because of the selective nature of jig gear and the low mortality rate of halibut caught with jig gear and released.

Under section 679.21(f)(2), NMFS annually allocates portions of either 47,591 or 60,000 Chinook salmon PSC among the AFA sectors, depending on past catch performance and on whether Chinook salmon bycatch incentive plan agreements are formed. If an AFA sector participates in an approved Chinook salmon bycatch incentive plan agreement, then NMFS will allocate a portion of the 60,000 PSC limit to that sector as specified in § 679.21(f)(3)(iii)(A). If no Chinook salmon bycatch incentive plan agreement is approved, or if the sector has exceeded its performance standard under § 679.21(f)(6), NMFS will allocate a portion of the 47,591 Chinook salmon PSC limit to that sector as specified in § 679.21(f)(3)(iii)(B). In 2014, the Chinook salmon PSC limit is 60,000, and the AFA sector Chinook salmon allocations are seasonally allocated with 70 percent of the allocation for the A season pollock fishery, and 30 percent of the allocation for the B season pollock fishery as stated in § 679.21(f)(3)(iii)(A). The basis for these PSC limits is described in detail in the final rule implementing management measures for Amendment 91 (75 FR 53026, August 30, 2010). NMFS publishes the approved Chinook salmon bycatch incentive plan agreements, allocations and reports at: *http://alaskafisheries.noaa.gov/sustainablefisheries/bycatch/default.htm.*

Section 679.21(e)(1)(viii) specifies 700 fish as the 2014 and 2015 Chinook salmon PSC limit for the AI subarea pollock fishery. Section 679.21(e)(3)(i)(A)(*3*)(*i*) allocates 7.5 percent, or 53 Chinook salmon, as the AI subarea PSQ for the CDQ program and allocates the remaining 647 Chinook salmon to the non-CDQ fisheries.

Section 679.21(e)(1)(vii) specifies 42,000 fish as the 2014 and 2015 non-

Chinook salmon PSC limit in the Catcher Vessel Operational Area (CVOA). Section 679.21(e)(3)(i)(A)(*3*)(*ii*) allocates 10.7 percent, or 4,494, non-Chinook salmon in the CVOA as the PSQ for the CDQ program, and allocates the remaining 37,506 non-Chinook salmon to the non-CDQ fisheries.

PSC limits for crab and herring are specified annually based on abundance and spawning biomass. Due to the lack of new information as of October 2013 regarding Zone 1 red king crab and BSAI herring PSC limits and apportionments, the Council recommended and NMFS proposes basing the crab and herring 2014 and 2015 PSC limits and apportionments on the 2012 survey data. The Council will reconsider these amounts in December 2013. Pursuant to § 679.21(e)(3)(i)(A)(*1*), 10.7 percent of each PSC limit specified for crab is allocated as a PSQ reserve for use by the groundfish CDQ program.

Based on 2012 survey data, the red king crab mature female abundance is estimated at 21.1 million red king crabs, and the effective spawning biomass is estimated at 44.2 million lb (20,049 mt). Based on the criteria set out at § 679.21(e)(1)(i), the proposed 2014 and 2015 PSC limit of red king crab in Zone 1 for trawl gear is 97,000 animals. This limit derives from the mature female abundance estimate of more than 8.4 million red king crab and the effective spawning biomass estimate of more than 55 million lbs (24,948 mt).

Section 679.21(e)(3)(ii)(B)(*2*) establishes criteria under which NMFS must specify an annual red king crab bycatch limit for the Red King Crab Savings Subarea (RKCSS). The regulations limit the RKCSS to up to 25 percent of the red king crab PSC allowance. NMFS proposes the Council's recommendation that the red king crab bycatch limit be equal to 25 percent of the red king crab PSC allowance within the RKCSS (Table 8). Based on 2012 survey data, Tanner crab (*Chionoecetes bairdi*) abundance is estimated at 711 million animals. Pursuant to criteria set out at § 679.21(e)(1)(ii), the calculated 2014 and 2015 *C. bairdi* crab PSC limit for trawl gear is 980,000 animals in Zone 1, and 2,970,000 animals in Zone 2. These limits derive from the *C. bairdi* crab abundance estimate being in excess of 400 million animals for both the Zone 1 and Zone 2 allocations. Pursuant to § 679.21(e)(1)(iii), the PSC limit for snow crab (*C. opilio*) is based on total abundance as indicated by the NMFS annual bottom trawl survey. The *C. opilio* crab PSC limit is set at 0.1133 percent of the Bering Sea abundance index minus 150,000 crabs. Based on the 2012 survey estimate of 9.401 billion animals, the calculated limit is 10,501,333 animals.

Pursuant to § 679.21(e)(1)(v), the PSC limit of Pacific herring caught while conducting any trawl operation for BSAI groundfish is 1 percent of the annual eastern Bering Sea herring biomass. The best estimate of 2014 and 2015 herring biomass is 264,802 mt. This amount was derived using 2012 survey data and an age-structured biomass projection model developed by the Alaska Department of Fish and Game. Therefore, the herring PSC limit proposed for 2014 and 2015 is 2,648 mt for all trawl gear as listed in Tables 7 and 8.

Section 679.21(e)(3)(i)(A) requires PSQ reserves to be subtracted from the total trawl PSC limits. The amount of the 2014 PSC limits assigned to the Amendment 80 and BSAI trawl limited access sectors are specified in Table 35 to part 679. The resulting allocation of PSC to CDQ PSQ, the Amendment 80 sector, and the BSAI trawl limited access sector are listed in Table 7. Pursuant to § 679.21(e)(1)(iv) and § 679.91(d) through (f), crab and halibut trawl PSC assigned to the Amendment 80 sector is then further allocated to Amendment 80 cooperatives as PSC cooperative quota as listed in Table 11. Two Amendment 80 cooperatives have formed for the 2014 fishing year. Because all Amendment 80 vessels are part of a cooperative, no allocation to the Amendment 80 limited access sector is required. NMFS will post 2014 Amendment 80 cooperative allocations on the Alaska Region Web site at *http://alaskafisheries.noaa.gov* prior to the start of the fishing year on January 1, 2014, based on the harvest specifications effective on that date.

The 2015 PSC allocations between Amendment 80 cooperatives and the Amendment 80 limited access sector will not be known until eligible participants apply for participation in the program by November 1, 2014. NMFS will post 2015 Amendment 80 cooperatives and Amendment 80 limited access allocations on the Alaska Region Web site at *http://alaskafisheries.noaa.gov* when they become available in December 2014.

Section 679.21(e)(5) authorizes NMFS, after consulting with the Council, to establish seasonal apportionments of PSC amounts for the BSAI trawl limited access and Amendment 80 limited access sectors to maximize the ability of the fleet to harvest the available groundfish TAC and to minimize bycatch. The factors considered are (1) seasonal distribution of prohibited species, (2) seasonal distribution of target groundfish species, (3) PSC bycatch needs on a seasonal basis relevant to prohibited species biomass, (4) expected variations in bycatch rates throughout the year, (5) expected start of fishing effort, and (6) economic effects of seasonal PSC apportionments on industry sectors.

NMFS proposes the Council's recommendation of the seasonal PSC apportionments in Table 9 to maximize harvest among gear types, fisheries, and seasons while minimizing bycatch of PSC based on the above criteria.

TABLE 7—PROPOSED 2014 AND 2015 APPORTIONMENT OF PROHIBITED SPECIES CATCH ALLOWANCES TO NON-TRAWL GEAR, THE CDQ PROGRAM, AMENDMENT 80, AND THE BSAI TRAWL LIMITED ACCESS SECTORS

PSC species and area [1]	Total non-trawl PSC	Non-trawl PSC remaining after CDQ PSQ [2]	Total trawl PSC	Trawl PSC remaining after CDQ PSQ [2]	CDQ PSQ reserve [2]	Amendment 80 sector [3]	BSAI trawl limited access fishery
Halibut mortality (mt)							
BSAI	900	832	3,675	3,349	393	2,325	875
Herring (mt) BSAI	n/a	n/a	2,648	n/a	n/a	n/a	n/a
Red king crab (animals)							
Zone 1	n/a	n/a	97,000	86,621	10,379	43,293	26,489
C. opilio (animals)							
COBLZ	n/a	n/a	10,501,333	9,377,690	1,123,643	4,609,135	3,013,990
C. bairdi crab (animals)							
Zone 1	n/a	n/a	980,000	875,140	104,860	368,521	411,228

TABLE 7—PROPOSED 2014 AND 2015 APPORTIONMENT OF PROHIBITED SPECIES CATCH ALLOWANCES TO NON-TRAWL GEAR, THE CDQ PROGRAM, AMENDMENT 80, AND THE BSAI TRAWL LIMITED ACCESS SECTORS—Continued

PSC species and area [1]	Total non-trawl PSC	Non-trawl PSC remaining after CDQ PSQ [2]	Total trawl PSC	Trawl PSC remaining after CDQ PSQ [2]	CDQ PSQ reserve [2]	Amendment 80 sector [3]	BSAI trawl limited access fishery
G. bairdi crab (animals) Zone 2	n/a	n/a	2,970,000	2,652,210	317,790	627,778	1,241,500

[1] Refer to § 679.2 for definitions of zones.

[2] Section 679.21(e)(3)(i)(A)(*2*) allocates 326 mt of the trawl halibut mortality limit and § 679.21(e)(4)(i)(A) allocates 7.5 percent, or 67 mt, of the non-trawl halibut mortality limit as the PSQ reserve for use by the groundfish CDQ program. The PSQ reserve for crab species is 10.7 percent of each crab PSC limit.

[3] The Amendment 80 program reduced apportionment of the trawl PSC limits by 150 mt for halibut mortality and 20 percent for crab PSC. These reductions are not apportioned to other gear types or sectors.

TABLE 8—PROPOSED 2014 AND 2015 HERRING AND RED KING CRAB SAVINGS SUBAREA PROHIBITED SPECIES CATCH ALLOWANCES FOR ALL TRAWL SECTORS

Fishery categories	Herring (mt) BSAI	Red king crab (animals) Zone 1
Yellowfin sole	180	n/a
Rock sole/flathead sole/other flatfish [1]	30	n/a
Greenland turbot/arrowtooth/sablefish [2]	20	n/a
Rockfish	13	n/a
Pacific cod	40	n/a
Midwater trawl pollock	2,165	n/a
Pollock/Atka mackerel/other species [3,4]	200	n/a
Red king crab savings subarea non-pelagic trawl gear [5]	n/a	24,250
Total trawl PSC	2,648	97,000

[1] "Other flatfish" for PSC monitoring includes all flatfish species, except for halibut (a prohibited species), arrowtooth flounder, flathead sole, Greenland turbot, Kamchatka flounder, rock sole, and yellowfin sole.

[2] "Arrowtooth flounder" for PSC monitoring includes Kamchatka flounder.

[3] Pollock other than pelagic trawl pollock, Atka mackerel, and "other species" fishery category.

[4] "Other species" for PSC monitoring includes sculpins, sharks, skates, and octopuses.

[5] In October 2013 the Council recommended that the red king crab bycatch limit for non-pelagic trawl fisheries within the RKCSS be limited to 25 percent of the red king crab PSC allowance (see § 679.21(e)(3)(ii)(B)(*2*)).

TABLE 9—PROPOSED 2014 AND 2015 PROHIBITED SPECIES BYCATCH ALLOWANCES FOR THE BSAI TRAWL LIMITED ACCESS SECTOR

BSAI trawl limited access fisheries	Prohibited species and area [1]				
	Halibut mortality (mt) BSAI	Red king crab (animals) Zone 1	*C. opilio* (animals) COBLZ	*C. bairdi* (animals)	
				Zone 1	Zone 2
Yellowfin sole	167	23,338	2,840,175	346,228	1,185,500
Rock sole/flathead sole/other flatfish [2]	0	0	0	0	0
Turbot/arrowtooth/sablefish [3]	0	0	0	0	0
Rockfish April 15–December 31	5	0	4,828	0	1,000
Pacific cod	453	2,954	120,705	60,000	50,000
Pollock/Atka mackerel/other species [4]	250	197	48,282	5,000	5,000
Total BSAI trawl limited access PSC	875	26,489	3,013,990	411,228	1,241,500

[1] Refer to § 679.2 for definitions of areas.

[2] "Other flatfish" for PSC monitoring includes all flatfish species, except for halibut (a prohibited species), arrowtooth flounder, flathead sole, Greenland turbot, Kamchatka flounder, rock sole, and yellowfin sole.

[3] "Arrowtooth flounder" for PSC monitoring includes Kamchatka flounder.

[4] "Other species" for PSC monitoring includes sculpins, sharks, skates, and octopuses.

TABLE 10—PROPOSED 2014 AND 2015 HALIBUT PROHIBITED SPECIES BYCATCH ALLOWANCES FOR NON-TRAWL FISHERIES

Non-trawl fisheries	Halibut mortality (mt) BSAI	
	Catcher/ processor	Catcher vessel
Pacific cod-Total	760	15
January 1–June 10	455	10
June 10–August 15	190	3
August 15–December 31	115	2
Other non-trawl-Total		58
May 1–December 31		58
Groundfish pot and jig		Exempt
Sablefish hook-and-line		Exempt
Total non-trawl PSC		833

TABLE 11—PROPOSED 2014 PROHIBITED SPECIES BYCATCH ALLOWANCE FOR THE BSAI AMENDMENT 80 COOPERATIVES

Cooperative	Prohibited species and zones [1]				
	Halibut mortality (mt) BSAI	Red king crab (animals) Zone 1	*C. opilio* (animals) COBLZ	*C. bairdi* (animals)	
				Zone 1	Zone 2
Alaska Groundfish Cooperative	723	14,008	1,651,657	110,580	196,583
Alaska Seafood Cooperative	1,602	29,285	2,957,478	257,941	431,195

[1] Refer to § 679.2 for definitions of zones.

Halibut Discard Mortality Rates (DMRs)

To monitor halibut bycatch mortality allowances and apportionments, the Regional Administrator uses observed halibut bycatch rates, DMRs, and estimates of groundfish catch to project when a fishery's halibut bycatch mortality allowance or seasonal apportionment is reached. The DMRs are based on the best information available, including information contained in the annual SAFE report.

NMFS proposes the halibut DMRs developed and recommended by the International Pacific Halibut Commission (IPHC) and the Council for the 2014 and 2015 BSAI groundfish fisheries for use in monitoring the 2014 and 2015 halibut bycatch allowances (see Tables 6, 7, 9, 10, and 11). The IPHC developed these DMRs for the 2013 to 2015 BSAI fisheries using the 10-year mean DMRs for those fisheries. The IPHC will analyze observer data annually and recommend changes to the DMRs when a fishery DMR shows large variation from the mean. A discussion of the DMRs and their justification is available from the Council (see **ADDRESSES**). Table 12 lists the 2014 and 2015 DMRs.

TABLE 12—PROPOSED 2014 AND 2015 ASSUMED PACIFIC HALIBUT DISCARD MORTALITY RATES FOR THE BSAI

Gear	Fishery	Halibut discard mortality rate (percent)
Non-CDQ hook-and-line	Greenland turbot	13
	Other species [1]	9
	Pacific cod	9
	Rockfish	4
Non-CDQ trawl	Alaska Plaice	71
	Arrowtooth flounder [2]	76
	Atka mackerel	77
	Flathead sole	73
	Greenland turbot	64
	Kamchatka flounder	71
	Non-pelagic pollock	77
	Pelagic pollock	88
	Other flatfish [3]	71
	Other species [1]	71
	Pacific cod	71
	Rockfish	79
	Rock sole	85
	Sablefish	75
	Yellowfin sole	83
Non-CDQ pot	Other species [1]	8
	Pacific cod	8
CDQ trawl	Atka mackerel	86
	Arrowtooth flounder [2]	76

TABLE 12—PROPOSED 2014 AND 2015 ASSUMED PACIFIC HALIBUT DISCARD MORTALITY RATES FOR THE BSAI—Continued

Gear	Fishery	Halibut discard mortality rate (percent)
	Flathead sole	79
	Kamchatka flounder	90
	Non-pelagic pollock	83
	Pelagic pollock	90
	Pacific cod	90
	Greenland turbot	89
	Rockfish	80
	Rock sole	88
	Yellowfin sole	86
CDQ hook-and-line	Greenland turbot	4
	Pacific cod	10
CDQ pot	Pacific cod	8
	Sablefish	34

[1] "Other species" includes skates, sculpins, sharks, squids, and octopuses.
[2] Arrowtooth flounder includes Kamchatka flounder.
[3] "Other flatfish" includes all flatfish species, except for halibut (a prohibited species), flathead sole, Greenland turbot, rock sole, yellowfin sole, Kamchatka flounder, and arrowtooth flounder.

Listed AFA Catcher/Processor Sideboard Limits

Pursuant to § 679.64(a), the Regional Administrator is responsible for restricting the ability of listed AFA catcher/processors to engage in directed fishing for groundfish species other than pollock, to protect participants in other groundfish fisheries from adverse effects resulting from the AFA and from fishery cooperatives in the directed pollock fishery. These restrictions are set out as "sideboard" limits on catch. The basis for these proposed sideboard limits is described in detail in the final rules implementing the major provisions of the AFA (67 FR 79692, December 30, 2002) and Amendment 80 (72 FR 52668, September 14, 2007). Table 13 lists the proposed 2014 and 2015 catcher/processor sideboard limits.

All harvests of groundfish sideboard species by listed AFA catcher/processors, whether as targeted catch or incidental catch, will be deducted from the sideboard limits in Table 13. However, groundfish sideboard species that are delivered to listed AFA catcher/processors by catcher vessels will not be deducted from the 2014 and 2015 sideboard limits for the listed AFA catcher/processors.

TABLE 13—PROPOSED 2014 AND 2015 BSAI GROUNDFISH SIDEBOARD LIMITS FOR LISTED AMERICAN FISHERIES ACT CATCHER/PROCESSORS (C/PS)

[Amounts are in metric tons]

Target species	Area	1995–1997			2014 and 2015 ITAC available to all trawl C/Ps [1]	2014 and 2015 AFA C/P sideboard limit
		Retained catch	Total catch	Ratio of retained catch of total catch		
Sablefish trawl	BS	8	497	0.016	629	10
	AI	0	145	0	427	0
Greenland turbot	BS	121	17,305	0.007	1,369	10
	AI	23	4,987	0.005	383	2
Arrowtooth flounder	BSAI	76	33,987	0.002	21,250	43
Kamchatka flounder	BSAI	76	33,987	0.002	6,035	12
Rock sole	BSAI	6,317	169,362	0.037	80,384	2,974
Flathead sole	BSAI	1,925	52,755	0.036	19,294	695
Alaska plaice	BSAI	14	9,438	0.001	20,145	20
Other flatfish	BSAI	3,058	52,298	0.058	2,975	173
Pacific ocean perch	BS	12	4,879	0.002	6,528	13
	Eastern AI	125	6,179	0.02	7,854	157
	Central AI	3	5,698	0.001	5,602	6
	Western AI	54	13,598	0.004	8,152	33
Northern rockfish	BSAI	91	13,040	0.007	2,550	18
Rougheye rockfish	EBS/EAI	50	2,811	0.018	161	3
	CAI/WAI	50	2,811	0.018	204	4
Shortraker rockfish	BSAI	50	2,811	0.018	315	6
Other rockfish	BS	18	621	0.029	340	10
	AI	22	806	0.027	402	11
Atka mackerel	Central AI					
	A season [2]	n/a	n/a	0.115	3,136	361
	B season [2]	n/a	n/a	0.115	3,136	361
	Western AI					
	A season [2]	n/a	n/a	0.2	670	134
	B season [2]	n/a	n/a	0.2	670	134
Skates	BSAI	553	68,672	0.008	20,400	163

TABLE 13—PROPOSED 2014 AND 2015 BSAI GROUNDFISH SIDEBOARD LIMITS FOR LISTED AMERICAN FISHERIES ACT CATCHER/PROCESSORS (C/PS)—Continued

[Amounts are in metric tons]

Target species	Area	1995–1997			2014 and 2015 ITAC available to all trawl C/Ps [1]	2014 and 2015 AFA C/P sideboard limit
		Retained catch	Total catch	Ratio of retained catch of total catch		
Sculpins	BSAI	553	68,672	0.008	4,760	38
Sharks	BSAI	553	68,672	0.008	128	1
Squids	BSAI	73	3,328	0.022	425	9
Octopuses	BSAI	553	68,672	0.008	425	3

[1] Aleutians Islands Pacific ocean perch, and BSAI Atka mackerel, flathead sole, rock sole, and yellowfin sole are multiplied by the remainder of the TAC of that species after subtracting the CDQ reserve under § 679.20(b)(1)(ii)(C).

[2] The seasonal apportionment of Atka mackerel in the open access fishery is 50 percent in the A season and 50 percent in the B season. Listed AFA catcher/processors are limited to harvesting no more than zero in the Eastern Aleutian District and Bering Sea subarea, 20 percent of the annual ITAC specified for the Western Aleutian District, and 11.5 percent of the annual ITAC specified for the Central Aleutian District.

Note: Section 679.64(a)(1)(v) exempts AFA catcher/processors from a yellowfin sole sideboard limit because the 2014 and 2015 aggregate ITAC of yellowfin sole assigned to the Amendment 80 sector and BSAI trawl limited access sector is greater than 125,000 mt.

Section 679.64(a)(2) and Tables 40 and 41 to part 679 establish a formula for calculating PSC sideboard limits for listed AFA catcher/processors. The basis for these sideboard limits is described in detail in the final rules implementing the major provisions of the AFA (67 FR 79692, December 30, 2002) and Amendment 80 (72 FR 52668, September 14, 2007).

PSC species listed in Table 14 that are caught by listed AFA catcher/processors participating in any groundfish fishery other than pollock will accrue against the proposed 2014 and 2015 PSC sideboard limits for the listed AFA catcher/processors. Section 679.21(e)(3)(v) authorizes NMFS to close directed fishing for groundfish other than pollock for listed AFA catcher/processors once a proposed 2014 or 2015 PSC sideboard limit listed in Table 14 is reached.

Crab or halibut PSC caught by listed AFA catcher/processors while fishing for pollock will accrue against the bycatch allowances annually specified for either the midwater pollock or the pollock/Atka mackerel/"other species" fishery categories, according to regulations at § 679.21(e)(3)(iv).

TABLE 14—PROPOSED 2014 AND 2015 BSAI PROHIBITED SPECIES SIDEBOARD LIMITS FOR AMERICAN FISHERIES ACT LISTED CATCHER/PROCESSORS

PSC species and area [1]	Ratio of PSC to total PSC	Proposed 2014 and 2015 PSC available to trawl	Proposed 2014 and 2015 C/P sideboard limit [1]
BSAI Halibut mortality	n/a	n/a	286
Red king crab Zone 1 [2]	0.007	86,621	606
C. opilio (COBLZ) [2]	0.153	9,377,690	1,434,787
C. bairdi	n/a	n/a	n/a
Zone 1 [2]	0.14	875,140	122,520
Zone 2 [2]	0.05	2,652,210	132,611

[1] Refer to § 679.2 for definitions of areas.

[2] Halibut amounts are in metric tons of halibut mortality. Crab amounts are in numbers of animals.

AFA Catcher Vessel Sideboard Limits

Pursuant to § 679.64(b), the Regional Administrator is responsible for restricting the ability of AFA catcher vessels to engage in directed fishing for groundfish species other than pollock, to protect participants in other groundfish fisheries from adverse effects resulting from the AFA and from fishery cooperatives in the directed pollock fishery. Section 679.64(b) establishes formulas for setting AFA catcher vessel groundfish and PSC sideboard limits for the BSAI. The basis for these sideboard limits is described in detail in the final rules implementing the major provisions of the AFA (67 FR 79692, December 30, 2002) and Amendment 80 (72 FR 52668, September 14, 2007).

Tables 15 and 16 list the proposed 2014 and 2015 AFA catcher vessel sideboard limits.

All catch of groundfish sideboard species made by non-exempt AFA catcher vessels, whether as targeted catch or as incidental catch, will be deducted from the 2014 and 2015 sideboard limits listed in Table 15.

TABLE 15—PROPOSED 2014 AND 2015 BSAI GROUNDFISH SIDEBOARD LIMITS FOR AMERICAN FISHERIES ACT CATCHER VESSELS (CVS)

[Amounts are in metric tons]

Species	Fishery by area/gear/season	Ratio of 1995–1997 AFA CV catch to 1995–1997 TAC	2014 and 2015 initial TAC[1]	2014 and 2015 AFA catcher vessel sideboard limits
Pacific cod	BSAI	n/a	n/a	n/a
	Jig gear	0	3,063	0
	Hook-and-line CV	n/a	n/a	n/a
	Jan 1-Jun 10	0.0006	222	0
	Jun 10-Dec 31	0.0006	214	0
	Pot gear CV	n/a	n/a	n/a
	Jan 1-Jun 10	0.0006	9,338	6
	Sept 1-Dec 31	0.0006	8,971	5
	CV< 60 ft LOA using hook-and-line or pot gear.	0.0006	4,359	3
	Trawl gear CV	n/a	n/a	n/a
	Jan 20-Apr 1	0.8609	35,780	30,803
	Apr 1-Jun 10	0.8609	5,319	4,579
	Jun 10-Nov 1	0.8609	7,253	6,244
Sablefish	BS trawl gear	0.0906	629	57
	AI trawl gear	0.0645	427	28
Atka mackerel	Eastern AI/BS	n/a	n/a	n/a
	Jan 1-Jun 10	0.0032	82,500	264
	Jun 10-Nov 1	0.0032	82,500	264
	Central AI	n/a	n/a	n/a
	Jan 1-Jun 10	0.0001	3,136	0
	Jun 10-Nov 1	0.0001	3,136	0
	Western AI	n/a	n/a	n/a
	Jan 1-Jun 10	0	670	0
	Jun 10-Nov 1	0	670	0
Greenland turbot	BS	0.0645	1,369	88
	AI	0.0205	383	8
Arrowtooth flounder	BSAI	0.069	21,250	1,466
Kamchatka flounder	BSAI	0.069	6,035	416
Rock sole	BSAI	0.0341	80,384	2,741
Flathead sole	BS trawl gear	0.0505	22,699	1,146
Alaska plaice	BSAI	0.0441	20,145	888
Other flatfish	BSAI	0.0441	2,975	131
Pacific ocean perch	BS	0.1	6,528	653
	Eastern AI	0.0077	7,854	60
	Central AI	0.0025	5,602	14
	Western AI	0	8,152	0
Northern rockfish	BSAI	0.0084	2,550	21
Rougheye rockfish	EBS/EAI	0.0037	161	1
	CAI/WAI	0.0037	204	1
Shortraker rockfish	BSAI	0.0037	315	1
Other rockfish	BS	0.0048	340	2
	AI	0.0095	402	4
Skates	BSAI	0.0541	20,400	1,104
Sculpins	BSAI	0.0541	4,760	258
Sharks	BSAI	0.0541	128	7
Squids	BSAI	0.3827	425	163
Octopuses	BSAI	0.0541	425	23

[1] Aleutians Islands Pacific ocean perch, Atka mackerel, flathead sole, rock sole, and yellowfin sole are multiplied by the remainder of the TAC of that species after the subtraction of the CDQ reserve under § 679.20(b)(1)(ii)(C).

Note: Section 679.64(b)(6) exempts AFA catcher vessels from a yellowfin sole sideboard limit because the 2014 and 2015 aggregate ITAC of yellowfin sole assigned to the Amendment 80 sector and BSAI trawl limited access sector is greater than 125,000 mt.

Halibut and crab PSC limits listed in Table 16 that are caught by AFA catcher vessels participating in any groundfish fishery other than pollock will accrue against the 2014 and 2015 PSC sideboard limits for the AFA catcher vessels. Sections 679.21(d)(8) and 679.21(e)(3)(v) authorize NMFS to close directed fishing for groundfish other than pollock for AFA catcher vessels once a proposed 2014 and 2015 PSC sideboard limit listed in Table 16 is reached. The PSC that is caught by AFA catcher vessels while fishing for pollock in the Bering Sea subarea will accrue against the bycatch allowances annually specified for either the midwater pollock or the pollock/Atka mackerel/"other species" fishery categories under regulations at § 679.21(e)(3)(iv).

TABLE 16—PROPOSED 2014 AND 2015 AMERICAN FISHERIES ACT CATCHER VESSEL PROHIBITED SPECIES CATCH SIDEBOARD LIMITS FOR THE BSAI [1]

PSC species and area [2]	Target fishery category [3]	AFA catcher vessel PSC sideboard limit ratio	Proposed 2014 and 2015 PSC limit after subtraction of PSQ reserves	Proposed 2014 and 2015 AFA catcher vessel PSC sideboard limit
Halibut	Pacific cod trawl	n/a	n/a	887
	Pacific cod hook-and-line or pot	n/a	n/a	2
	Yellowfin sole total	n/a	n/a	101
	Rock sole/flathead sole/other flatfish [4]	n/a	n/a	228
	Greenland turbot/arrowtooth/sablefish [5]	n/a	n/a	0
	Rockfish	n/a	n/a	2
	Pollock/Atka mackerel/other species [6]	n/a	n/a	5
Red king crab Zone 1	n/a	0.299	86,621	25,900
C. opilio COBLZ	n/a	0.168	9,377,690	1,575,452
C. bairdi Zone 1	n/a	0.33	875,140	288,796
C. bairdi Zone 2	n/a	0.186	2,652,210	493,311

[1] Halibut amounts are in metric tons of halibut mortality. Crab amounts are in numbers of animals.
[2] Refer to § 679.2 for definitions of areas.
[3] Target fishery categories are defined in regulation at § 679.21(e)(3)(iv).
[4] "Other flatfish" for PSC monitoring includes all flatfish species, except for halibut (a prohibited species), arrowtooth flounder, flathead sole, Greenland turbot, rock sole, and yellowfin sole.
[5] Arrowtooth for PSC monitoring includes Kamchatka flounder.
[6] "Other species" for PSC monitoring includes skates, sculpins, sharks, and octopuses.

Classification

NMFS has determined that the proposed harvest specifications are consistent with the FMP and preliminarily determined that the proposed harvest specifications are consistent with the Magnuson-Stevens Act and other applicable laws.

This action is authorized under 50 CFR 679.20 and is exempt from review under Executive Orders 12866 and 13563.

NMFS prepared an EIS for this action and made it available to the public on January 12, 2007 (72 FR 1512). On February 13, 2007, NMFS issued the Record of Decision (ROD) for the EIS. A Supplemental Information Report (SIR) that assesses the need to prepare a Supplemental EIS is being prepared for the final action. Copies of the EIS, ROD, and SIR for this action are available from NMFS (see **ADDRESSES**). The EIS analyzes the environmental consequences of the proposed groundfish harvest specifications and alternative harvest strategies on resources in the action area. The EIS found no significant environmental consequences from the proposed action or its alternatives.

NMFS prepared an Initial Regulatory Flexibility Analysis (IRFA), as required by section 603 of the Regulatory Flexibility Act, analyzing the methodology for establishing the relevant TACs. The IRFA evaluates the impacts on small entities of alternative harvest strategies for the groundfish fisheries in the exclusive economic zone off Alaska. As set forth in the methodology, TACs are set to a level that fall within the range of ABCs recommended by the SSC; the sum of the TACs must achieve OY specified in the FMP. While the specific numbers that the methodology may produce vary from year to year, the methodology itself remains constant.

A description of the proposed action, why it is being considered, and the legal basis for this proposed action are contained in the preamble above. A copy of the analysis is available from NMFS (see **ADDRESSES**). A summary of the IRFA follows. The action under consideration is a harvest strategy to govern the catch of groundfish in the BSAI. The preferred alternative is the existing harvest strategy in which TACs fall within the range of ABCs recommended by the SSC, but, as discussed below, NMFS considered other alternatives. This action is taken in accordance with the FMP prepared by the Council pursuant to the Magnuson-Stevens Act.

The entities directly regulated by this action are those that harvest groundfish in the exclusive economic zone of the BSAI and in parallel fisheries within State of Alaska waters. These include entities operating catcher vessels and catcher/processors within the action area, and entities receiving direct allocations of groundfish.

On June 20, 2013, the Small Business Administration (SBA) issued a final rule revising the small business size standards for several industries effective July 22, 2013 (78 FR 37398; June 20, 2013). The rule increased the size standard for Finfish Fishing from $4.0 to 19.0 million, Shellfish Fishing from $4.0 to 5.0 million, and Other Marine Fishing from $4.0 to 7.0 million. The new size standards were used to prepare the IRFA for this action. Fishing vessels are considered small entities if their total annual gross receipts, from all their activities combined, are less than $19.0 million.

The directly regulated small entities include approximately 428 small catcher vessels, seven small catcher/processors, and six CDQ groups. The IRFA estimates the number of harvesting vessels that are considered small entities, but these estimates may overstate the number of small entities because (1) some vessels may also be active as tender vessels in the salmon fishery, fish in areas other than Alaska and the West Coast, or generate revenue from other non-fishing sources; and (2) all affiliations are not taken into account, especially if the vessel has affiliations not tracked in available data (i.e., ownership of multiple vessel or affiliation with processors) and may be misclassified as a small entity. Because the 428 CVs and seven C/Ps meet this size standard, they are considered to be small entities for the purposes of this analysis.

The preferred alternative (Alternative 2) was compared to four other alternatives. These included Alternative 1, which would have set TACs to generate fishing rates equal to the maximum permissible ABC (if the full TAC were harvested), unless the sum of TACs exceeded the BSAI OY, in which

case TACs would have been limited to the OY. Alternative 3 would have set TACs to produce fishing rates equal to the most recent 5-year average fishing rates. Alternative 4 would have set TACs equal to the lower limit of the BSAI OY range. Alternative 5, the "no action" alternative, would have set TACs equal to zero.

The TACs associated with the preferred harvest strategy are those adopted by the Council in October 2013, as per Alternative 2. OFLs and ABCs for the species were based on recommendations prepared by the Council's BSAI Plan Team in September 2013, and reviewed and modified by the Council's SSC in October 2013. The Council based its TAC recommendations on those of its AP, which were consistent with the SSC's OFL and ABC recommendations.

Alternative 1 selects harvest rates that will allow fishermen to harvest stocks at the level of ABCs, unless total harvests were constrained by the upper bound of the BSAI OY of two million mt. As shown in Table 1 of the preamble, the sum of ABCs in 2014 and 2015 would be about 2,686,688 mt, which falls above the upper bound of the OY range. The sum of TACs is equal to the sum of ABCs. In this instance, Alternative 1 is consistent with the preferred alternative (Alternative 2), meets the objectives of that action, and has small entity impacts that are equivalent to the preferred alternative.

Alternative 3 selects harvest rates based on the most recent 5 years of harvest rates (for species in Tiers 1 through 3) or for the most recent 5 years of harvests (for species in Tiers 4 through 6). This alternative is inconsistent with the objectives of this action, (the Council's preferred harvest strategy) because it does not take account of the most recent biological information for this fishery. Harvest rates are listed for each species category for each year in the SAFE report (see **ADDRESSES**).

Alternative 4 would lead to significantly lower harvests of all species and reduce TACs from the upper end of the OY range in the BSAI, to its lower end of 1.4 million mt. Overall, this would reduce 2014 TACs by about 30 percent, which would lead to significant reductions in harvests of species by small entities. While reductions of this size would be associated with offsetting price increases, the size of these increases is very uncertain. There are close substitutes for BSAI groundfish species available from the GOA. While production declines in the BSAI would undoubtedly be associated with significant price increases in the BSAI, these increases would still be constrained by production of substitutes, and are very unlikely to offset revenue declines from smaller production. Thus, this alternative action would have a detrimental impact on small entities.

Alternative 5, which sets all harvests equal to zero, would have a significant adverse impact on small entities and would be contrary to obligations to achieve OY on a continuing basis, as mandated by the Magnuson-Stevens Act.

In 2012, there were 595 individual catcher vessels with gross revenues less than or equal to $5 million. Many of these vessels are members of AFA inshore pollock cooperatives, GOA rockfish cooperatives, or crab rationalization cooperatives, and, since under the RFA it is the aggregate gross receipts of all participating members of the cooperative that must meet the "under $19 million" threshold, they are considered to be large entities within the meaning of the RFA. After accounting for membership in these cooperatives, NMFS estimates that there are an estimated 428 small catcher vessel entities remaining in the BSAI groundfish sector. These 428 vessels had average gross revenues of about $0.4 million.

In 2012, 45 catcher/processors grossed less than $19 million. In 2012, seven vessels in this group were affiliated through membership in three cooperatives (the Amendment 80 "Alaska Seafood Cooperative," the Freezer Longline Conservation Cooperative, or the crab rationalization Intercooperative Exchange). After taking account of these affiliations, NMFS estimates that there are seven small catcher/processor entities. These seven entities had average gross revenues of about $1.8 million in 2012.

The proposed harvest specifications extend the current 2014 OFLs, ABCs, and TACs to 2014 and 2015, except for Pacific cod and Kamchatka flounder. As noted in the IRFA, the Council may modify these OFLs, ABCs, and TACs in December 2013, when it reviews the November 2013 meeting report from its groundfish Plan Team, and the December Council meeting reports of its SSC and AP. Because most 2014 TACs in the proposed 2014 and 2015 harvest specifications are unchanged from the 2014 harvest specification TACs, NMFS does not expect adverse impacts on small entities. Also, NMFS does not expect any changes made by the Council in December to be large enough to have an impact on small entities.

This action does not modify recordkeeping or reporting requirements, or duplicate, overlap, or conflict with any Federal rules.

Adverse impacts on marine mammals resulting from fishing activities conducted under these harvest specifications are discussed in the EIS (see **ADDRESSES**), and in the 2012 SIR (*http://www.alaskafisheries.noaa.gov/analyses/specs/2012-13supplementaryinfoJan2012.pdf*).

Authority: 16 U.S.C. 773 *et seq.*; 16 U.S.C. 1540(f); 16 U.S.C. 1801 *et seq.*; 16 U.S.C. 3631 *et seq.*; Pub. L. 105–277; Pub. L. 106–31; Pub. L. 106–554; Pub. L. 108–199; Pub. L. 108–447; Pub. L. 109–241; Pub. L. 109–479.

Dated: December 3, 2013.

Alan D. Risenhoover,

Director, Office of Sustainable Fisheries, performing the functions and duties of the Deputy Assistant Administrator for Regulatory Programs, National Marine Fisheries Service.

[FR Doc. 2013–29352 Filed 12–9–13; 8:45 am]

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DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 679

[Docket No. 130925836–3836–01]

RIN 0648–XC895

Fisheries of the Exclusive Economic Zone Off Alaska; Gulf of Alaska; Proposed 2014 and 2015 Harvest Specifications for Groundfish

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

ACTION: Proposed rule; request for comments.

SUMMARY: NMFS proposes 2014 and 2015 harvest specifications, apportionments, and Pacific halibut prohibited species catch limits for the groundfish fishery of the Gulf of Alaska (GOA). This action is necessary to establish harvest limits for groundfish during the 2014 and 2015 fishing years and to accomplish the goals and objectives of the Fishery Management Plan for Groundfish of the Gulf of Alaska. The intended effect of this action is to conserve and manage the groundfish resources in the GOA in accordance with the Magnuson-Stevens Fishery Conservation and Management Act.

DATES: Comments must be received by January 9, 2014.

ADDRESSES: You may submit comments on this document, identified by Docket Number NOAA–NMFS–2013–0147, by any one of the following methods:

- *Electronic Submissions:* Submit all electronic public comments via the Federal e-Rulemaking Portal. Go to *www.regulations.gov/#!docketDetail;D=NOAA-NMFS-2013-0147*, click the "Comment Now!" icon, complete the required fields, and enter or attach your comments.
- *Mail:* Submit written comments to Glenn Merrill, Assistant Regional Administrator, Sustainable Fisheries Division, Alaska Region NMFS, Attn: Ellen Sebastian. Mail comments to P.O. Box 21668, Juneau, AK 99802–1668.
- *Fax:* Address written comments to Glenn Merrill, Assistant Regional Administrator, Sustainable Fisheries Division, Alaska Region NMFS, Attn: Ellen Sebastian. Fax comments to (907) 586–7557.

Instructions: Comments sent by any other method, to any other address or individual, or received after the end of the comment period, may not be considered by NMFS. All comments received are a part of the public record and will generally be posted for public viewing on *www.regulations.gov* without change. All personal identifying information (e.g., name, address), confidential business information, or otherwise sensitive information submitted voluntarily by the sender will be publicly accessible. NMFS will accept anonymous comments (enter "N/A" in the required fields if you wish to remain anonymous). Attachments to electronic comments will be accepted in Microsoft Word, Excel, or Adobe PDF file formats only.

Electronic copies of the Alaska Groundfish Harvest Specifications Final Environmental Impact Statement (Final EIS), Supplementary Information Report (SIR) to the EIS, and the Initial Regulatory Flexibility Analysis (IRFA) prepared for this action may be obtained from *http://www.regulations.gov* or from the Alaska Region Web site at *http://alaskafisheries.noaa.gov*. The final 2012 Stock Assessment and Fishery Evaluation (SAFE) report for the groundfish resources of the GOA, dated November 2012, is available from the North Pacific Fishery Management Council (Council) at 605 West 4th Avenue, Suite 306, Anchorage, AK 99501, phone 907–271–2809, or from the Council's Web site at *http://alaskafisheries.noaa.gov/npfmc*. The draft 2013 SAFE report for the GOA is available from the same source.

FOR FURTHER INFORMATION CONTACT: Obren Davis, 907–586–7228.

SUPPLEMENTARY INFORMATION: NMFS manages the GOA groundfish fisheries in the exclusive economic zone (EEZ) of the GOA under the Fishery Management Plan for Groundfish of the Gulf of Alaska (FMP). The Council prepared the FMP under the authority of the Magnuson-Stevens Fishery Conservation and Management Act (Magnuson-Stevens Act), 16 U.S.C. 1801, *et seq.* Regulations governing U.S. fisheries and implementing the FMP appear at 50 CFR parts 600, 679, and 680.

The FMP and its implementing regulations require NMFS, after consultation with the Council, to specify the total allowable catch (TAC) for each target species, the sum of which must be within the optimum yield (OY) range of 116,000 to 800,000 metric tons (mt). Section 679.20(c)(1) further requires NMFS to publish and solicit public comment on proposed annual TACs, Pacific halibut prohibited species catch (PSC) limits, and seasonal allowances of pollock and Pacific cod. The proposed harvest specifications in Tables 1 through 20 of this document satisfy these requirements. For 2014 and 2015, the sum of the proposed TAC amounts is 427,068 mt.

Under § 679.20(c)(3), NMFS will publish the final 2014 and 2015 harvest specifications after (1) considering comments received within the comment period (see **DATES**), (2) consulting with the Council at its December 2013 meeting, (3) considering information presented in the 2013 Supplementary Information Report that assesses the need to prepare a Supplemental EIS (see **ADDRESSES**) and, (4) the final 2013 SAFE report prepared for the 2014 and 2015 groundfish fisheries.

Other Actions Potentially Affecting the 2014 and 2015 Harvest Specifications

Amendment 95: Halibut Prohibited Species Catch Limit Revisions

At its June 2012 meeting, the Council took final action to reduce halibut PSC limits in the GOA trawl and hook-and-line groundfish fisheries. That action, Amendment 95 to the FMP, would change the process for setting halibut PSC limits, as well as reducing such limits from their current amounts. Halibut PSC limits would be established in Federal regulations and would remain in effect until changed by Secretarial approval of a subsequent Council action to amend those regulations.

NMFS published a notice of availability for Amendment 95 on August 29, 2013 (78 FR 53419). The public comment period for the notice of availability on Amendment 95 ended on October 28, 2013. The proposed rule that would implement Amendment 95 published on September 17, 2013 (78 FR 57106), with public comments accepted through October 17, 2013. That proposed rule describes the various reductions to the GOA halibut PSC limits and other, associated components of the action. If approved by the Secretary of Commerce (Secretary), Amendment 95 would reduce the GOA halibut PSC limit for the groundfish trawl gear sector and groundfish catcher vessel (CV) hook-and-line gear sector by 15 percent. The proposed reductions would be phased in over 3 years: 7 percent in year 1, 5 percent in year 2 (to 12 percent), and 3 percent in year 3 (for a total of 15 percent). The proposed reduction for the catcher/processor (C/P) hook-and-line gear sector would be 7 percent, which would occur during the first year of implementation. Finally, the proposed reduction for the hook-and-line demersal shelf rockfish (DSR) fishery in the Southeast Outside district of the GOA would be 1 mt. The proposed reductions to the trawl halibut PSC limits use 1,973 mt as the baseline for the reductions. That baseline limit was established with the implementation of the Central GOA Rockfish Program (Rockfish Program) in 2011 (76 FR 81248, December 27, 2011).

Amendment 95 would result in a new trawl sector halibut PSC limit of 1,848 mt in the first year of implementation (in 2014), 1,759 mt (in 2015), and 1,706 mt (in 2016 and later years). The DSR fishery halibut PSC limit would be 9 mt. The hook-and-line sector halibut PSC limits would vary annually, as these limits are based on how the Pacific cod TAC is annually apportioned between the Central and Western regulatory areas of the GOA. Based on 2013 Pacific cod TACs in the Western and Central GOA the hook-and-line C/P sector would receive a 115 mt halibut PSC limit. The hook-and-line CV sector PSC limit would be 154 mt (in 2014), 146 mt (in 2015), and 141 mt (in 2016 and later years). These limits are representative of the proposed halibut PSC reductions, but not the actual limits that would be implemented in future years. The proposed rule associated with Amendment 95 provides additional details about these limits (78 FR 57106, September 17, 2013).

Amendment 97: Chinook Salmon Prohibited Species Catch Limits in the Non-Pollock Trawl Groundfish Fisheries

In June 2013, the Council took action to recommend Amendment 97 to the

FMP, as well as accompanying regulations. If approved by the Secretary, Amendment 97 would implement measures to control Chinook salmon PSC in all non-pollock trawl groundfish fisheries in the Western and Central GOA. The directed pollock fishery is not included in the Council's recommended action, as that fishery is already subject to Chinook PSC limits (§ 679.21(h)). The Council's preferred alternative would set an initial annual limit of 7,500 Chinook salmon apportioned among the sectors of catcher/processors, catcher vessels active in the Rockfish Program, and non-Rockfish Program catcher vessels. A sector would be prohibited from directed fishing for groundfish if it caught its apportioned amount of the total Chinook PSC limit. NMFS currently is developing a proposed rulemaking for this Chinook PSC action. If approved by the Secretary, the earliest these Chinook salmon PSC limits could be implemented would be 2015.

Combining Central and Western GOA Other Rockfish Acceptable Biological Catches (ABCs) and TACs

At its November 2013 meeting, the Council's GOA Groundfish Plan Team (Plan Team) recommended combining the Western and Central GOA "other rockfish" ABCs and TACs. The "other rockfish" category in those areas include "other rockfish" (19 species) and demersal shelf rockfish (7 species). The Plan Team recommended combining these ABCs and TACs based on the challenges associated with conducting a comprehensive assessment of all of the species in the "other rockfish" category in the Western and Central GOA. The Council and its Scientific and Statistical Committee (SSC) will consider this recommendation at the December 2013 Council meeting, and may recommend combining these ABCs and TACs as recommended by the Plan Team. NMFS does not anticipate any adverse management or conservation effects if this were to occur, as directed fishing for other rockfish would continue to be prohibited in the Western and Central GOA.

Changes to GOA State of Alaska (State) Pacific Cod Guideline Harvest Level Fisheries

In addition to the Federal Pacific cod fisheries in the GOA, there are Pacific cod fisheries managed by the State of Alaska (State). The State's guideline harvest level (GHL) fisheries are conducted independently of the Federal groundfish fisheries under direct regulation of the State. The State derives GHLs from the Federal ABC for each GOA management area, and the TAC for each area is the amount available after the Council deducts the annual GHL percentage from the ABC. Thus, Pacific cod TACs are affected by the State's Pacific cod GHLs. In October 2013, the Alaska Board of Fisheries, a regulatory body for the State's Department of Fish and Game, adopted a proposal to increase the GHL in the South Alaska Peninsula management area to 30 percent from 25 percent of the Western GOA ABC. Once implemented, this would decrease the proposed Pacific cod TAC for the Western GOA. This is described in further detail in the section of this preamble that discusses the "Specification and Apportionment of TAC Amounts."

Proposed Acceptable Biological Catch (ABC) and TAC Specifications

In October 2013, the Council, its SSC, and its Advisory Panel (AP) reviewed the most recent biological and harvest information about the condition of groundfish stocks in the GOA. This information was compiled by the GOA Groundfish Plan Team and presented in the final 2012 SAFE report for the GOA groundfish fisheries, dated November 2012 (see **ADDRESSES**). The SAFE report contains a review of the latest scientific analyses and estimates of each species' biomass and other biological parameters, as well as summaries of the available information on the GOA ecosystem and the economic condition of the groundfish fisheries off Alaska. From these data and analyses, the Plan Team estimates an OFL and ABC for each species or species group. The amounts proposed for the 2014 and 2015 ABCs are based on the 2012 SAFE report. The AP and Council recommended that the proposed 2014 and 2015 TACs be set equal to proposed ABCs for all species and species groups, with the exception of the species categories further discussed below. The proposed ABCs and TACs could be changed in the final harvest specifications depending on the most recent scientific information contained in the final 2013 SAFE report.

In November 2013, the Plan Team updated the 2012 SAFE report to include new information collected during 2013, such as NMFS stock surveys, revised stock assessments, and catch data. The Plan Team compiled this information and produced the draft 2013 SAFE report for presentation at the December 2013 Council meeting. At that meeting, the Council will consider information in the draft 2013 SAFE report, recommendations from the November 2013 Plan Team meeting and December 2013 SSC and AP meetings, public testimony, and relevant written public comments in making its recommendations for the final 2014 and 2015 harvest specifications. Pursuant to section 3.2.3.4.1 of the FMP, the Council could recommend adjusting the TACs if "warranted on the basis of bycatch considerations, management uncertainty, or socioeconomic considerations, or if required in order to cause the sum of the TACs to fall within the OY range."

In previous years, the largest changes from the proposed to the final harvest specifications have been for OFLs and ABCs based on the most recent NMFS stock surveys, which provide updated estimates of stock biomass and spatial distribution, and changes to the models used for producing stock assessments. NMFS scientists presented updated and new survey results, changes to assessment models, and accompanying stock estimates at the September 2013 Plan Team meeting, and the SSC reviewed this information at the October 2013 Council meeting. The species with possible model changes are pollock, Pacific cod, flathead sole, dover sole, rock sole, "other rockfish," and demersal shelf rockfish. In November 2013, the Plan Team considered updated stock assessments for groundfish, which were included in the draft 2013 SAFE report.

If the draft 2013 SAFE report indicates that the stock biomass trend is increasing for a species, then the final 2014 and 2015 harvest specifications for that species may reflect an increase from the proposed harvest specifications. The draft 2013 SAFE reports indicate that the biomass trend for pollock, Pacific cod, deep-water flatfish, Pacific ocean perch, northern rockfish, shortraker rockfish, dusky rockfish, thornyhead rockfish, other rockfish, longnose skates, other skates, and octopuses may be increasing. Conversely, if the draft 2013 SAFE report indicates that the stock biomass trend is decreasing for a species, then the final 2014 and 2015 harvest specifications may reflect a decrease from the proposed harvest specifications. The draft 2013 SAFE reports indicate that the biomass trend for sablefish, shallow-water flatfish, rex sole, arrowtooth flounder, flathead sole, rougheye rockfish, demersal shelf rockfish, big skate, sculpins, and sharks may be decreasing. The biomass trends for Atka mackerel and squid species are relatively stable.

The proposed OFLs, ABCs, and TACs are based on the best available biological and socioeconomic information, including projected biomass trends, information on assumed

distribution of stock biomass, and revised methods used to calculate stock biomass. The FMP specifies the formulas, or tiers, to be used to compute OFLs and ABCs. The formulas applicable to a particular stock or stock complex are determined by the level of reliable information available to the fisheries scientists. This information is categorized into a successive series of six tiers to define OFL and ABC amounts, with tier one representing the highest level of information quality available and tier six representing the lowest level of information quality available. The Plan Team used the FMP tier structure to calculate OFLs and ABCs for each groundfish species.

The SSC adopted the proposed 2014 and 2015 OFLs and ABCs recommended by the Plan Team for all groundfish species. The Council adopted the SSC's OFL and ABC recommendations and the AP's TAC recommendations. These amounts are unchanged from the final 2014 harvest specifications published in the **Federal Register** on February 26, 2013 (78 FR 13162), with three exceptions. The TACs for three species and area combinations in the final 2014 harvest specifications were mis-specified and would be corrected in this proposed action. These include the TACs for shallow-water flatfish in the West Yakutat and Southeast Outside Districts of the GOA, and the TAC for rex sole in the West Yakutat District. The 2013 TACs for these species and areas were inadvertently carried forward and published as the 2014 TACs in the final 2014 harvest specifications. The 2014 TACs for these three species should have been set equal to the 2014 ABCs for these species. This resulted in these three TACs being specified as greater than the available 2014 ABCs. The proposed 2014 and 2015 TACs for these species incorporate corrections to these mis-specifications.

Specification and Apportionment of TAC Amounts

The Council recommended proposed 2014 and 2015 TACs that are equal to proposed ABCs for all species and species groups, with the exceptions of Atka mackerel, arrowtooth flounder, flathead sole, and shallow-water flatfish, "other rockfish," rex sole, Pacific cod, and pollock. The Atka mackerel TAC is set to accommodate incidental catch amounts of this species in other directed fisheries. The arrowtooth flounder, flathead sole, and shallow-water flatfish TACs are set to conserve the halibut PSC limit for use in other fisheries. The "other rockfish" TAC is set to reduce the potential amount of discards in the Southeast Outside (SEO) District. The rex sole TAC in the West Yakutat District was set to accommodate incidental catch amounts of this species in other directed fisheries.

The Pacific cod TACs are set to accommodate the State's GHL for Pacific cod so that ABCs are not exceeded. State GHL fisheries for Pacific cod are established in the Western and Central Regulatory Areas, as well as in Prince William Sound (PWS). The Plan Team, SSC, AP, and Council recommended that the sum of all State and Federal water Pacific cod removals from the GOA not exceed ABC recommendations. Accordingly, the Council reduced the proposed 2014 and 2015 Pacific cod TACs in the Eastern, Central, and Western Regulatory Areas to account for State GHLs. Therefore, the proposed 2014 and 2015 Pacific cod TACs are less than the proposed ABCs by the following amounts: (1) Eastern GOA, 842 mt; (2) Central GOA, 12,841 mt; and (3) Western GOA, 7,368 mt. These amounts reflect the sum of the State's 2014 and 2015 GHLs in these areas, which are 25 percent of the Eastern, Central, and Western GOA proposed ABCs, respectively. As described above, the State adopted an increase to the GHL for the State Pacific cod fishery in the Western GOA in October 2013. This increase, to 30 percent from 25 percent, would decrease the Western GOA Pacific cod TAC proposed by this action to 20,629 mt from 22,103 mt. This change will be incorporated in the final 2014 and 2015 harvest specifications, following the Council's review of this change at its December 2013 meeting. The final Western GOA Pacific cod TAC may be either lower or higher than the above amount (20,629 mt), as the 2014 and 2015 Pacific cod ABCs will probably differ from those proposed in this action, based on the updated stock biomass trends that will be contained in the draft 2013 SAFE report.

The ABC for the pollock stock in the combined Western, Central, and West Yakutat Regulatory Areas (W/C/WYK) has been adjusted to reflect the GHL established by the State for the PWS pollock fishery since its inception in 1995. Genetic studies have led fisheries scientists to believe that the pollock in PWS is not a separate stock from the combined W/C/WYK population. The Plan Team has had a protocol of recommending that the GHL amount be deducted from the Gulf-wide ABC since 1996. Accordingly, the Council recommended decreasing the W/C/WYK pollock ABC to account for the State's PWS GHL. For 2014 and 2015, the proposed PWS pollock GHL is 2,583 mt, as recommended by State fisheries managers.

NMFS proposed apportionment for groundfish species are based on the distribution of biomass among the regulatory areas under which NMFS manages the species. Additional regulations govern the apportionment of Pacific cod, pollock, and sablefish. Additional detail on the apportionment of Pacific cod and pollock are described below, and briefly summarized here.

NMFS proposes Pacific cod TACs in the Western, Central, and Eastern GOA (see Table 1). NMFS also proposes seasonal apportionment of the Pacific cod TACs in the Western and Central Regulatory Areas. Sixty percent of the annual TAC is apportioned to the A season for hook-and-line, pot, or jig gear from January 1 through June 10, and for trawl gear from January 20 through June 10. Forty percent of the annual TAC is apportioned to the B season for jig gear from June 10 through December 31, for hook-and-line or pot gear from September 1 through December 31, and for trawl gear from September 1 through November 1 (§§ 679.23(d)(3) and 679.20(a)(12)). The Western and Central GOA Pacific cod gear and sector apportionments are discussed in detail below; Table 3 lists these amounts.

NMFS proposes pollock TACs in the Western, Central, West Yakutat Regulatory Areas, and the Southeast Outside District of the GOA (see Table 1). NMFS also proposes seasonal apportionment of the annual pollock TAC in the Western and Central Regulatory Areas of the GOA among Statistical Areas 610, 620, and 630, and divided equally among each of the following four seasons: the A season (January 20 through March 10), the B season (March 10 through May 31), the C season (August 25 through October 1), and the D season (October 1 through November 1) (§ 679.23(d)(2)(i) through (iv), and § 679.20(a)(5)(iv)(A) and (B)). Additional detail is provided below; Table 2 lists these amounts.

The Council's recommendation for sablefish area apportionments takes into account the prohibition on the use of trawl gear in the SEO District of the Eastern Regulatory Area and makes available 5 percent of the combined Eastern Regulatory Area TACs to trawl gear for use as incidental catch in other directed groundfish fisheries in the WYK District (§ 679.20(a)(4)(i)). Additional detail is provided below; Tables 4 and 5 list these amounts.

The sum of the proposed TACs for all GOA groundfish is 427,068 mt for 2014 and 2015, which is within the OY range specified by the FMP. The sums of the proposed 2014 and 2015 TACs are lower than the final 2013 TACs currently specified for the GOA groundfish

fisheries (78 FR 13162, February 26, 2013). The proposed 2014 and 2015 TACs for Pacific cod, flathead sole, and rougheye rockfish are higher than the final 2013 TACs for these species. The proposed 2014 and 2015 TACs for pollock, sablefish, shallow-water flatfish, rex sole, Pacific ocean perch, northern rockfish, and dusky rockfish are lower than the final 2013 TACs for these species. The proposed 2014 and 2015 TACs for the remaining species are equal to the final 2013 TACs.

For 2014 and 2015, the Council recommends and NMFS proposes the OFLs, ABCs, and TACs listed in Table 1. The proposed ABCs reflect harvest amounts that are less than the specified overfishing levels. The sum of the proposed 2014 and 2015 ABCs for all assessed groundfish is 584,094 mt, which is lower than the final 2013 ABC total of 595,920 mt (78 FR 13162, February 26, 2013).

Table 1 lists the proposed 2014 and 2015 OFLs, ABCs, TACs, and area apportionments of groundfish in the GOA. These amounts are consistent with the biological condition of groundfish stocks as described in the 2012 SAFE report, and adjusted for other biological and socioeconomic considerations, including maintaining the total TAC within the required OY range. These proposed amounts and apportionments by area, season, and sector are subject to change pending consideration of the draft 2013 SAFE report and the Council's recommendations for the final 2014 and 2015 harvest specifications during its December 2013 meeting.

TABLE 1—PROPOSED 2014 AND 2015 ABCS, TACS, AND OFLS OF GROUNDFISH FOR THE WESTERN/CENTRAL/WEST YAKUTAT (W/C/WYK), WESTERN (W), CENTRAL (C), EASTERN (E) REGULATORY AREAS, AND IN THE WEST YAKUTAT (WYK), SOUTHEAST OUTSIDE (SEO), AND GULFWIDE (GW) DISTRICTS OF THE GULF OF ALASKA

[Values are rounded to the nearest metric ton]

Species	Area [1]	OFL	ABC	TAC
Pollock [2]	Shumagin (610)	n/a	25,648	25,648
	Chirikof (620)	n/a	47,004	47,004
	Kodiak (630)	n/a	25,011	25,011
	WYK (640)	n/a	3,093	3,093
	W/C/WYK (subtotal)	138,610	100,756	100,756
	SEO (650)	14,366	10,774	10,774
	Total	152,976	111,530	111,530
Pacific cod [3]	W	n/a	29,470	22,103
	C	n/a	51,362	38,522
	E	n/a	3,368	2,526
	Total	101,100	84,200	63,150
Sablefish [4]	W	n/a	1,641	1,641
	C	n/a	5,195	5,195
	WYK	n/a	1,902	1,902
	SEO	n/a	2,993	2,993
	E (WYK and SEO) (subtotal)	n/a	4,895	4,895
	Total	13,871	11,731	11,731
Shallow-water flatfish [6]	W	n/a	18,033	13,250
	C	n/a	18,660	18,000
	WYK	n/a	4,299	4,299
	SEO	n/a	1,092	1,092
	Total	51,580	42,084	36,641
Deep-water flatfish [5]	W	n/a	176	176
	C	n/a	2,308	2,308
	WYK	n/a	1,581	1,581
	SEO	n/a	1,061	1,061
	Total	6,834	5,126	5,126
Rex sole	W	n/a	1,287	1,287
	C	n/a	6,310	6,310
	WYK	n/a	823	823
	SEO	n/a	1,040	822
	Total	12,362	9,460	9,242
Arrowtooth flounder	W	n/a	26,970	14,500
	C	n/a	140,424	75,000
	WYK	n/a	20,754	6,900
	SEO	n/a	20,663	6,900
	Total	245,262	208,811	103,300
Flathead sole	W	n/a	16,063	8,650

TABLE 1—PROPOSED 2014 AND 2015 ABCS, TACS, AND OFLS OF GROUNDFISH FOR THE WESTERN/CENTRAL/WEST YAKUTAT (W/C/WYK), WESTERN (W), CENTRAL (C), EASTERN (E) REGULATORY AREAS, AND IN THE WEST YAKUTAT (WYK), SOUTHEAST OUTSIDE (SEO), AND GULFWIDE (GW) DISTRICTS OF THE GULF OF ALASKA—Continued

[Values are rounded to the nearest metric ton]

Species	Area [1]	OFL	ABC	TAC
	C	n/a	27,126	15,400
	WYK	n/a	4,785	4,785
	SEO	n/a	1,797	1,797
	Total	62,296	49,771	30,632
Pacific ocean perch [7]	W	n/a	2,005	2,005
	C	n/a	10,740	10,740
	WYK	n/a	1,613	1,613
	W/C/WYK	16,555		
	SEO	2,046	1,775	1,775
	Total	18,061	16,133	16,133
Northern rockfish [8]	W	n/a	1,899	1,899
	C	n/a	2,951	2,951
	E	n/a		
	Total	5,791	4,850	4,850
Shortraker rockfish [9]	W	n/a	104	104
	C	n/a	452	452
	E	n/a	525	525
	Total	1,441	1,081	1,081
Dusky rockfish [10]	W	n/a	354	354
	C	n/a	3,317	3,317
	WYK	n/a	465	465
	SEO	n/a	277	277
	Total	5,395	4,413	4,413
Rougheye rockfish [11]	W	n/a	83	83
	C	n/a	871	871
	E	n/a	300	300
	Total	1,508	1,254	1,254
Demersal shelf rockfish [12]	SEO	487	303	303
Thornyhead rockfish [13]	W	n/a	150	150
	C	n/a	766	766
	E	n/a	749	749
	Total	2,220	1,665	1,665
Other rockfish [14 15]	W	n/a	44	44
	C	n/a	606	606
	WYK	n/a	230	230
	SEO	n/a	3,165	200
	Total	5,305	4,045	1,080
Atka mackerel	GW	6,200	4,700	2,000
Big skates [16]	W	n/a	469	469
	C	n/a	1,793	1,793
	E	n/a	1,505	1,505
	Total	5,023	3,767	3,767
Longnose skates [17]	W	n/a	70	70
	C	n/a	1,879	1,879
	E	n/a	676	676
	Total	3,500	2,625	2,625
Other skates [18]	GW	2,706	2,030	2,030
Sculpins	GW	7,614	5,884	5,884
Sharks	GW	8,037	6,028	6,028
Squid	GW	1,530	1,148	1,148

TABLE 1—PROPOSED 2014 AND 2015 ABCs, TACs, AND OFLs OF GROUNDFISH FOR THE WESTERN/CENTRAL/WEST YAKUTAT (W/C/WYK), WESTERN (W), CENTRAL (C), EASTERN (E) REGULATORY AREAS, AND IN THE WEST YAKUTAT (WYK), SOUTHEAST OUTSIDE (SEO), AND GULFWIDE (GW) DISTRICTS OF THE GULF OF ALASKA—Continued

[Values are rounded to the nearest metric ton]

Species	Area [1]	OFL	ABC	TAC
Octopuses	GW	1,941	1,455	1,455
Total		723,580	584,094	427,068

[1] Regulatory areas and districts are defined at § 679.2. (W=Western Gulf of Alaska; C=Central Gulf of Alaska; E=Eastern Gulf of Alaska; WYK=West Yakutat District; SEO=Southeast Outside District; GW=Gulf-wide).

[2] Pollock is apportioned in the Western/Central Regulatory Areas among three statistical areas. Table 2 lists the proposed 2014 and 2015 seasonal apportionments. In the West Yakutat and Southeast Outside Districts of the Eastern Regulatory Area, pollock is not divided into seasonal allowances.

[3] Section 679.20(a)(12)(i) requires the allocation of the Pacific cod TACs in the Western and Central Regulatory Areas of the GOA among gear and operational sectors. The annual Pacific cod TAC is apportioned among various sectors 60 percent to the A season and 40 percent to the B season in the Western and Central Regulatory Areas of the GOA. In the Eastern Regulatory Area of the GOA, Pacific cod is allocated 90 percent for processing by the inshore component and 10 percent for processing by the offshore component. Table 3 lists the proposed 2014 and 2015 Pacific cod seasonal apportionments.

[4] Sablefish is allocated to hook-and-line and trawl gear in 2014 and trawl gear in 2015. Tables 4 and 5 list the proposed 2014 and 2015 allocations of sablefish TACs.

[5] "Deep-water flatfish" means Dover sole, Greenland turbot, Kamchatka flounder, and deep-sea sole.

[6] "Shallow-water flatfish" means flatfish not including "deep-water flatfish," flathead sole, rex sole, or arrowtooth flounder.

[7] "Pacific ocean perch" means *Sebastes alutus*.

[8] "Northern rockfish" means *Sebastes polyspinous*. For management purposes the 3 mt apportionment of ABC to the WYK District of the Eastern Gulf of Alaska has been included in the slope rockfish species group.

[9] "Shortraker rockfish" means *Sebastes borealis*.

[10] "Dusky rockfish" means *Sebastes variabilis*.

[11] "Rougheye rockfish" means *Sebastes aleutianus* (rougheye) and *Sebastes melanostictus* (blackspotted).

[12] "Demersal shelf rockfish" means *Sebastes pinniger* (canary), *S. nebulosus* (china), *S. caurinus* (copper), *S. maliger* (quillback), *S. helvomaculatus* (rosethorn), *S. nigrocinctus* (tiger), and *S. ruberrimus* (yelloweye).

[13] "Thornyhead rockfish" means "*Sebastes* species"

[14] "Other rockfish (slope rockfish)" means *Sebastes aurora* (aurora), *S. melanostomus* (blackgill), *S. paucispinis* (bocaccio), *S. goodei* (chilipepper), *S. crameri* (darkblotch), *S. elongatus* (greenstriped), *S. variegatus* (harlequin), *S. wilsoni* (pygmy), *S. babcocki* (redbanded), *S. proriger* (redstripe), *S. zacentrus* (sharpchin), *S. jordani* (shortbelly), *S. brevispinis* (silvergray), *S. diploproa* (splitnose), *S. saxicola* (stripetail), *S. miniatus* (vermilion), *S. reedi* (yellowmouth), *S. entomelas* (widow), and *S. flavidus* (yellowtail). In the Eastern GOA only, other rockfish also includes northern rockfish, *S. polyspinous*.

[15] "Other rockfish" in the Western and Central Regulatory Areas and in the West Yakutat District means other rockfish and demersal shelf rockfish.

[16] "Big skate" means *Raja binoculata*.

[17] "Longnose skate" means *Raja rhina*.

[18] "Other skates" means *Bathyraja* spp.

Proposed Apportionment of Reserves

Section 679.20(b)(2) requires NMFS to set aside 20 percent of each TAC for pollock, Pacific cod, flatfish, skates, sharks, squids, sculpins, and octopuses in reserves for possible apportionment at a later date during the fishing year. In 2013, NMFS apportioned all of the reserves in the final harvest specifications. For 2014 and 2015, NMFS proposes reapportionment of all the reserves for pollock, Pacific cod, flatfish, skates, sharks, squids, sculpins, and octopuses in anticipation of the projected annual catch of these species. The TACs in Table 1 reflect the apportionment of reserve amounts for these species and species groups. Each proposed TAC for the above mentioned species categories contains the full TAC recommended by the Council, since none of the relevant species and species groups' TACs contributed to a reserve that could be used for future reapportionments.

Proposed Apportionments of Pollock TAC Among Seasons and Regulatory Areas, and Allocations for Processing by Inshore and Offshore Components

As noted earlier, pollock is apportioned by season and area, and is further allocated for processing by inshore and offshore components. Pursuant to § 679.20(a)(5)(iv)(B), the annual pollock TAC specified for the Western and Central Regulatory Areas of the GOA is apportioned into four equal seasonal allowances of 25 percent. As established by § 679.23(d)(2)(i) through (iv), the A, B, C, and D season allowances are available from January 20 through March 10, March 10 through May 31, August 25 through October 1, and October 1 through November 1, respectively.

Pollock TACs in the Western and Central Regulatory Areas of the GOA are apportioned among Statistical Areas 610, 620, and 630, pursuant to § 679.20(a)(5)(iv)(A). In the A and B seasons, the apportionments have historically been based on the proportional distribution of pollock biomass based on the four most recent NMFS winter surveys. In the C and D seasons, the apportionments are in proportion to the distribution of pollock biomass based on the four most recent NMFS summer surveys. However, for 2014 and 2015, the Council recommends, and NMFS proposes, averaging the winter and summer distribution of pollock in the Central Regulatory Area for the A season instead of using the distribution based on only the winter surveys. This combination of summer and winter distribution has been used since 2002. The average is intended to reflect the best available information about migration patterns, distribution of pollock, and the performance of the fishery in the area during the A season. During the A season, the apportionment is based on the proposed adjusted estimate of the relative distribution of pollock biomass of approximately 16 percent, 62 percent, and 22 percent in Statistical Areas 610, 620, and 630, respectively. During the B season, the apportionment is based on the relative distribution of pollock biomass of approximately 16 percent, 74 percent, and 10 percent in Statistical

Areas 610, 620, and 630, respectively. During the C and D seasons, the apportionment is based on the relative distribution of pollock biomass of approximately 36 percent, 28 percent, and 35 percent in Statistical Areas 610, 620, and 630, respectively.

Within any fishing year, the amount by which a seasonal allowance is underharvested or overharvested may be added to, or subtracted from, subsequent seasonal allowances in a manner to be determined by the Regional Administrator (§ 679.20(a)(5)(iv)(B)). The rollover amount is limited to 20 percent of the unharvested seasonal apportionment for the statistical area. Any unharvested pollock above the 20-percent limit could be further distributed to the other statistical areas, in proportion to the estimated biomass in the subsequent season in those statistical areas (§ 679.20(a)(5)(iv)(B)). The proposed 2014 and 2015 pollock TACs in the WYK District of 3,093 mt and SEO District of 10,774 mt are not allocated by season.

Section 679.20(a)(6)(i) requires the allocation of 100 percent of the pollock TAC in all regulatory areas and all seasonal allowances to vessels catching pollock for processing by the inshore component after subtraction of pollock amounts projected by the Regional Administrator to be caught by, or delivered to, the offshore component incidental to directed fishing for other groundfish species. Thus, the amount of pollock available for harvest by vessels harvesting pollock for processing by the offshore component is that amount that will be taken as incidental catch during directed fishing for groundfish species other than pollock, up to the maximum retainable amounts allowed under § 679.20(e) and (f). At this time, these incidental catch amounts of pollock are unknown and will be determined as fishing activity occurs during the fishing year by the offshore component.

Table 2 lists the proposed 2014 and 2015 seasonal biomass distribution of pollock in the Western and Central Regulatory Areas, area apportionments, and seasonal allowances. The amounts of pollock for processing by the inshore and offshore components are not shown.

TABLE 2—PROPOSED 2014 AND 2015 DISTRIBUTION OF POLLOCK IN THE CENTRAL AND WESTERN REGULATORY AREAS OF THE GULF OF ALASKA; SEASONAL BIOMASS DISTRIBUTION, AREA APPORTIONMENTS, AND SEASONAL ALLOWANCES OF ANNUAL TAC [1]

[Values are rounded to the nearest metric ton]

Season [2]	Shumagin (Area 610)		Chirikof (Area 620)		Kodiak (Area 630)		Total
A (Jan 20–Mar 10)	3,921	(16.06%)	15,015	(61.50%)	5,481	(22.45%)	24,416
B (Mar 10–May 31)	3,921	(16.06%)	18,102	(67.25%)	2,393	(9.80%)	24,416
C (Aug 25–Oct 1)	8,903	(36.47%)	6,944	(28.44%)	8,568	(32.10%)	24,416
D (Oct 1–Nov 1)	8,903	(36.47%)	6,944	(28.44%)	8,568	(32.10%)	24,415
Annual Total [3]	25,648		47,004		25,011		97,663

[1] Area apportionments and seasonal allowances may not total precisely due to rounding.
[2] As established by § 679.23(d)(2)(i) through (iv), the A, B, C, and D season allowances are available from January 20 to March 10, March 10 to May 31, August 25 to October 1, and October 1 to November 1, respectively. The amounts of pollock for processing by the inshore and offshore components are not shown in this table.
[3] The WYK and SEO District pollock TACs are not allocated by season and are not included in the total pollock TACs shown in this table.

Proposed Annual and Seasonal Apportionments of Pacific Cod

Section 679.20(a)(6)(ii) requires the allocation of the Pacific cod TAC between the inshore and offshore components in the Eastern Regulatory Area of the GOA. Additional apportionment by gear, operational sectors, and season are not required in the Eastern Regulatory Area of the GOA.

Pursuant to § 679.20(a)(12)(i), NMFS proposes allocations for the 2014 and 2015 Pacific cod TACs in the Western and Central Regulatory Areas of the GOA. Section 679.20(a)(12)(i) requires allocation of the Pacific cod TAC among gear and operational sectors in each area. In the Central GOA, the Pacific cod TAC is apportioned seasonally among vessels using jig gear, CVs less than 50 feet in length overall using hook-and-line gear, CVs equal to or greater than 50 feet in length overall using hook-and-line gear, C/Ps using hook-and-line gear, CVs using trawl gear, C/Ps using trawl gear, and vessels using pot gear. In the Western GOA, the Pacific cod TAC is apportioned seasonally among vessels using jig gear, CVs using hook-and-line gear, C/Ps using hook-and-line gear, CVs using trawl gear, and vessels using pot gear. The overall seasonal apportionments in the Western and Central GOA are 60 percent of the annual TAC to the A season and 40 percent of the annual TAC to the B season.

In accordance with the FMP, the annual jig sector allocations may increase up to 6 percent of the annual Western and Central GOA Pacific cod TACs depending on the annual performance of the jig sector (See Table 1 of Amendment 83 to the FMP for a detailed discussion of the jig sector allocation process (76 FR 74670, December 1, 2011)). NMFS proposes that the jig sector receive 2.5 percent of the annual Pacific cod TAC in the Western GOA. This includes a base allocation of 1.5 percent and an additional 1.0 percent because this sector harvested greater than 90 percent of its initial 2012 allocation in the Western GOA. NMFS also proposes that the jig sector would receive 2.0 percent of the annual Pacific cod TAC in the Central GOA. This includes a base allocation of 1.0 percent and an additional 1.0 percent because this sector harvested greater than 90 percent of its initial 2012 allocation in the Central GOA. In 2013, neither the Western nor Central GOA jig sectors harvested 90 percent of their respective 2013 Pacific cod allocations. However, jig sector allocation increases are established for a minimum of 2 years. In 2014, NMFS will re-evaluate the annual 2013 and 2014 harvest performance of each jig sector and determine whether to maintain or decrease the jig sector allocations proposed by this action in conjunction with the 2015 and 2016 proposed harvest specifications. The jig sector allocations are further apportioned between the A (60 percent) and B (40 percent) season.

After allocation to the jig sector, the non-jig sector allocations based on gear type, operation type, and vessel length overall are allocated the remainder of the annual Pacific cod TAC in the Western and Central GOA. Table 3 lists

the seasonal apportionments and allocations of the proposed 2014 and 2015 Pacific cod TACs.

Under § 679.20(a)(12)(ii), any overage or underage of the Pacific cod allowance from the A season will be subtracted from, or added to, the subsequent B season allowance. In addition, any portion of the hook-and-line, trawl, pot, or jig sector allocations that is determined by NMFS as likely to go unharvested by a sector may be reapportioned to other sectors for harvest during the remainder of the fishery year.

TABLE 3—PROPOSED 2014 AND 2015 SEASONAL APPORTIONMENTS AND ALLOCATIONS OF PACIFIC COD TAC AMOUNTS TO GEAR TYPES, OPERATIONAL TYPES, AND VESSEL LENGTH OVERALL IN THE WESTERN AND CENTRAL GULF OF ALASKA AND ALLOCATIONS FOR PROCESSING BY THE INSHORE AND OFFSHORE COMPONENTS IN THE EASTERN GULF OF ALASKA

[Values are rounded to the nearest metric ton]

Regulatory area and sector	Annual allocation (mt)	A season		B season	
		Sector % of annual non-jig TAC	Seasonal allowances (mt)	Sector % of annual non-jig TAC	Seasonal allowances (mt)
Western GOA					
Jig (2.5% of TAC)	553	N/A	332	N/A	221
Hook-and-line CV	302	0.70	151	0.70	151
Hook-and-line C/P	4,267	10.90	2,349	8.90	1,918
Trawl CV	8,275	27.70	5,969	10.70	2,306
Trawl C/P	517	0.90	194	1.50	323
Pot CV and Pot C/P	8,189	19.80	4,267	18.20	3,922
Total	22,103	60.00	13,262	40.00	8,841
Central GOA					
Jig (2.0% of TAC)	770	N/A	462	N/A	308
Hook-and-line < 50 CV	5,513	9.32	3,517	5.29	1,996
Hook-and-line ≥ 50 CV	2,532	5.61	2,118	1.10	414
Hook-and-line C/P	1,927	4.11	1,550	1.00	377
Trawl CV	15,698	21.13	7,979	20.45	7,720
Trawl C/P	1,585	2.00	756	2.19	828
Pot CV and Pot C/P	10,497	17.83	6,731	9.97	3,766
Total	38,522	60.00	23,113	40.00	15,409
Eastern GOA	2,526	Inshore (90% of Annual TAC)	2,273	Offshore (10% of Annual TAC)	253

Proposed Allocations of the Sablefish TAC Amounts to Vessels Using Hook-and-Line and Trawl Gear

Section 679.20(a)(4)(i) and (ii) require allocations of sablefish TACs for each of the regulatory areas and districts to hook-and-line and trawl gear. In the Western and Central Regulatory Areas, 80 percent of each TAC is allocated to hook-and-line gear, and 20 percent of each TAC is allocated to trawl gear. In the Eastern Regulatory Area, 95 percent of the TAC is allocated to hook-and-line gear and 5 percent is allocated to trawl gear. The trawl gear allocation in the Eastern GOA may only be used to support incidental catch of sablefish in directed fisheries for other target species (§ 679.20(a)(4)(i)).

In recognition of the prohibition against trawl gear in the SEO District of the Eastern Regulatory Area, the Council recommended and NMFS proposes the allocation of 5 percent of the combined Eastern Regulatory Area sablefish TAC to trawl gear in the WYK District, making the remainder of the WYK sablefish TAC available to vessels using hook-and-line gear. As a result, NMFS proposes to allocate 100 percent of the sablefish TAC in the SEO District to vessels using hook-and-line gear. This recommendation results in a proposed 2014 allocation of 245 mt to trawl gear and 1,657 mt to hook-and-line gear in the WYK District, and 2,993 mt to hook-and-line gear in the SEO District. Table 4 lists the allocations of the proposed 2014 sablefish TACs to hook-and-line and trawl gear. Table 5 lists the allocations of the proposed 2015 sablefish TACs to trawl gear.

The Council recommended that the hook-and-line sablefish TAC be established annually to ensure that the Individual Fishery Quota (IFQ) fishery is conducted concurrent with the halibut IFQ fishery and is based on recent survey information. The Council also recommended that only the trawl sablefish TAC be established for 2 years so that retention of incidental catch of sablefish by trawl gear could commence in January in the second year of the groundfish harvest specifications. Since there is an annual assessment for sablefish and the final harvest specifications are expected to be published before the IFQ season begins (typically, in early March), the Council recommended that the sablefish TAC be set on an annual basis, rather than for 2 years, so that the best available scientific information could be considered in establishing the ABCs and TACs. With the exception of the trawl allocations that are provided to the Rockfish Program cooperatives (see Table 28c to part 679), directed fishing for sablefish with trawl gear is closed during the fishing year. Also, fishing for groundfish with trawl gear is prohibited prior to January 20. Therefore, it is not likely that the sablefish allocation to trawl gear would be reached before the effective date of the final 2014 and 2015 harvest specifications.

TABLE 4—PROPOSED 2014 SABLEFISH TAC AMOUNTS IN THE GULF OF ALASKA AND ALLOCATIONS TO HOOK-AND-LINE AND TRAWL GEAR

[Values are rounded to the nearest metric ton]

Area/district	TAC	Hook-and-line allocation	Trawl allocation
Western	1,641	1,313	328
Central	5,195	4,156	1,039
West Yakutat [1]	1,902	1,657	245
Southeast Outside	2,993	2,993	0
Total	11,731	10,119	1,612

[1] The proposed trawl allocation is based on allocating 5 percent of the combined Eastern Regulatory Area (West Yakutat and Southeast Outside districts combined) sablefish TAC to trawl gear in the West Yakutat district.

TABLE 5—PROPOSED 2015 SABLEFISH TAC AMOUNTS IN THE GULF OF ALASKA AND ALLOCATION TO TRAWL GEAR [1]

[Values are rounded to the nearest metric ton]

Area/District	TAC	Hook-and-line allocation	Trawl allocation
Western	1,641	n/a	328
Central	5,195	n/a	1,039
West Yakutat[2]	1,902	n/a	245
Southeast Outside	2,993	n/a	0
Total	11,731	n/a	1,612

[1] The Council recommended that harvest specifications for the hook-and-line gear sablefish Individual Fishing Quota fisheries be limited to 1 year.

[2] The proposed trawl allocation is based on allocating 5 percent of the combined Eastern Regulatory Area (West Yakutat and Southeast Outside districts combined) sablefish TAC to trawl gear in the West Yakutat district.

Proposed Apportionments to the Rockfish Program

These proposed 2014 and 2015 harvest specifications for the GOA include the various fishery cooperative allocations and sideboard limitations established by the Rockfish Program. Program participants are primarily trawl catcher vessels and trawl catcher/processors, with limited participation by vessels using longline gear. The Rockfish Program assigns quota share and cooperative quota to participants for primary and secondary species, allows a participant holding a license limitation program (LLP) license with rockfish quota share to form a rockfish cooperative with other persons, and allows holders of C/P LLP licenses to opt-out of the fishery. The Rockfish Program also has an entry level fishery for rockfish primary species for vessels using longline gear.

Under the Rockfish Program, rockfish primary species (Pacific ocean perch, northern rockfish, and dusky rockfish) in the Central GOA are allocated to participants after deducting for incidental catch needs in other directed groundfish fisheries. Participants in the Rockfish Program also receive a portion of the Central GOA TAC of specific secondary species (Pacific cod, rougheye rockfish, sablefish, shortraker rockfish, and thornyhead rockfish).

Additionally, the Rockfish Program establishes sideboard limits to restrict the ability of harvesters operating under the Rockfish Program to increase their participation in other, non-Rockfish Program fisheries. Besides groundfish species, the Rockfish Program allocates a portion of the halibut PSC limit from the third season deep-water species fishery allowance for the GOA trawl fisheries to Rockfish Program participants. (Rockfish Program sideboards and halibut PSC limits are discussed below.)

Section 679.81(a)(2)(ii) requires allocations of 5 mt of Pacific ocean perch, 5 mt of northern rockfish, and 30 mt of dusky rockfish to the entry level longline fishery in 2014 and 2015. The allocation for the entry level longline fishery would increase incrementally each year if the catch exceeds 90 percent of the allocation of a species. The incremental increase in the allocation would continue each year until it is the maximum percent of the TAC for that species. In 2013, the catch did not exceed 90 percent of any allocated rockfish species. Therefore, NMFS is not proposing an increase to the entry level longline fishery 2014 and 2015 allocations in the Central GOA. The remainder of the TACs for the rockfish primary species would be allocated to the CV and C/P cooperatives. Table 6 lists the allocations of the proposed 2014 and 2015 TACs for each rockfish primary species to the entry level longline fishery, the incremental increase for future years, and the maximum percent of the TAC for the entry level longline fishery.

TABLE 6—PROPOSED 2014 AND 2015 ALLOCATIONS OF ROCKFISH PRIMARY SPECIES TO THE ENTRY LEVEL LONGLINE FISHERY IN THE CENTRAL GULF OF ALASKA.

Rockfish primary species	Allocations of the proposed 2014 and 2015 TAC	Incremental increase per year if catch exceeds 90 percent of the allocation of:	Up to maximum percent of each TAC of: (%)
Pacific ocean perch	5 metric tons	5 metric tons	1
Northern rockfish	5 metric tons	5 metric tons	2

TABLE 6—PROPOSED 2014 AND 2015 ALLOCATIONS OF ROCKFISH PRIMARY SPECIES TO THE ENTRY LEVEL LONGLINE FISHERY IN THE CENTRAL GULF OF ALASKA.—Continued

Rockfish primary species	Allocations of the proposed 2014 and 2015 TAC	Incremental increase per year if catch exceeds 90 percent of the allocation of:	Up to maximum percent of each TAC of: (%)
Dusky rockfish	30 metric tons	20 metric tons	5

Section 679.81(a)(2)(iii) requires allocations of rockfish primary species among various components of the Rockfish Program. Table 7 lists the proposed 2014 and 2015 allocations of rockfish in the Central GOA to the entry level longline fishery and other participants in the Rockfish Program, which include CV and C/P cooperatives. NMFS also proposes setting aside incidental catch amounts (ICAs) for other directed fisheries in the Central GOA of 1,200 mt of Pacific ocean perch, 200 mt of northern rockfish, and 200 mt of dusky rockfish. These amounts are based on recent average incidental catches in the Central GOA by other groundfish fisheries.

Allocations among vessels belonging to CV or C/P cooperatives are not included in these proposed harvest specifications. Rockfish Program applications for CV cooperatives and C/P cooperatives are not due to NMFS until March 1 of each calendar year; therefore, NMFS cannot calculate 2014 and 2015 allocations in conjunction with these proposed harvest specifications. NMFS will post these allocations on the Alaska Region Web site at (*http://alaskafisheries.noaa.gov/sustainablefisheries/goarat/default.htm*) when they become available after March 1.

TABLE 7—PROPOSED 2014 AND 2015 ALLOCATIONS OF ROCKFISH PRIMARY SPECIES IN THE CENTRAL GULF OF ALASKA TO THE ENTRY LEVEL LONGLINE FISHERY AND OTHER PARTICIPANTS IN THE ROCKFISH PROGRAM

[Values are rounded to the nearest metric ton]

Rockfish primary species	TAC	Incidental catch allowance	TAC minus ICA	Allocation to the entry level longline [1] fishery	Allocation to other participants in rockfish program [2]
Pacific ocean perch	10,740	1,200	9,540	5	9,535
Northern rockfish	2,951	200	2,751	5	2,746
Dusky rockfish	3,317	200	3,117	30	3,087
Total	17,008	1,600	15,408	40	15,368

[1] Longline gear includes hook-and-line, jig, troll, and handline gear.
[2] Other participants in the Rockfish Program include vessels in CV and C/P cooperatives.

Section 679.81(c) requires allocations of rockfish secondary species to CV and C/P cooperatives in the GOA. CV cooperatives receive allocations of Pacific cod, sablefish from the trawl gear allocation, and thornyhead rockfish. C/P cooperatives receive allocations of sablefish from the trawl allocation, rougheye rockfish, shortraker rockfish, and thornyhead rockfish. Table 8 lists the apportionments of the proposed 2014 and 2015 TACs of rockfish secondary species in the Central GOA to CV and C/P cooperatives.

TABLE 8—PROPOSED 2014 AND 2015 APPORTIONMENTS OF ROCKFISH SECONDARY SPECIES IN THE CENTRAL GOA TO CATCHER VESSEL (CV) AND CATCHER PROCESSOR (C/P) COOPERATIVES

[Values are in metric tons]

Rockfish secondary species	Central GOA annual TAC	CV cooperatives		C/P cooperatives	
		Percentage of TAC	Apportionment (mt)	Percentage of TAC	Apportionment (mt)
Pacific cod	38,522	3.81	1,468	N/A	N/A
Sablefish	5,195	6.78	352	3.51	182
Shortraker rockfish	452	N/A	N/A	40.00	181
Rougheye rockfish	871	N/A	N/A	58.87	513
Thornyhead rockfish	766	7.84	60	26.50	203

Proposed Halibut PSC Limits

As discussed above, NMFS published a proposed rule to implement Amendment 95 to the GOA FMP (78 FR 57106, September 17, 2013). Amendment 95 would include GOA halibut PSC limits in Federal regulations and reduce halibut PSC limits in the GOA trawl and hook-and-line groundfish fisheries. For most gear and operational types, the proposed reductions would be phased-in over 3

years. This 3-year period could begin as early as 2014, if a final rule implementing Amendment 95 is approved. Implementation of the Amendment 95 final rule would require reductions to the 2014 halibut PSC limits in these proposed harvest specifications.

Section 679.21(d) establishes annual halibut PSC limit apportionments to trawl and hook-and-line gear, and authorizes the establishment of apportionments for pot gear. In October 2013, the Council recommended proposed halibut PSC limits of 1,973 mt for trawl gear and 300 mt for hook-and-line gear for the 2014 and 2015 groundfish fisheries.

With respect to this proposed action, 10 mt of the 300 mt hook-and-line halibut PSC limit is further allocated to the DSR fishery in the SEO District. The DSR fishery is defined at § 679.21(d)(4)(iii)(A). This fishery has been apportioned 10 mt of the halibut PSC limit in recognition of its small-scale harvests of groundfish.

Most vessels in the DSR fishery are less than 60 ft (18.3 m) length overall and until 2013, have been exempt from observer coverage. Therefore, observer data were not available to verify actual halibut bycatch amounts. In 2013, NMFS implemented a restructured observer program in the GOA groundfish fisheries. Observers were placed on vessels between 40 and 60 feet length overall, which has provided additional data about groundfish and halibut PSC. NMFS does not yet have complete data from 2013 to evaluate halibut PSC use in the DSR fishery. NMFS estimates low halibut bycatch in the DSR fishery because (1) the duration of the DSR fisheries and the gear soak times are short, (2) the DSR fishery occurs in the winter when less overlap occurs in the distribution of DSR and halibut, and (3) the directed commercial DSR fishery has a low DSR TAC. The Alaska Department of Fish and Game sets the GHL for the DSR fishery after estimates of DSR incidental catch in all fisheries (including halibut and subsistence) and allocation to the DSR sport fish fishery have been deducted. Of the 303 mt TAC for DSR in 2013, 249 mt were available for the DSR commercial directed fishery, of which 212 mt were harvested.

The FMP authorizes the Council to exempt specific gear from the halibut PSC limits. NMFS, after consultation with the Council, proposes to exempt pot gear, jig gear, and the sablefish IFQ hook-and-line gear fishery categories from the non-trawl halibut PSC limit for 2014 and 2015. The Council recommended, and NMFS is proposing, these exemptions because (1) pot gear fisheries have low annual halibut bycatch mortality, (2) IFQ program regulations prohibit discard of halibut if any halibut IFQ permit holder on board a CV holds unused halibut IFQ (§ 679.7(f)(11)), (3) sablefish IFQ fishermen typically hold halibut IFQ permits and are therefore required to retain the halibut they catch while fishing sablefish IFQ, and (4) NMFS estimates negligible halibut mortality for the jig gear fisheries. NMFS estimates halibut mortality is negligible in the jig gear fisheries given the small amount of groundfish harvested by jig gear, the selective nature of jig gear, and the high survival rates of halibut caught and released with jig gear.

NMFS implemented a restructured observer program in 2013 (77 FR 70062, November 21, 2012). The restructured observer program provides data on fisheries that have previously been unobserved or were subject to very limited observer coverage. Specifically, the restructured observer program will improve biological and fisheries data, including halibut PSC, for pot and sablefish IFQ fisheries. NMFS will continue to review halibut PSC data collected in pot and sablefish IFQ fisheries in 2013, and provide input to the GOA Plan Team and Council. These data could be considered in future years when deciding whether to exempt specific gear from halibut PSC limits.

Section 679.21(d)(5) authorizes NMFS to seasonally apportion the halibut PSC limits after consultation with the Council. The FMP and regulations require that the Council and NMFS consider the following information in seasonally apportioning halibut PSC limits: (1) Seasonal distribution of halibut, (2) seasonal distribution of target groundfish species relative to halibut distribution, (3) expected halibut bycatch needs on a seasonal basis relative to changes in halibut biomass and expected catch of target groundfish species, (4) expected bycatch rates on a seasonal basis, (5) expected changes in directed groundfish fishing seasons, (6) expected actual start of fishing effort, and (7) economic effects of establishing seasonal halibut allocations on segments of the target groundfish industry.

The final 2013 and 2014 harvest specifications (78 FR 13162, February 26, 2013) summarized the Council's and NMFS' findings with respect to halibut PSC for each of these FMP considerations. The Council's and NMFS' findings for 2014 and 2015 are unchanged from 2013. Table 9 lists the proposed 2014 and 2015 Pacific halibut PSC limits, allowances, and apportionments. Section 679.21(d)(5)(iii) and (iv) specify that any underages or overages of a seasonal apportionment of a PSC limit will be deducted from or added to the next respective seasonal apportionment within the fishing year.

TABLE 9—PROPOSED 2014 AND 2015 PACIFIC HALIBUT PSC LIMITS, ALLOWANCES, AND APPORTIONMENTS

[Values are in metric tons]

Trawl gear			Hook-and-line gear [1]				
			Other than DSR			DSR	
Season	Percent	Amount	Season	Percent	Amount	Season	Amount
January 20–April 1	27.5	543	January 1–June 10	86	250	January 1–December 31	10
April 1–July 1	20	395	June 10–September 1	2	5		
July 1–September 1	30	592	September 1–December 31.	12	35		
September 1–October 1	7.5	148					
October 1–December 31	15	296					
Total		1,973			290		10

[1] The Pacific halibut PSC limit for hook-and-line gear is allocated to the demersal shelf rockfish (DSR) fishery and fisheries other than DSR. The hook-and-line IFQ sablefish fishery is exempt from halibut PSC limits, as are pot and jig gear for all groundfish fisheries.

Section 679.21(d)(3)(ii) authorizes further apportionment of the trawl halibut PSC limit as bycatch allowances to trawl fishery categories. The annual apportionments are based on each category's proportional share of the anticipated halibut bycatch mortality during a fishing year and optimization of the total amount of groundfish harvest under the halibut PSC limit. The fishery categories for the trawl halibut PSC limits are (1) a deep-water species fishery, composed of sablefish, rockfish, deep-water flatfish, rex sole, and arrowtooth flounder; and (2) a shallow-water species fishery, composed of pollock, Pacific cod, shallow-water flatfish, flathead sole, Atka mackerel, and "other species" (skates, sharks, squids, sculpins, and octopuses) (§ 679.21(d)(3)(iii)). Table 10 lists the proposed 2014 and 2015 seasonal apportionments of trawl halibut PSC limits between the trawl gear deep-water and the shallow-water species fisheries. Based on public comment and the information presented in the final 2013 SAFE report, the Council may recommend or NMFS may make changes to the seasonal, gear-type, or fishery category apportionments of halibut PSC limits for the final 2014 and 2015 harvest specifications.

TABLE 10—PROPOSED 2014 AND 2015 SEASONAL APPORTIONMENTS OF THE PACIFIC HALIBUT PSC LIMIT APPORTIONED BETWEEN THE TRAWL GEAR SHALLOW-WATER AND DEEP-WATER SPECIES FISHERIES

(Values are in metric tons)

Season	Shallow-water [1]	Deep-water [1]	Total
January 20–April 1	444	99	543
April 1–July 1	99	296	395
July 1–September 1	197	395	592
September 1–October 1	148	Any remainder	148
Subtotal, January 20–October 1	888	789	1,677
October 1–December 31 [2]			296
Total			1,973

[1] Vessels participating in cooperatives in the Rockfish Program will receive 191 mt of the third season (July 1 through September 1) deep-water species fishery halibut PSC apportionment.

[2] There is no apportionment between trawl shallow-water and deep-water species fisheries during the fifth season (October 1 through December 31).

Section 679.21(d)(4) requires that the "other than DSR" halibut PSC apportionment to vessels using hook-and-line gear must be divided between CVs and C/Ps. NMFS must calculate the halibut PSC limit apportionments for the entire GOA to hook-and-line CVs and C/Ps in accordance with § 679.21(d)(4)(iii)(B)(*1*) and (*2*) in conjunction with these harvest specifications. A comprehensive description and example of the calculations necessary to apportion the "other than DSR" hook-and-line halibut PSC limit between the hook-and-line CV and C/P sectors were included in the proposed rule to implement Amendment 83 (76 FR 44700, July 26, 2011) and is not repeated here.

For 2014 and 2015, NMFS proposes annual halibut PSC limit allocations of 166 mt to hook-and-line CVs and 124 mt to hook-and-line C/P sectors. In addition, these annual halibut PSC limits are divided into three seasonal apportionments, using seasonal percentages of 86 percent, 2 percent, and 12 percent. Table 11 lists the proposed 2014 and 2015 annual halibut PSC limits and seasonal apportionments between the hook-and-line sectors in the GOA.

No later than November 1 of each year, NMFS calculates the projected unused amount of halibut PSC limit by either of the hook-and-line sectors for the remainder of the year. The projected unused amount of halibut PSC limit is made available to the other hook-and-line sector for the remainder of that fishing year if NMFS determines that an additional amount of halibut PSC limit is necessary for that sector to continue its directed fishing operations (§ 679.21(d)(4)(iii)(B)(*3*)).

TABLE 11—PROPOSED 2014 AND 2015 APPORTIONMENTS OF THE "OTHER HOOK-AND-LINE FISHERIES" HALIBUT PSC ALLOWANCE BETWEEN THE HOOK-AND-LINE GEAR CATCHER VESSEL AND CATCHER/PROCESSOR SECTORS

[Values are in metric tons]

"Other than DSR" allowance	Hook-and-line sector	Percent of annual allowance	Sector annual amount	Season	Seasonal percentage	Sector seasonal amount
290	Catcher Vessel	57.3	166	January 1–June 10	86	143
				June 10–September 1	2	3
				September 1–December 31	12	20
	Catcher/Processor	42.7	124	January 1–June 10	86	106
				June 10–September 1	2	2
				September 1–December 31	12	15

Estimated Halibut Bycatch in Prior Years

The best available information on estimated halibut bycatch consists of data collected by fisheries observers during 2013. The calculated halibut bycatch mortality through November 2, 2013, is 1,076 mt for trawl gear, 145 mt for hook-and-line gear, and 13 mt for pot gear for a total halibut mortality of 1,234 mt. This halibut mortality was calculated using groundfish and halibut catch data from the NMFS Alaska Region's catch accounting system. This system contains historical and recent

catch information compiled from each Alaska groundfish fishery.

Halibut bycatch restrictions seasonally constrained trawl gear fisheries during the 2013 fishing year. Table 12 lists the closure dates for fisheries that resulted from the attainment of seasonal or annual halibut PSC limits.

TABLE 12—2013 FISHERY CLOSURES DUE TO ATTAINMENT OF PACIFIC HALIBUT PSC LIMITS

Fishery category	Opening date	Closure date	Federal Register citation
Trawl Deep-water,[1] season 2	April 1, 2013	May 18, 2013	78 FR 12195, May 22, 2013.
Hook-and-line gear, all sectors and targets[2]	January 1, 2013	Remains open	

[1] With the exception of vessels participating in the Rockfish Program and vessels fishing for pollock using pelagic trawl gear.
[2] With the exception of the IFQ sablefish fishery, which is open March 23, 2013, through November 7, 2013.

Halibut Discard Mortality Rates

To monitor halibut bycatch mortality allowances and apportionments, the Regional Administrator uses observed halibut incidental catch rates, discard mortality rates (DMRs), and estimates of groundfish catch to project when a fishery's halibut bycatch mortality allowance or seasonal apportionment is reached. The DMRs are based on the best information available, including information contained in the annual SAFE report.

NMFS proposes the Council's recommendation that the halibut DMRs developed and recommended by the International Pacific Halibut Commission (IPHC) for the 2013 through 2015 GOA groundfish fisheries be used to monitor the proposed 2014 and 2015 halibut bycatch mortality allowances (see Tables 9 through 11). The IPHC developed the DMRs for the 2013 through 2015 GOA groundfish fisheries using the 10-year mean DMRs for those fisheries. Long-term average DMRs were not available for some fisheries, so rates from the most recent years were used. For the sculpin, shark, squid, skate, and octopus fisheries, where insufficient mortality data are available, the mortality rate of halibut caught in the Pacific cod fishery for that gear type was recommended as a default rate. The IPHC will analyze observer data annually and recommend changes to the DMRs when a fishery DMR shows large variation from the mean. A discussion of the DMRs and how the IPHC establishes them is available from the Council (see **ADDRESSES**). Table 13 lists the proposed 2014 and 2015 DMRs.

TABLE 13—PROPOSED 2014 AND 2015 HALIBUT DISCARD MORTALITY RATES FOR VESSELS FISHING IN THE GULF OF ALASKA

[Values are percent of halibut assumed to be dead]

Gear	Target fishery	Mortality rate (%)
Hook-and-line	Other fisheries[1]	11
	Skates	11
	Pacific cod	11
	Rockfish	9
Trawl	Arrowtooth flounder	73
	Deep-water flatfish	43
	Flathead sole	65
	Non-pelagic pollock	60
	Other fisheries	62
	Pacific cod	62
	Pelagic pollock	71
	Rex sole	69
	Rockfish	66
	Sablefish	71
	Shallow-water flatfish	67
Pot	Other fisheries	17
	Pacific cod	17

[1] Other fisheries includes all gear types for Atka mackerel, sculpins, sharks, squids, octopuses, and hook-and-line sablefish.

Chinook Salmon Prohibited Species Catch Limits

Amendment 93 to the FMP (77 FR 42629, July 20, 2012) established separate Chinook salmon PSC limits in the Western and Central GOA in the directed pollock fishery. These limits require NMFS to close the pollock directed fishery in the Western and Central regulatory areas of the GOA if the applicable limit is reached (§ 679.21(h)(6)). The annual Chinook salmon PSC limits in the pollock directed fishery of 6,684 salmon in the Western GOA and 18,316 salmon in the Central GOA are set in regulation at § 679.21(h)(2)(i) and (ii). In addition, all salmon (regardless of species), taken in the pollock directed fisheries in the Western and Central GOA must be retained until an observer at the processing facility that takes delivery of the catch is provided an opportunity to count the number of salmon and to collect any scientific data or biological samples from the salmon (§ 679.21(h)(4)).

American Fisheries Act (AFA) Catcher/Processor and Catcher Vessel Groundfish Sideboard Limits

Section 679.64 establishes groundfish harvesting and processing sideboard limits on AFA C/Ps and CVs in the GOA. These sideboard limits are necessary to protect the interests of fishermen and processors who do not directly benefit from the AFA from

those fishermen and processors who receive exclusive harvesting and processing privileges under the AFA. Section 679.7(k)(1)(ii) prohibits listed AFA C/Ps from harvesting any species of fish in the GOA. Additionally, § 679.7(k)(1)(iv) prohibits listed AFA C/Ps from processing any pollock harvested in a directed pollock fishery in the GOA and any groundfish harvested in Statistical Area 630 of the GOA.

AFA CVs that are less than 125 ft (38.1 meters) length overall, have annual landings of pollock in the Bering Sea and Aleutian Islands of less than 5,100 mt, and have made at least 40 landings of GOA groundfish from 1995 through 1997 are exempt from GOA sideboard limits under § 679.64(b)(2)(ii). Sideboard limits for non-exempt AFA CVs operating in the GOA are based on their traditional harvest levels of TAC in groundfish fisheries covered by the FMP. Section 679.64(b)(3)(iii) establishes the groundfish sideboard limitations in the GOA based on the retained catch of non-exempt AFA CVs of each sideboard species from 1995 through 1997 divided by the TAC for that species over the same period.

Table 14 lists the proposed 2014 and 2015 groundfish sideboard limits for non-exempt AFA CVs. NMFS will deduct all targeted or incidental catch of sideboard species made by non-exempt AFA CVs from the sideboard limits listed in Table 14.

TABLE 14—PROPOSED 2014 AND 2015 GOA NON-EXEMPT AMERICAN FISHERIES ACT CATCHER VESSEL (CV) GROUNDFISH HARVEST SIDEBOARD LIMITS[1]

[Values are rounded to the nearest metric ton]

Species	Apportionments by season/gear	Area/component	Ratio of 1995–1997 non-exempt AFA CV catch to 1995–1997 TAC	Proposed 2014 and 2015 TACs	Proposed 2014 and 2015 non-exempt AFA CV sideboard limit
Pollock	A Season, January 20–March 10.	Shumagin (610)	0.6047	3,921	2,371
		Chirikof (620)	0.1167	15,015	1,752
		Kodiak (630)	0.2028	5,480	1,112
	B Season, March 10–May 31.	Shumagin (610)	0.6047	3,921	2,371
		Chirikof (620)	0.1167	18,102	2,112
		Kodiak (630)	0.2028	2,393	485
	C Season, August 25–October 1.	Shumagin (610)	0.6047	8,903	5,384
		Chirikof (620)	0.1167	6,943	810
		Kodiak (630)	0.2028	8,570	1,738
	D Season, October 1–November 1.	Shumagin (610)	0.6047	8,903	5,384
		Chirikof (620)	0.1167	6,943	810
		Kodiak (630)	0.2028	8,570	1,738
	Annual	WYK (640)	0.3495	3,093	1,081
		SEO (650)	0.3495	10,774	3,766
Pacific cod	A Season [1], January 1–June 10.	W	0.1331	13,262	1,765
		C	0.0692	23,113	1,599
	B Season [2], September 1–December 31.	W	0.1331	8,841	1,177
		C	0.0692	15,409	1,066
	Annual	E inshore	0.0079	2,273	18
		E offshore	0.0078	253	2
Sablefish	Annual, trawl gear	W	0.0000	328	0
		C	0.0642	1,039	67
		E	0.0433	245	11
Flatfish, shallow-water	Annual	W	0.0156	13,250	207
		C	0.0587	18,000	1,057
		E	0.0126	5,391	68
Flatfish, deep-water	Annual	W	0.0000	176	
		C	0.0647	2,308	149
		E	0.0128	2,642	34
Rex sole	Annual	W	0.0007	1,287	1
		C	0.0384	6,310	242
		E	0.0029	1,645	5
Arrowtooth flounder	Annual	W	0.0021	14,500	30
		C	0.0280	75,000	2,100
		E	0.0002	13,800	3
Flathead sole	Annual	W	0.0036	8,650	31
		C	0.0213	15,400	328
		E	0.0009	6,582	6
Pacific ocean perch	Annual	W	0.0023	2,005	5
		C	0.0748	10,740	803
		E	0.0466	3,388	158
Northern rockfish	Annual	W	0.0003	1,899	1
		C	0.0277	2,951	82

TABLE 14—PROPOSED 2014 AND 2015 GOA NON-EXEMPT AMERICAN FISHERIES ACT CATCHER VESSEL (CV) GROUNDFISH HARVEST SIDEBOARD LIMITS—Continued

[Values are rounded to the nearest metric ton]

Species	Apportionments by season/ gear	Area/component	Ratio of 1995–1997 non-exempt AFA CV catch to 1995–1997 TAC	Proposed 2014 and 2015 TACs	Proposed 2014 and 2015 non-exempt AFA CV sideboard limit
Shortraker rockfish	Annual	W	0.0000	104	0
		C	0.0218	452	10
		E	0.0110	525	6
Dusky rockfish	Annual	W	0.0001	354	0
		C	0.0000	3,317	0
		E	0.0067	742	5
Rougheye rockfish	Annual	W	0.0000	83	0
		C	0.0237	871	21
		E	0.0124	300	4
Demersal shelf rockfish	Annual	SEO	0.0020	303	1
Thornyhead rockfish	Annual	W	0.0280	150	4
		C	0.0280	766	21
		E	0.0280	749	21
Other Rockfish	Annual	W	0.0034	44	0
		C	0.1699	606	103
		E	0.0000	430	0
Atka mackerel	Annual	Gulfwide	0.0309	2,000	62
Big skates	Annual	W	0.0063	469	3
		C	0.0063	1,793	11
		E	0.0063	1,505	9
Longnose skates	Annual	W	0.0063	70	0
		C	0.0063	1,879	12
		E	0.0063	676	4
Other skates	Annual	Gulfwide	0.0063	2,030	13
Squids	Annual	Gulfwide	0.0063	5,884	37
Sharks	Annual	Gulfwide	0.0063	6,028	38
Octopuses	Annual	Gulfwide	0.0063	1,148	7
Sculpins	Annual	Gulfwide	0.0063	1,455	9

[1] The Pacific cod A season for trawl gear does not open until January 20.
[2] The Pacific cod B season for trawl gear closes November 1.

Non-Exempt AFA Catcher Vessel Halibut PSC Limits

The halibut PSC sideboard limits for non-exempt AFA CVs in the GOA are based on the aggregate retained groundfish catch by non-exempt AFA CVs in each PSC target category from 1995 through 1997 divided by the retained catch of all vessels in that fishery from 1995 through 1997 (§ 679.64(b)(4)). Table 15 lists the proposed 2014 and 2015 non-exempt AFA CV halibut PSC limits for vessels using trawl gear in the GOA.

TABLE 15—PROPOSED 2014 AND 2015 NON-EXEMPT AMERICAN FISHERIES ACT CATCHER VESSEL HALIBUT PROHIBITED SPECIES CATCH (PSC) LIMITS FOR VESSELS USING TRAWL GEAR IN THE GOA

[PSC limits are rounded to the nearest whole metric ton]

Season	Season dates	Target fishery	Ratio of 1995–1997 non-exempt AFA CV retained catch to total retained catch	Proposed 2014 and 2015 PSC limit	Proposed 2014 and 2015 non-exempt AFA CV PSC limit
1	January 20–April 1	shallow-water	0.340	444	151
		deep-water	0.070	99	7
2	April 1–July 1	shallow-water	0.340	99	34
		deep-water	0.070	296	21
3	July 1–September 1	shallow-water	0.340	197	67
		deep-water	0.070	395	28
4	September 1–October 1	shallow-water	0.340	148	50
		deep-water	0.070	0	0
5	October 1–December 31	all targets	0.205	296	61

Non-AFA Crab Vessel Groundfish Sideboard Limits

Section 680.22 establishes groundfish catch limits for vessels with a history of participation in the Bering Sea snow crab fishery to prevent these vessels from using the increased flexibility provided by the Crab Rationalization Program to expand their level of participation in the GOA groundfish fisheries. Sideboard limits restrict these vessels' catch to their collective historical landings in each GOA groundfish fishery (except the fixed-gear sablefish fishery). Sideboard limits also apply to landings made using an LLP license derived from the history of a restricted vessel, even if that LLP license is used on another vessel.

The basis for these sideboard limits is described in detail in the final rules implementing the major provisions of the Crab Rationalization Program, including Amendments 18 and 19 to the Fishery Management Plan for Bering Sea/Aleutian Islands King and Tanner Crabs (Crab FMP) (70 FR 10174, March 2, 2005) and Amendment 34 to the Crab FMP (76 FR 35772, June 20, 2011). In addition, Amendment 83 to the GOA FMP (76 FR 74670, December 1, 2011) further modified the calculation of these sideboard limits.

Table 16 lists these proposed 2014 and 2015 groundfish sideboard limitations for non-AFA crab vessels. All targeted or incidental catch of sideboard species made by non-AFA crab vessels or associated LLP licenses will be deducted from these sideboard limits.

TABLE 16—PROPOSED 2014 AND 2015 GOA NON-AMERICAN FISHERIES ACT CRAB VESSEL GROUNDFISH HARVEST SIDEBOARD LIMITS

[Values are rounded to the nearest metric ton]

Species	Season/gear	Area/component/gear	Ratio of 1996–2000 non-AFA crab vessel catch to 1996–2000 total harvest	Proposed 2014 and 2015 TACs	Proposed 2014 and 2015 non-AFA crab vessel sideboard limit
Pollock	A Season, January 20–March 10.	Shumagin (610)	0.0098	3,921	38
		Chirikof (620)	0.0031	15,015	47
		Kodiak (630)	0.0002	5,481	1
	B Season, March 10–May 31.	Shumagin (610)	0.0098	3,920	38
		Chirikof (620)	0.0031	18,102	56
		Kodiak (630)	0.0002	2,393	0
	C Season, August 25–October 1.	Shumagin (610)	0.0098	8,903	87
		Chirikof (620)	0.0031	6,944	22
		Kodiak (630)	0.0002	8,568	2
	D Season, October 1–November 1.	Shumagin (610)	0.0098	8,903	87
		Chirikof (620)	0.0031	6,944	22
		Kodiak (630)	0.0002	8,568	2
	Annual	WYK (640)	0.0000	3,093	0
		SEO (650)	0.0000	10,774	0
Pacific cod	A Season,[1] January 1–June 10.	W Jig CV	0.0000	13,262	0
		W Hook-and-line CV	0.0004	13,262	5
		W Hook-and-line C/P	0.0018	13,262	24
		W Pot CV	0.0997	13,262	1,322
		W Pot C/P	0.0078	13,262	103
		W Trawl CV	0.0007	13,262	9
		C Jig CV	0.0000	23,113	0
		C Hook-and-line CV	0.0001	23,113	2
		C Hook-and-line C/P	0.0012	23,113	28
		C Pot CV	0.0474	23,113	1,096
		C Pot C/P	0.0136	23,113	314
		C Trawl CV	0.0012	23,113	28
	B Season,[2] September 1–December 31.	W Jig CV	0.0000	8,841	0
		W Hook-and-line CV	0.0004	8,841	4
		W Hook-and-line C/P	0.0018	8,841	16
		W Pot CV	0.0997	8,841	881
		W Pot C/P	0.0078	8,841	69
		W Trawl CV	0.0007	8,841	6
		C Jig CV	0.0000	15,409	0
		C Hook-and-line CV	0.0001	15,409	2
		C Hook-and-line C/P	0.0012	15,409	18
		C Pot CV	0.0474	15,409	730
		C Pot C/P	0.0136	15,409	210
		C Trawl CV	0.0012	15,409	18
	Annual	E inshore	0.0110	2,273	25
		E offshore	0.0000	253	0
Sablefish	Annual, trawl gear	W	0.0000	328	0
		C	0.0000	1,039	0

TABLE 16—PROPOSED 2014 AND 2015 GOA NON-AMERICAN FISHERIES ACT CRAB VESSEL GROUNDFISH HARVEST SIDEBOARD LIMITS—Continued

[Values are rounded to the nearest metric ton]

Species	Season/gear	Area/component/gear	Ratio of 1996–2000 non-AFA crab vessel catch to 1996–2000 total harvest	Proposed 2014 and 2015 TACs	Proposed 2014 and 2015 non-AFA crab vessel sideboard limit
		E	0.0000	245	0
Flatfish, shallow-water	Annual	W	0.0059	13,250	78
		C	0.0001	18,000	2
		E	0.0000	5,391	0
Flatfish, deep-water	Annual	W	0.0035	176	1
		C	0.0000	2,308	0
		E	0.0000	2,642	0
Rex sole	Annual	W	0.0000	1,287	0
		C	0.0000	6,310	0
		E	0.0000	1,645	0
Arrowtooth flounder	Annual	W	0.0004	14,500	6
		C	0.0001	75,000	8
		E	0.0000	13,800	0
Flathead sole	Annual	W	0.0002	8,650	2
		C	0.0004	15,400	6
		E	0.0000	6,582	0
Pacific ocean perch	Annual	W	0.0000	2,005	0
		C	0.0000	10,740	0
		E	0.0000	3,388	0
Northern rockfish	Annual	W	0.0005	1,899	1
		C	0.0000	2,951	0
Shortraker rockfish	Annual	W	0.0013	104	0
		C	0.0012	452	1
		E	0.0009	525	0
Dusky rockfish	Annual	W	0.0017	354	1
		C	0.0000	3,317	0
		E	0.0000	742	0
Rougheye rockfish	Annual	W	0.0067	83	1
		C	0.0047	871	4
		E	0.0008	300	0
Demersal shelf rockfish	Annual	SEO	0.0000	303	0
Thornyhead rockfish	Annual	W	0.0047	150	1
		C	0.0066	766	5
		E	0.0045	749	3
Other rockfish	Annual	W	0.0035	44	0
		C	0.0033	606	2
		E	0.0000	430	0
Atka mackerel	Annual	Gulfwide	0.0000	2,000	0
Big skate	Annual	W	0.0392	469	18
		C	0.0159	1,793	29
		E	0.0000	1,505	0
Longnose skate	Annual	W	0.0392	70	3
		C	0.0159	1,879	30
		E	0.0000	676	0
Other skates	Annual	Gulfwide	0.0176	2,030	36
Sculpins	Annual	Gulfwide	0.0176	5,884	104
Sharks	Annual	Gulfwide	0.0176	6,028	106
Squids	Annual	Gulfwide	0.0176	1,148	20
Octopuses	Annual	Gulfwide	0.0176	1,455	26

[1] The Pacific cod A season for trawl gear does not open until January 20.
[2] The Pacific cod B season for trawl gear closes November 1.

Rockfish Program Groundfish Sideboard and Halibut PSC Limitations

The Rockfish Program establishes three classes of sideboard provisions: CV groundfish sideboard restrictions, C/P rockfish sideboard restrictions, and C/P opt-out vessel sideboard restrictions. These sideboards are intended to limit the ability of rockfish harvesters to expand into other fisheries.

CVs participating in the Rockfish Program may not participate in directed fishing for dusky rockfish, northern rockfish, and Pacific ocean perch in the Western GOA and West Yakutat Districts from July 1 through July 31. Also, CVs may not participate in directed fishing for arrowtooth flounder, deep-water flatfish, and rex sole in the GOA from July 1 through July 31 (§ 679.82(d)).

Catcher/processors participating in Rockfish Program cooperatives are restricted by rockfish and halibut PSC sideboard limits. These C/Ps are prohibited from directed fishing for

northern rockfish, Pacific ocean perch, and dusky rockfish in the Western GOA and West Yakutat District from July 1 through July 31. Holders of C/P-designated LLP licenses that opt-out of participating in a rockfish cooperative will receive the portion of each sideboard limit that is not assigned to rockfish cooperatives. Table 17 lists the proposed 2014 and 2015 Rockfish Program C/P rockfish sideboard limits in the Western GOA and West Yakutat District. Due to confidentiality requirements associated with fisheries data, the sideboard limits for the West Yakutat District are not displayed.

TABLE 17—PROPOSED 2014 AND 2015 ROCKFISH PROGRAM HARVEST LIMITS FOR THE WESTERN GOA AND WEST YAKUTAT DISTRICT BY FISHERY FOR THE CATCHER/PROCESSOR SECTOR

[Values are rounded to the nearest metric ton]

Area	Fishery	C/P sector (% of TAC)	Proposed 2014 and 2015 TACs	Proposed 2014 and 2015 C/P limit
Western GOA	Dusky rockfish	72.3	354	256
	Pacific ocean perch	50.6	2,005	1,015
	Northern rockfish	74.3	1,899	1,411
West Yakutat District	Dusky rockfish	Confid.[1]	465	N/A
	Pacific ocean perch	Confid.[1]	1,613	N/A

[1] Not released due to confidentiality requirements associated with fish ticket data established by NMFS and the State of Alaska.

The C/P sector is subject to halibut PSC sideboard limits for the trawl deep-water and shallow-water species fisheries from July 1 through July 31. No halibut PSC sideboard limits apply to the CV sector as vessels participating in a rockfish cooperative receive a portion of the annual halibut PSC limit. C/Ps that opt-out of the Rockfish Program would be able to access that portion of the deep-water and shallow-water halibut PSC sideboard limit not assigned to C/P rockfish cooperatives. The sideboard provisions for C/Ps that elect to opt-out of participating in a rockfish cooperative are described in § 679.82(c), (e), and (f). Sideboards are linked to the catch history of specific vessels that may choose to opt-out. The applications for C/Ps electing to opt-out are due to NMFS on March 1 of each calendar year; therefore, NMFS cannot calculate proposed 2014 and 2015 allocations. Once opt-out applications (if any) are received in 2014, the ratios and amounts used to calculate opt-out sideboard ratios will be known. NMFS will then calculate any applicable opt-out sideboards and post these allocations on the Alaska Region Web site at *http://alaskafisheries.noaa.gov/sustainablefisheries/goarat/default.htm*) when they have been prepared.

Table 18 lists the 2014 and 2015 proposed Rockfish Program halibut PSC limits for the C/P sector.

TABLE 18—PROPOSED 2014 AND 2015 ROCKFISH PROGRAM HALIBUT MORTALITY LIMITS FOR THE CATCHER/PROCESSOR SECTOR

[Values are rounded to the nearest metric ton]

Sector	Shallow-water species fishery halibut PSC sideboard ratio (percent)	Deep-water species fishery halibut PSC sideboard ratio (percent)	Annual halibut mortality limit (mt)	Annual shallow-water species fishery halibut PSC sideboard limit (mt)	Annual deep-water species fishery halibut PSC sideboard limit (mt)
Catcher/processor	0.10	2.50	1,973	2	49

If approved by the Secretary, implementation of Amendment 95 would phase in a 15-percent reduction to the Rockfish Program halibut PSC sideboard limits.

Amendment 80 Program Groundfish Sideboard and PSC Limits

Amendment 80 to the Fishery Management Plan for Groundfish of the Bering Sea and Aleutian Islands Management Area (Amendment 80 Program) established a limited access privilege program for the non-AFA trawl C/P sector. To limit the ability of participants eligible for the Amendment 80 Program to expand their harvest efforts in the GOA, the Amendment 80 Program established groundfish and halibut PSC limits for Amendment 80 Program participants.

Section 679.92 establishes groundfish harvesting sideboard limits on all Amendment 80 Program vessels, other than the F/V *Golden Fleece*, to amounts no greater than the limits shown in Table 37 to part 679. Under regulations at § 679.92(d), the F/V *Golden Fleece* is prohibited from directed fishing for pollock, Pacific cod, Pacific ocean perch, dusky rockfish, and northern rockfish in the GOA.

Groundfish sideboard limits for Amendment 80 Program vessels operating in the GOA are based on their average aggregate harvests from 1998 to 2004. Table 19 lists the proposed 2014 and 2015 sideboard limits for Amendment 80 Program vessels. NMFS will deduct all targeted or incidental catch of sideboard species made by Amendment 80 Program vessels from the sideboard limits in Table 19.

TABLE 19—PROPOSED 2014 AND 2015 GOA GROUNDFISH SIDEBOARD LIMITS FOR AMENDMENT 80 PROGRAM VESSELS

[Values are rounded to the nearest metric ton]

Species	Season	Area	Ratio of Amendment 80 sector vessels 1998–2004 catch to TAC	Proposed 2014 and 2015 TAC (mt)	Proposed 2014 and 2015 Amendment 80 vessel sideboards (mt)
Pollock	A Season, January 20–February 25.	Shumagin (610)	0.003	3,921	12
		Chirikof (620)	0.002	15,015	30
		Kodiak (630)	0.002	5,481	11
	B Season, March 10–May 31	Shumagin (610)	0.003	3,920	12
		Chirikof (620)	0.002	18,102	36
		Kodiak (630)	0.002	2,393	5
	C Season, August 25–September 15.	Shumagin (610)	0.003	8,903	27
		Chirikof (620)	0.002	6,944	14
		Kodiak (630)	0.002	8,568	17
	D Season, October 1–November 1.	Shumagin (610)	0.003	8,903	27
		Chirikof (620)	0.002	6,944	14
		Kodiak (630)	0.002	8,568	17
	Annual	WYK (640)	0.002	3,093	6
Pacific cod	A Season,[1] January 1–June 10.	W	0.020	13,262	265
		C	0.044	23,113	1,017
	B Season,[2] September 1–December 31.	W	0.020	8,841	177
		C	0.044	15,409	678
	Annual	WYK	0.034	2,526	86
Pacific ocean perch	Annual	W	0.994	2,005	1,993
		WYK	0.961	1,613	1,550
Northern rockfish	Annual	W	1.000	1,899	1,899
Dusky rockfish	Annual	W	0.764	354	270
		WYK	0.896	465	417

[1] The Pacific cod A season for trawl gear does not open until January 20.
[2] The Pacific cod B season for trawl gear closes November 1.

The halibut PSC sideboard limits for Amendment 80 Program vessels in the GOA are based on the historic use of halibut PSC by Amendment 80 Program vessels in each PSC target category from 1998 through 2004. These values are slightly lower than the average historic use to accommodate two factors: Allocation of halibut PSC cooperative quota under the Rockfish Program and the exemption of the F/V *Golden Fleece* from this restriction (§ 679.92(b)(2)).

Table 20 lists the proposed 2014 and 2015 halibut PSC limits for Amendment 80 Program vessels, as contained in Table 38 to 50 CFR part 679.

TABLE 20—PROPOSED 2014 AND 2015 HALIBUT PSC SIDEBOARD LIMITS FOR AMENDMENT 80 PROGRAM VESSELS IN THE GOA

[Values are rounded to the nearest metric ton]

Season	Season dates	Fishery category	Historic Amendment 80 use of the annual halibut PSC limit (ratio)	Proposed 2014 and 2015 annual PSC limit (mt)	Proposed 2014 and 2015 Amendment 80 vessel PSC sideboard limit (mt)
1	January 20–April 1	shallow-water	0.0048	1,973	9
		deep-water	0.0115	1,973	23
2	April 1–July 1	shallow-water	0.0189	1,973	37
		deep-water	0.1072	1,973	212
3	July 1–September 1	shallow-water	0.0146	1,973	29
		deep-water	0.0521	1,973	103
4	September 1–October 1	shallow-water	0.0074	1,973	15
		deep-water	0.0014	1,973	3
5	October 1–December 31	shallow-water	0.0227	1,973	45
		deep-water	0.0371	1,973	73

Classification

NMFS has determined that the proposed harvest specifications are consistent with the FMP and preliminarily determined that the proposed harvest specifications are consistent with the Magnuson-Stevens Act and other applicable laws.

This action is authorized under 50 CFR 679.20 and is exempt from review under Executive Order 12866 and 13563.

NMFS prepared an EIS for this action and made it available to the public on January 12, 2007 (72 FR 1512). On

February 13, 2007, NMFS issued the Record of Decision (ROD) for the EIS. Copies of the EIS and ROD for this action are available from NMFS (see **ADDRESSES**). The EIS analyzes the environmental consequences of the proposed groundfish harvest specifications and alternative harvest strategies on resources in the action area. The EIS found no significant environmental consequences from the proposed action or its alternatives.

NMFS prepared an Initial Regulatory Flexibility Analysis (IRFA) as required by section 603 of the Regulatory Flexibility Act (RFA), analyzing the methodology for establishing the relevant TACs. The IRFA evaluated the impacts on small entities of alternative harvest strategies for the groundfish fisheries in the EEZ off Alaska. As set forth in the methodology, TACs are set to a level that fall within the range of ABCs recommended by the SSC; the sum of the TACs must achieve the OY specified in the FMP. While the specific numbers that the methodology produces may vary from year to year, the methodology itself remains constant.

A description of the proposed action, why it is being considered, and the legal basis for this proposed action are contained in the preamble above. A copy of the analysis is available from NMFS (see **ADDRESSES**). A summary of the IRFA follows.

The action under consideration is a harvest strategy to govern the catch of groundfish in the GOA. The preferred alternative is the existing harvest strategy in which TACs fall within the range of ABCs recommended by the SSC. This action is taken in accordance with the FMP prepared by the Council pursuant to the Magnuson-Stevens Act.

The entities directly regulated by this action are those that harvest groundfish in the EEZ of the GOA and in parallel fisheries within State waters. These include entities operating CVs and C/Ps within the action area and entities receiving direct allocations of groundfish. On June 20, 2013, the Small Business Administration issued a final rule revising the small business size standards for several industries effective July 22, 2013 (78 FR 37398; June 20, 2013). The rule increased the size standard for Finfish Fishing from $4.0 to 19.0 million, Shellfish Fishing from $4.0 to 5.0 million, and Other Marine Fishing from $4.0 to 7.0 million. The new size standards were used to prepare the IRFA for this action. Fishing vessels are considered small entities if their total annual gross receipts, from all their activities combined, are less than $19.0 million. The IRFA estimates the number of harvesting vessels that are considered small entities, but these estimates may overstate the number of small entities because (1) some vessels may also be active as tender vessels in the salmon fishery, fish in areas other than Alaska and the West Coast, or generate revenue from other non-fishing sources; and (2) all affiliations are not taken into account, especially if the vessel has affiliations not tracked in available data (i.e., ownership of multiple vessel or affiliation with processors) and may be misclassified as a small entity

The IRFA shows that, in 2012, there were 1,424 individual catcher vessels with gross revenues less than or equal to $19 million. Some of these vessels are members of AFA inshore pollock cooperatives, GOA rockfish cooperatives, or BSAI crab rationalization cooperatives. Therefore, under the RFA, it is the aggregate gross receipts of all participating members of the cooperative that must meet the "under $19 million" threshold. Vessels that participate in these cooperatives are considered to be large entities within the meaning of the RFA. After accounting for membership in these cooperatives, there are an estimated 1,378 small catcher vessel entities remaining in the GOA groundfish sector. This latter group of small vessels had average gross revenues of about $359,000. Additionally, data presented in the IRFA indicates that in 2012, 32 catcher/processors grossed less than $19 million. Twenty-five vessels in this group were estimated to be large entities because of their affiliations with other vessels through an Amendment 80 cooperative and the Freezer Longline Conservation Cooperative. After taking account of these affiliations, NMFS estimates that seven of these vessels are small entities. The average gross revenue for these seven small catcher/processor entities was $1.6 million.

The preferred alternative (Alternative 2) was compared to four other alternatives. Alternative 1 would have set TACs to generate fishing rates equal to the maximum permissible ABC (if the full TAC were harvested), unless the sum of TACs exceeded the GOA OY, in which case harvests would be limited to the OY. Alternative 3 would have set TACs to produce fishing rates equal to the most recent 5-year average fishing rate. Alternative 4 would have set TACs to equal the lower limit of the GOA OY range. Alternative 5, the "no action alternative," would have set TACs equal to zero.

The TACs associated with the preferred harvest strategy are those adopted by the Council in October 2013, as per Alternative 2. OFLs and ABCs for the species were based on recommendations prepared by the Council's GOA Plan Team in September 2013, and reviewed by the Council's SSC in October 2013. The Council based its TAC recommendations on those of its AP, which were consistent with the SSC's OFL and ABC recommendations.

Alternative 1 selects harvest rates that would allow fishermen to harvest stocks at the level of ABCs, unless total harvests were constrained by the upper bound of the GOA OY of 800,000 mt. As shown in Table 1 of the preamble, the sum of ABCs in 2014 and 2015 would be 584,094 mt, which falls below the upper bound of the OY range. The sum of TACs is 427,068 mt, which is less than the sum of ABCs. In this instance, Alternative 1 is consistent with the preferred alternative (Alternative 2), meets the objectives of that action, and has small entity impacts that are equivalent to the preferred alternative. In some instances, the selection of Alternative 1 would not reflect the practical implications that increased TACs (where the sum of TACs equals the sum of ABCs) for some species probably would not be fully harvested. This could be due to a lack of commercial or market interest in such species. Additionally, an underharvest of some TACs could result due to constraints such as the fixed, and therefore constraining, PSC limits associated with the harvest of the GOA groundfish species.

Alternative 3 selects harvest rates based on the most recent 5 years of harvest rates (for species in Tiers 1 through 3) or for the most recent 5 years of harvests (for species in Tiers 4 through 6). This alternative is inconsistent with the objectives of this action, the Council's preferred harvest strategy, because it does not take account of the most recent biological information for this fishery. NMFS annually conducts at-sea stock surveys for different species, as well as statistical modeling, to estimate stock sizes and permissible harvest levels. Actual harvest rates or harvest amounts are a component of these estimates, but in and of themselves may not accurately portray stock sizes and conditions. Harvest rates are listed for each species category for each year in the SAFE report (see **ADDRESSES**).

Alternative 4 reduces the TACs from the upper end of the OY range in the GOA, to its lower end of 116,000 mt, which would lead to significantly lower harvests of all species. Overall, this would reduce 2014 TACs by about 73 percent and would lead to significant reductions in harvests of species harvested by small entities. While reductions of this size would be

associated with offsetting price increases, the size of these increases is very uncertain. There are close substitutes for GOA groundfish species available in significant quantities from the Bering Sea and Aleutian Islands management area. While production declines in the GOA would undoubtedly be associated with significant price increases in the GOA, these increases would still be constrained by production of substitutes, and are very unlikely to offset revenue declines from smaller production. Thus, this alternative would have a detrimental impact on small entities.

Alternative 5, which sets all harvests equal to zero, would have a significant adverse economic impact on small entities and would be contrary to obligations to achieve OY on a continuing basis, as mandated by the Magnuson-Stevens Act. Under Alternative 5, all 1,378 individual catcher vessels impacted by this rule would have gross revenues of $0. Additionally, the seven small catcher/processor impacted by this rule also would have gross revenues of $0.

The proposed harvest specifications (Alternative 2) extend the current 2014 OFLs, ABCs, and TACs to 2014 and 2015. As noted in the IRFA, the Council may modify these OFLs, ABCs, and TACs in December 2013, when it reviews the November 2013 SAFE reports from its Groundfish Plan Teams, and the December 2013 meeting reports of its SSC and AP. Because TACs in the proposed 2014 and 2015 harvest specifications are unchanged from the 2014 TACs, NMFS does not expect adverse impacts on small entities. Also, NMFS does not expect any changes made by the Council in December 2013 to have significant adverse impacts on small entities.

This action does not modify recordkeeping or reporting requirements, or duplicate, overlap, or conflict with any Federal rules.

Adverse impacts on marine mammals or endangered species resulting from fishing activities conducted under this rule are discussed in the EIS and its accompanying annual SIRs (see **ADDRESSES**).

Authority: 16 U.S.C. 773 *et seq.;* 16 U.S.C. 1540(f); 16 U.S.C. 1801 *et seq.;* 16 U.S.C. 3631 *et seq.;* Pub. L. 105–277; Pub. L. 106–31; Pub. L. 106–554; Pub. L. 108–199; Pub. L. 108–447; Pub. L. 109–241; Pub. L. 109–479.

Dated: December 3, 2013.

Alan D. Risenhoover,

Director, Office of Sustainable Fisheries, performing the functions and duties of the Deputy Assistant Administrator for Regulatory Programs, National Marine Fisheries Service.

[FR Doc. 2013–29354 Filed 12–9–13; 8:45 am]

BILLING CODE 3510–22–P

Notices

Federal Register
Vol. 78, No. 237
Tuesday, December 10, 2013

This section of the FEDERAL REGISTER contains documents other than rules or proposed rules that are applicable to the public. Notices of hearings and investigations, committee meetings, agency decisions and rulings, delegations of authority, filing of petitions and applications and agency statements of organization and functions are examples of documents appearing in this section.

DEPARTMENT OF AGRICULTURE

Submission for OMB Review; Comment Request

December 5, 2013.

The Department of Agriculture has submitted the following information collection requirement(s) to OMB for review and clearance under the Paperwork Reduction Act of 1995, Public Law 104–13. Comments regarding (a) Whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility; (b) the accuracy of the agency's estimate of burden including the validity of the methodology and assumptions used; (c) ways to enhance the quality, utility and clarity of the information to be collected; (d) ways to minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology.

Comments regarding this information collection received by January 9, 2014 will be considered. Written comments should be addressed to: Desk Officer for Agriculture, Office of Information and Regulatory Affairs, Office of Management and Budget (OMB), New Executive Office Building, 725—17th Street NW., Washington, DC 20502. Commenters are encouraged to submit their comments to OMB via email to: *OIRA_Submission@OMB.EOP.GOV* or fax (202) 395–5806 and to Departmental Clearance Office, USDA, OCIO, Mail Stop 7602, Washington, DC 20250–7602. Copies of the submission(s) may be obtained by calling (202) 720–8958.

An agency may not conduct or sponsor a collection of information unless the collection of information displays a currently valid OMB control number and the agency informs potential persons who are to respond to the collection of information that such persons are not required to respond to the collection of information unless it displays a currently valid OMB control number.

Farm Service Agency

Title: (7 CFR part 767), Farm Loan Program—Inventory Property Management.

OMB Control Number: 0560–0234.

Summary of Collection: The Farm Loan Program provides supervised credit in the form of loans to family farmers to purchase real estate and equipment and finance agricultural production. Authority to establish the regulatory requirements contained in 7 CFR part 767 is provided under section 302 of the Act (7 U.S.C. 1922) which provides that "the Secretary is authorized to make and insure under this title to farmers . . ." Section 339 of the Act (7 U.S.C. 1989) further provides that "the Secretary is authorized to make such rules and regulations, prescribe the terms and conditions for making . . . loans, security instruments and agreements, except as otherwise specified herein, and to make such delegations of authority as he deems necessary to carry out this title."

Need and Use of the Information: Information collections are submitted by applicants to the local agency office serving the country in which their business is headquartered. The information is necessary to thoroughly evaluate an applicant's request to purchase inventory property and is used by the agency to determine an applicant's eligibility to lease or purchase inventory property and to ensure payment of the lease or purchase amount.

Description of Respondents: Business or other for-profit.

Number of Respondents: 314.

Frequency of Responses: Reporting: On occasion; Other (upon request).

Total Burden Hours: 551.

Ruth Brown,

Departmental Information Collection Clearance Officer.

[FR Doc. 2013–29437 Filed 12–9–13; 8:45 am]

BILLING CODE 3410–05–P

DEPARTMENT OF AGRICULTURE

[Submission for OMB Review; Comment Request]

December 5, 2013.

The Department of Agriculture has submitted the following information collection requirement(s) to OMB for review and clearance under the Paperwork Reduction Act of 1995, Public Law 104–13. Comments regarding (a) Whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility; (b) the accuracy of the agency's estimate of burden including the validity of the methodology and assumptions used; (c) ways to enhance the quality, utility and clarity of the information to be collected; (d) ways to minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology.

Comments regarding this information collection received by January 9, 2014 will be considered. Written comments should be addressed to: Desk Officer for Agriculture, Office of Information and Regulatory Affairs, Office of Management and Budget (OMB), New Executive Office Building, 725 17th Street NW., Washington, DC 20502. Commenters are encouraged to submit their comments to OMB via email to: *OIRA_Submission@OMB.EOP.GOV* or fax (202) 395–5806 and to Departmental Clearance Office, USDA, OCIO, Mail Stop 7602, Washington, DC 20250–7602. Copies of the submission(s) may be obtained by calling (202) 720–8958.

An agency may not conduct or sponsor a collection of information unless the collection of information displays a currently valid OMB control number and the agency informs potential persons who are to respond to the collection of information that such persons are not required to respond to the collection of information unless it displays a currently valid OMB control number.

Animal and Plant Health Inspection Service

Title: Plum Pox Compensation
OMB Control Number: 0579–0159

Summary of Collection: Under the Plant Protection Act (7 U.S.C. 7701 *et seq.*), the Secretary of Agriculture is authorized to prohibit or restrict the importation, entry, or movement of plants and plant pests to prevent the introduction of plant pests into the United States or their dissemination within the United States. The regulations in 7 CFR 301.74–5 permit owners of commercial stone fruit orchards and owners of fruit tree nurseries to receive compensation under certain circumstances. Owners of commercial stone fruit orchards may receive compensation for losses associated with trees destroyed to control plum pox pursuant to an emergency action notification (EAN) issued by the Animal & Plant Health Inspection Service (APHIS). Owners of fruit tree nurseries may receive compensation for net revenue losses associated with movement or sale of nursery stock prohibited under an EAN issued by APHIS with respect to regulated articles within the nursery in order to control plum pox. Plum Pox is an extremely serious viral disease of plants that can affect many stone fruit species, including plum, peach, apricot, almond, and nectarine. APHIS will collect information using form PPQ 651 Application for Plum Pox Compensation and PPQ 523 Emergency Action Notification.

Need and Use of the Information: APHIS will collect the owner's name and address, a description of the owner's property, and a certification statement that the trees removed from the owner's property were stone fruit trees from commercial fruit orchards or fruit tree nurseries. For claims made by owners of stone fruit orchards, the completed application must be accompanied by a copy of the EAN ordering the destruction of their trees, the notification's accompanying inventory describing the acreage and ages of trees removed and documentation verifying that the destruction of the trees have been completed and the date of that completion. For claims made by owners of fruit tree nurseries, the completed application must be accompanied by a copy of the EAN prohibiting the same or movement of the nursery stock, the notification's accompanying inventory describing the total number of trees covered by the EAN, their age and variety, and documentation indicating the final disposition of the nursery stock. Without the information APHIS would be unable to compensate eligible grove and nursery owners for their losses.

Description of Respondents: Farms; Business or other for-profit.

Number of Respondents: 2,512.

Frequency of Responses: Reporting: On occasion.

Total Burden Hours: 89.

Animal and Plant Health Inspection Service

Title: Interstate Movement of Fruit from Hawaii

OMB Control Number: 0579–0331

Summary of Collection: Under the Plant Protection Act (7 U.S.C. 7701 *et seq.*), the Secretary of Agriculture is authorized to prohibit or restrict the importation, entry, or movement of plants and plant pests to prevent the introduction of plant pests into the United States or their dissemination within the United States. The Hawaii fruit and vegetables regulations contained in 7 CFR 318.13–1 through 318.13–25 govern, among other things, the interstate movement of fruits and vegetables from Hawaii. These regulations are necessary to prevent the spread of plant diseases and pest that occur in Hawaii but not on the mainland United States. The Animal and Plant Health Inspection Service (APHIS) regulations allow mangosteen, dragon fruit, melon, pods of cowpea and its relatives, breadfruit, jackfruit, and fresh drumstick tree pods to be moved interstate from Hawaii under certain conditions to the mainland United States while continuing to provide protection against the spread of plant pests from Hawaii in the continental United States.

Need and Use of the Information: APHIS will collect information using PPQ 530 and 540 forms to prevent the interstate spread of a number of destructive and economically damaging agricultural pests. If APHIS did not collect this information the effectiveness of APHIS' Hawaiian fruits and vegetables quarantine program would be severely compromised and could result in millions of dollars in damage to American agriculture.

Description of Respondents: Business or other for-profit.

Number of Respondents: 110.

Frequency of Responses: Reporting: On occasion.

Total Burden Hours: 545.

Ruth Brown,

Departmental Information Collection Clearance Officer.

[FR Doc. 2013–29435 Filed 12–9–13; 8:45 am]

BILLING CODE 3410–34–P

DEPARTMENT OF AGRICULTURE

Grain Inspection, Packers and Stockyards Administration

Solicitation of Nominations for Members of the USDA Grain Inspection Advisory Committee

AGENCY: Grain Inspection, Packers and Stockyards Administration, USDA.

ACTION: Notice to solicit nominees.

SUMMARY: The Department of Agriculture's (USDA) Grain Inspection, Packers and Stockyards Administration (GIPSA) is seeking nominations for individuals to serve on the USDA Grain Inspection Advisory Committee (Advisory Committee). The Advisory Committee meets annually to advise GIPSA on the programs and services it delivers under the U.S. Grain Standards Act (USGSA). Recommendations by the Advisory Committee help GIPSA better meet the needs of its customers who operate in a dynamic and changing marketplace.

DATES: GIPSA will consider nominations received by January 24, 2014.

ADDRESSES: Submit nominations for the Advisory Committee by completing form AD–755 and mail to:

- Terri L. Henry, U.S. Department of Agriculture, 1400 Independence Ave. SW., Mail Stop 3611, Washington, DC 20250–3611, or
- FAX: 202–690–2173

Form AD–755 may be obtained via USDA's Web site: *http://www.ocio.usda.gov/forms/doc/AD-755.pdf.*

FOR FURTHER INFORMATION CONTACT: Terri L. Henry, telephone (202) 205–8281 or email *Terri.L.Henry@usda.gov.*

SUPPLEMENTARY INFORMATION: As required by section 21 of the USGSA (7 U.S.C. 87j), as amended, the Secretary of Agriculture (Secretary) established the Advisory Committee on September 29, 1981, to provide advice to the GIPSA Administrator on implementation of the USGSA. The current authority for the Advisory Committee expires on September 30, 2015. As specified in the USGSA, each member's term is 3 years and no member may serve successive terms.

The Advisory Committee consists of 15 members, appointed by the Secretary, who represent the interests of grain producers, processors, handlers, merchandisers, consumers, exporters, and scientists with expertise in research related to the policies in section 2 of the USGSA (7 U.S.C. 74). While members of the Advisory Committee serve without

compensation, USDA reimburses them for travel expenses, including per diem in lieu of subsistence, for travel away from their homes or regular places of business in performance of Advisory Committee service (see 5 U.S.C. 5703).

A list of current Advisory Committee members and other relevant information are available on the GIPSA Web site at *http://www.gipsa.usda.gov/fgis/adcommit.html.*

GIPSA is seeking nominations for individuals to serve on the Advisory Committee to replace seven members whose terms will expire May 2014.

Nominations are open to all individuals without regard to race, color, religion, gender, national origin, age, mental or physical disability, marital status, or sexual orientation. To ensure that recommendations of the Advisory Committee take into account the needs of the diverse groups served by the USDA, membership shall include, to the extent practicable, individuals with demonstrated ability to represent minorities, women, and persons with disabilities.

The final selection of Advisory Committee members and alternates is made by the Secretary.

Larry Mitchell,

Administrator, Grain Inspection, Packers and Stockyards Administration.

[FR Doc. 2013–29348 Filed 12–9–13; 8:45 am]

BILLING CODE 3410–KD–P

DEPARTMENT OF AGRICULTURE

Rural Housing Service

Notice of Request for Extension of a Currently Approved Information Collection

AGENCY: Rural Housing Service (RHS), USDA.

ACTION: Proposed collection; Comments requested.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995, this notice announces the intention of the above-named Agency to request an extension for a currently approved information collection in support of the Community Facilities Grant Program.

DATES: Comments on this notice must be received by February 10, 2014 to be assured of consideration.

FOR FURTHER INFORMATION CONTACT: Derek L. Jones, Loan Specialist, Community Programs, RHS, USDA, 1400 Independence Ave. SW., Mail Stop 0787, Washington, DC 20250–0787. Telephone: (202) 720–1504. Email: *derek.jones@wdc.usda.gov.*

SUPPLEMENTARY INFORMATION:

Title: Community Facilities Grant Program.

OMB Number: 0575–0173.

Expiration Date of Approval: January 31, 2014.

Type of Request: Extension of a currently approved information collection.

Abstract: Community Programs, a division of the Rural Housing Service (RHS), is part of the United States Department of Agriculture's Rural Development mission area. The Agency is authorized by Section 306(a) of the Consolidated Farm and Rural Development Act (7 U.S.C. 1926), as amended, to make grants to public agencies, nonprofit corporations, and Indian tribes to develop essential community facilities and services for public use in rural areas. These facilities include schools, libraries, child care, hospitals, clinics, assisted-living facilities, fire and rescue stations, police stations, community centers, public buildings, and transportation. Through its Community Programs, the Department of Agriculture is striving to ensure that such facilities are readily available to all rural communities.

Information will be collected by the field offices from applicants, consultants, lenders, and public entities. The collection of information is considered the minimum necessary to effectively evaluate the overall scope of the project.

Failure to collect information could have an adverse impact on effectively carrying out the mission, administration, processing, and program requirements.

Estimate of Burden: Public reporting burden for this collection of information is estimated to average 2.00 hours per response.

Respondents: Public bodies, nonprofit corporations and associations, and federally recognized Indian tribes.

Estimated Number of Respondents: 922.

Estimated Number of Responses per Respondent: 3.27.

Estimated Number of Responses: 3,015

Estimated Total Annual Burden on Respondents: 6,030 hours.

Copies of this information collection can be obtained from Jeanne Jacobs, Regulations and Paperwork Management Branch, at (202) 692–0040. Comments are invited on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the Agency, including whether the information will have practical utility; (b) the accuracy of the Agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology.

Comments may be sent to Jeanne Jacobs, Regulations and Paperwork Management Branch, U.S. Department of Agriculture, Rural Development, STOP 0742, 1400 Independence Ave. SW., Washington, DC 20250–0742. All responses to this notice will be summarized and included in the request for OMB approval. All comments will also become a matter of public record.

Dated: November 27, 2013.

Richard A. Davis,

Acting Administrator, Rural Housing Service.

[FR Doc. 2013–29364 Filed 12–9–13; 8:45 am]

BILLING CODE 3410–XV–P

DEPARTMENT OF AGRICULTURE

Rural Housing Service

Notice of Request for Extension of a Currently Approved Information Collection

AGENCY: Rural Housing Service, USDA.

ACTION: Proposed collection; Comments requested.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995, this notice announces the Rural Housing Service's intention to request an extension for a currently approved information collection in support of the program for Fire and Rescue Loans.

DATES: Comments on this notice must be received by February 10, 2014 to be assured of consideration.

FOR FURTHER INFORMATION CONTACT: Derek L. Jones, Loan Specialist, Community Programs Division, RHS, U.S. Department of Agriculture, Stop 0787, 1400 Independence Avenue SW., Washington, DC 20250–0787. Telephone (202) 720–1504.

SUPPLEMENTARY INFORMTION:

Title: Fire and Rescue Loans.

OMB Number: 0575–0120.

Expiration Date of Approval: February 28, 2014.

Type of Request: Extension of a currently approved information collection.

Abstract: The Fire and Rescue Loan program is authorized by Section 306 of

the Consolidated Farm and Rural Development Act (7 U.S.C. 1926) to make loans to public entities, nonprofit corporations, and Indian tribes for the development of community facilities for public use in rural areas and is covered by 7 CFR 1942–C. The primary regulation for administering the Community Facilities program is 7 CFR 1942–A (OMB Number 0575–0015) that outlines eligibility, project feasibility, security, and monitoring requirements.

The Community Facilities fire and rescue program has been in existence for many years. This program has financed a wide range of fire and rescue projects varying in size and complexity from construction of a fire station with fire fighting and rescue equipment to financing a 911 emergency system. These facilities are designed to provide fire protection and emergency rescue services to rural communities.

Information will be collected by the field offices from applicants, borrowers, and consultants. This information will be used to determine applicant/borrower eligibility, project feasibility, and to ensure borrowers operate on a sound basis and use funds for authorized purposes. Failure to collect proper information could result in improper determination of eligibility, improper use of funds, and/or unsound loans.

Estimate of Burden: Public reporting burden for this collection of information is estimated to average 2.16 hours per response.

Respondents: Not-for-profit institutions, State, local, or tribal governments.

Estimated Number of Respondents: 2,500.

Estimated Number of Responses per Respondent: 4.95.

Estimated Number of Responses: 12,375.

Estimated Total Annual Burden on Respondents: 26,730 hours.

Copies of this information collection can be obtained from Jeanne Jacobs, Regulations and Paperwork Management Branch, (202) 692–0040.

Comments:

Comments are invited on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the Rural Housing Service (RHS), including whether the information will have practical utility; (b) the accuracy of RHS' estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology. Comments may be sent to Jeanne Jacobs, Regulations and Paperwork Management Branch, U.S. Department of Agriculture, Rural Development, STOP 0742, 1400 Independence Ave. SW., Washington, DC 20250. All responses to this notice will be summarized and included in the request for OMB approval. All comments will also become a matter of public record.

Dated: November 27, 2013.

Richard A. Davis,

Acting Administrator, Rural Housing Service.

[FR Doc. 2013–29363 Filed 12–9–13; 8:45 am]

BILLING CODE 3410–XV–P

DEPARTMENT OF AGRICULTURE

Rural Housing Service

Notice of Intent To Review Online Homeownership Education Courses for Nationwide Use in the Single Family Housing Section 502 Direct Loan Program

AGENCY: Rural Housing Service, USDA.

ACTION: Notice.

SUMMARY: On September 23, 2013, the Rural Housing Service (RHS) Single Family Housing Direct Program published a Notice in the **Federal Register**, "Notice of Intent To Review Online Homeownership Education Courses for Nationwide Use in the Single Family Housing Section 502 Direct Loan Program" (78 FR 58272). Through this action, RHS is extending the submission deadline of online homeownership education course packages for National Office approval to December 31, 2013.

DATES: Online homeownership education providers interested in having their courses reviewed should submit a complete package to the Single Family Housing, Direct Loan Division on or before December 31, 2013.

Submissions may be sent electronically to *SFHDIRECTPROGRAM@wdc.usda.gov* or by mail to 1400 Independence Avenue, Stop 0783, Washington, DC 20250–0783.

FOR FURTHER INFORMATION CONTACT: Shantelle Gordon, *shantelle.gordon@wdc.usda.gov* or (202) 205–9567.

SUPPLEMENTARY INFORMATION: Effective on May 7, 2007, first-time homebuyers financed under the direct loan program must successfully complete an approved homeownership education course prior to loan closing. 7 CFR Part 3550.11 outlines the order of preference given to courses. First preference is given to classroom, one-on-one counseling, or interactive video conference. These formats are generally extensive and require a significant time and participation commitment from the Agency applicants. Second preference is given to interactive home-study or interactive telephone counseling of at least four hours duration. These formats may only be used if the formats under the first preference are not reasonably available. Third preference, which can only be used if all other formats are not reasonably available, is given to online counseling. The regulation also outlines the requirements an education provider and their course must meet in order to be approved for use by Agency applicants.

While approval is generally made by the Agency at the state level, there is currently one nationally approved online education provider. To expand the Agency applicants' access to and options of approved education providers, the Agency will consider approving other online education providers on a national level. Approval will be subject to meeting course criteria, a recommendation by the Agency-selected panel of housing partners, and signoff by the Administrator. Approval will be given as a third preference format unless the education provider is able to demonstrate and document how their online course along with a required supplemented service provides the same level of training and individualized attention as a first or second preference.

A notice of education providers approved through this process will be issued via a memorandum to the Rural Development (RD) state offices. The memorandum will list the format preference assigned to each provider. A copy of the memorandum will be simultaneously emailed to all education providers who applied through this notice.

Approvals are not subject to expiration. However, an approval may be revoked for justifiable cause.

At a minimum, courses submitted for consideration must contain the following content:

- Preparing for homeownership (evaluate readiness to go from rental to homeownership)
- Budgeting (pre and post purchase)
- Credit counseling
- Shopping for a home
- Lender differences (predatory lending)

- Obtaining a mortgage (mortgage process, different types of mortgages)
- Loan closing (closing process, documentation, closing costs)
- Post-occupancy counseling (delinquency and foreclosure prevention)
- Life as a homeowner (homeowner warranties, maintenance, and repairs)

The Agency-selected panel will base their recommendation on the following considerations:

- Certificate of completion
- Fee (must be nominal)
- Duration
- Topics covered
- System features (chat function, bookmarks, start-stop, audio, etc.)
- Readability (level of complexity in language used)
- User Friendliness
- Bi-lingual Spanish
- Multi-lingual
- Pre/Post assessment of knowledge
- Attractiveness of site/course

Submission packages should include course background, copy of certificate of completion, price sheet, and contact information (name, phone number, and email address).

If an education provider wishes to be considered as a first or second format preference, they must express which one in their submission package, provide strong written justification, and supporting materials.

Due to the lapse in federal funding that caused a partial closing of federal government operations from October 1 through October 16, 2013, RHS is extending this notice and submission deadline for review of online homeownership education courses to December 31, 2013.

Non-Discrimination Statement

USDA prohibits discrimination in all its programs and activities on the basis of race, color, national origin, age, disability, and where applicable, sex, marital status, familial status, parental status, religion, sexual orientation, political beliefs, genetic information, reprisal, or because all or part of an individual's income is derived from any public assistance program. (Not all prohibited bases apply to all programs.)

To file a complaint of discrimination, complete, sign and mail a program discrimination complaint form, (available at any USDA office location or online at *www.ascr.usda.gov,* or write to: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue SW., STOP 9410, Washington, DC 20250–9410.

Or call toll-free (866) 632–9992 (voice) to obtain additional information, the appropriate office or to request documents. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877–8339 or (877) 845–6136 (in Spanish). "USDA is an equal opportunity provider, employer and lender."

Persons with disabilities who require alternative means for communication of program information (e.g. Braille, large print, audiotape, etc.) should contact USDA TARTET Center at (202) 720–2600 (voice and TDD).

Dated: November 20, 2013.

Richard A. Davis,

Acting Administrator, Rural Housing Service.

[FR Doc. 2013–29335 Filed 12–9–13; 8:45 am]

BILLING CODE 3410–XV–P

COMMISSION ON CIVIL RIGHTS

District of Columbia Advisory Committee

AGENCY: United States Commission on Civil Rights.

ACTION: Notice of period during which individuals may apply to be appointed to the District of Columbia Advisory Committee; request for applications.

SUMMARY: Because the terms of the members of the District of Columbia Advisory Committee are expiring as of March 21, 2014, the United States Commission on Civil Rights hereby invites any individual who is eligible to be appointed to apply. The memberships covered by this notice are exclusively for the District of Columbia Advisory Committee, and applicants must be residents of District of Columbia to be considered. Letters of interest must be received by the Eastern Regional Office of the U.S. Commission on Civil Rights no later than January 21, 2014. Letters of interest must be sent to the address listed below.

DATES: Letters of interest for membership on the District of Columbia Advisory Committee should be received no later than January 21, 2014.

ADDRESSES: Send letters of interest to: U.S. Commission on Civil Rights, Eastern Regional Office, 1331 Pennsylvania Ave. NW., Suite 1150, Washington, DC 20425. Letter can also be sent via email to *eroaa@usccr.gov.*

FOR FURTHER INFORMATION CONTACT: Ivy Davis, Regional Director, Eastern Regional Office, (202) 376–7533, *idavis@usccr.gov.*

SUPPLEMENTARY INFORMATION: The District of Columbia Advisory Committee (SAC) is a statutorily mandated advisory committee of the U.S. Commission on Civil Rights (Commission) pursuant to 42 U.S.C. 1975a. Under the charter for the SAC, the purpose is to provide advice and recommendations to the Commission on a broad range of civil rights matters in its respective state that pertain to alleged deprivations of voting rights or discrimination or denials of equal protection of the laws because of race, color, religion, sex, age, disability, or national origin, or the administration of justice. SACs also provide assistance to the Commission in its statutory obligation to serve as a national clearinghouse for civil rights information.

The SAC consists of not more than 19 members, each of whom will serve a two-year term. Members serve as unpaid Special Government Employees who are reimbursed for travel and expenses. To be eligible to be on a SAC, applicants must be residents of the District of Columbia and have demonstrated expertise or interest in civil rights issues.

The Commission is an independent, bipartisan agency established by Congress in 1957 to focus on matters of race, color, religion, sex, age, disability, or national origin. Its mandate is to:

- Investigate complaints from citizens that their voting rights are being deprived,
- study and collect information about discrimination or denials of equal protection under the law,
- appraise federal civil rights laws and policies,
- serve as a national clearinghouse on discrimination laws,
- submit reports and findings and recommendations to the President and the Congress, and
- issue public service announcements to discourage discrimination.

The Commission invites any individual who is eligible to be appointed a member of the District of Columbia Advisory Committee covered by this notice to send a letter of interest and a resume to the address above.

Dated: December 5, 2013.

David Mussatt,

Acting Chief, Regional Programs Coordination Unit.

[FR Doc. 2013–29412 Filed 12–9–13; 8:45 am]

BILLING CODE P

DEPARTMENT OF COMMERCE

Submission for OMB Review; Comment Request

The Department of Commerce will submit to the Office of Management and

Budget (OMB) for clearance the following proposal for collection of information under the provisions of the Paperwork Reduction Act (44 U.S.C. Chapter 35).

Agency: Bureau of Industry and Security (BIS).

Title: Special Comprehensive License.

OMB Control Number: 0694–0089.

Form Number(s): BIS–752P, BIS–752A.

Type of Request: Regular submission (extension of a currently approved information collection).

Number of Respondents: 64.

Average Hours per Response: 30 minutes to 40 hours.

Burden Hours: 542.

Needs and Uses: The Special Comprehensive License (SCL) procedure authorizes multiple shipments of items from the U.S. or from approved consignees abroad who are approved in advance by the Bureau of Industry and Security (BIS) to conduct the following activities: Servicing, support services, stocking spare parts, maintenance, capital expansion, manufacturing, support scientific data acquisition, reselling and reexporting in the form received, and other activities as approved on a case-by-case basis. An application for an SCL requires submission of additional supporting documentation, such as the company's internal control program. This additional information is needed by BIS to ensure that the requirements and the restrictions of this procedure are strictly observed.

Affected Public: Businesses and other for-profit organizations.

Frequency: On occasion.

Respondent's Obligation: Required to obtain benefits.

Copies of the above information collection proposal can be obtained by calling or writing Jennifer Jessup, Departmental Paperwork Clearance Officer, Department of Commerce, (202) 482–0336, Room 6616, 14th and Constitution Avenue NW., Washington, DC 20230 (or via the Internet at *JJessup@doc.gov*.

Written comments and recommendations for the proposed information collection should be sent within 30 days of publication of this notice to Jasmeet Seehra, Office of Management and Budget (OMB), by email to *Jasmeet_K._Seehra@omb.eop.gov*, or by fax to (202) 395–5167.

Dated: December 5, 2013.

Gwellnar Banks,

Management Analyst, Office of the Chief Information Officer.

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DEPARTMENT OF COMMERCE

Economic Development Administration

Announcement of Federal Interagency Competition, Fiscal Year 2014 Investing in Manufacturing Communities Partnership

AGENCY: Economic Development Administration, U.S. Department of Commerce.

ACTION: Notice.

Authority: The Public Works and Economic Development Act of 1965, as amended (42 U.S.C. 3121 et seq.)

SUMMARY: This notice outlines a competition to designate up to 12 communities as manufacturing communities (Manufacturing Communities) through the Investing in Manufacturing Communities Partnership (IMCP), including proposal submission requirements and instructions, and eligibility and selection criteria that will be used to evaluate proposals. Manufacturing Communities will receive preference for a range of future Federal economic development funding and technical assistance offered by IMCP participating agencies. Some Manufacturing Communities, as discussed in the Supplementary Information section of this notice and subject to the availability of funds, may receive financial assistance awards from IMCP participating agencies to assist in cultivating an environment for businesses to create well-paying manufacturing jobs in regions across the country.

DATES: The deadline for receipt of applications is 11:59 p.m. Eastern Time on March 14, 2014. Applications received after this deadline will not be reviewed or considered. Applications will be accepted in electronic form. Applicants are advised to carefully read the application and submission information provided in the Supplementary Information section of this notice.

ADDRESSES: You may submit applications by any of the following methods. All comments must include the title, "Proposals for designation as a Manufacturing Community" and Docket No: 131121981–3981.

Email: IMCP@eda.gov. Include "Proposals for designation as a Manufacturing Community" and Docket No. 131121981–3981 in the subject line of the message.

Fax: (202) 482–2838, Attention: Office of Performance and National Programs.

Please indicate "Proposals for designation as a Manufacturing Community" and Docket No. 131121981–3981 on the cover page.

Mail: Economic Development Administration, Office of Performance and National Programs, U.S. Department of Commerce, 1401 Constitution Avenue NW., Suite 71030, Washington, DC 20230. Please indicate "Proposals for designation as a Manufacturing Community" and Docket No. 131121981–3981 on the envelope.

FOR FURTHER INFORMATION CONTACT: Ryan Hedgepeth, U.S. Department of Commerce, Economic Development Administration, 1401 Constitution Avenue NW., Suite 78006, Washington, DC 20230 or via email at *rhedgepeth@eda.gov*.

SUPPLEMENTARY INFORMATION:

I. Overview

The Investing in Manufacturing Communities Partnership (IMCP) is a new government-wide initiative that will help communities cultivate an environment for businesses to create well-paying manufacturing jobs in regions across the country and thereby accelerate the resurgence of manufacturing. The IMCP is designed to reward communities that demonstrate best practices in attracting and expanding manufacturing by bringing together key local stakeholders and using long-term planning that integrates targeted investments across a community's industrial ecosystem to create broad-based prosperity. Research has shown that vibrant ecosystems may create a virtuous cycle of development for a key technology or supply chain through integrated investments and relationships among the following elements:

- Workforce and training;
- Supplier network;
- Research and innovation;
- Infrastructure/site development;
- Trade and international investment; and
- Operational improvement and capital access.

Interactions within and between these elements create "public goods," or assets upon which many firms can draw and that are fundamental in creating an advantage for industry but are not adequately provided by the private sector. Thus, well-designed public investment is a key part of developing a self-sustaining ecosystem that attracts private investment from new and existing manufacturers and leads to broad-based prosperity.

Designation as an IMCP manufacturing community (each a Manufacturing Community, and collectively the Manufacturing

Communities) will be given to communities with the best strategies for designing and making such investments in public goods. The Federal agencies participating in IMCP are the: Department of Commerce, Economic Development Administration; Department of Defense; Department of Education; Appalachian Regional Commission; Delta Regional Authority; Department of Energy; Department of Housing and Urban Development; Department of Labor, Employment and Training Administration; Department of Transportation; Environmental Protection Agency; National Science Foundation; Small Business Administration; and the Department of Agriculture (each an IMCP Participating Agency, and collectively the IMCP Participating Agencies). IMCP Participating Agencies will coordinate with each other to leverage complementary activities while also preventing duplication of efforts. Manufacturing Communities will receive preferential consideration for other Federal programs identified by IMCP Participating Agencies consistent with each program's eligibility requirements and evaluation criteria (see Section II. of this notice). Additionally, a Federal point of contact (POC) will be made available to help the winning community access Federal funds and resources. Manufacturing Communities will have access to generally available technical assistance resources developed through IMCP, namely: (1) An online data portal centralizing data available across agencies to enable communities to evaluate their strengths and weaknesses; and (2) a "playbook" that identifies existing Federal planning grant and technical assistance resources, and catalogues economic development best practices.

Some Manufacturing Communities, subject to the availability of funds, may receive awards from IMCP Participating Agencies (see Section II. of this notice).

II. Benefits of IMCP Manufacturing Communities Designation

Up to 12 communities will be designated as Manufacturing Communities for a period of two years. After two years, communities will be invited to apply to renew their designation as Manufacturing Communities; they will be evaluated based on: (a) Performance against the terms of the designation and post-designation awards received (if any); and (b) progress against project-specific metrics as proposed by communities in their applications, designed to also help communities track their own progress. See Section V.A.2. of this notice for more information on self-defined metrics.

Co-applicants and identified partners in Manufacturing Communities' original IMCP proposals will be eligible for the following benefits:

1. Preferential consideration (or supplemental awards for existing grantees) for funding streams identified by the IMCP Participating Agencies as furthering IMCP goals and thereby assisting Manufacturing Communities in bolstering their economic development plans. Manufacturing Communities will only receive preference when applying for grants and projects consistent with the community's economic development strategy. (*Note:* In the event that co-applicants and partners submit multiple applications to a given funding stream, only one of the applicants may claim preference.)

2. A POC to help the Manufacturing Community access Federal economic development funding and non-funding related to specialized services provided by the IMCP Participating Agencies. These specialized services include but are not limited to: Big data analytics; capacity-building assistance; and capital access consulting.

3. Branding and promotion under the Manufacturing Community designation that may be helpful in attracting partners and investors behind the community's development strategy.

4. In addition, subject to the availability of funds, some Manufacturing Communities may be invited to submit additional documentation (e.g. budget information) for consideration for Federal financial assistance through Challenge Grant Awards from EDA with the possibility of additional funding from other Federal programs. Challenge Grant Awards are intended to support large public goods investments, such as transit or digital infrastructure, workforce training, and business incubators. The total sum for Challenge Grant Awards, subject to the availability of funding, is expected to be up to $20 million.

Publication of this announcement does not obligate the IMCP Participating Agencies to award Manufacturing Communities any specific grant or cooperative agreement, and the IMCP Participating Agencies reserve the right to fund, in whole or in part, any, all, or none of the applications submitted in response to future solicitations.

The following 9 IMCP Participating Agencies have agreed to provide preferential consideration, and/or consideration in the determination of application merit, and/or grant supplemental awards (totaling approximately $1.3 billion) for Manufacturing Communities for the following 18economic development programs:

1. Appalachian Regional Commission

a. Local Access Road Program: The Appalachian Regional Commission program aims to better link the Region's businesses, communities, and residents to the Appalachian Development Highway System and to other key parts of the Region's transportation network. The program offers a flexible approach designed to meet local needs and provide a financing mechanism to support a variety of economic development opportunities throughout the Region. Funding is available to provide access to industrial sites, business parks, and commercial areas where significant employment opportunities are present. Other eligible sites include timberlands with significant commercial value and areas where educational services are provided. Proposals for the use of this program should be developed in coordination with the State ARC Program Office and State Department of Transportation as required lead times can span multiple fiscal years and/or project cycles.

b. Area Development Program: The Appalachian Regional Commission program addresses three of the four goals identified in the Commission's strategic plan: (1) Increase job opportunities and per capita income in Appalachia to reach parity with the nation; (2) Strengthen the capacity of the people of Appalachia to compete in the global economy; and (3) Develop and improve Appalachia's infrastructure to make the Region economically competitive. Projects funded in these program areas create thousands of new jobs; improve local water and sewer systems; increase school readiness; expand access to health care; assist local communities with strategic planning; and provide technical and managerial assistance to emerging businesses. Proposals for the use of this program should be developed in coordination with the State ARC Program Office.

2. Delta Regional Authority

a. States' Economic Development Assistance Program (SEDAP): DRA's primary investment, SEDAP provides for investments in Basic Public Infrastructure, Transportation Infrastructure, Workforce Development, and Business Development with an emphasis in entrepreneurship. SEDAP funds are allocated to Lower Mississippi Delta designated counties in eight states (Alabama, Arkansas, Illinois, Kentucky,

Louisiana, Mississippi, Missouri, and Tennessee).

3. Department of Housing and Urban Development

a. Office of Economic Resiliency Integrated Planning & Investment Grants (pending program funding) will offer $75 million in Integrated Planning and Investment Grants that will seed locally-created, comprehensive blueprints that strategically direct investments in development and infrastructure to projects that result in: attracting jobs and building diverse and resilient economies, significant municipal cost savings, and stronger, more unified local leadership. Integrated Planning and Investment Grants will incorporate some of the same features of the previously-funded Regional Plans for Sustainable Communities and the Community Challenge Grants offered by the Office of Sustainable Housing and Communities, but, using lessons learned from that program and feedback from local leaders, will place a greater emphasis on supporting actionable economic development strategies, reducing redundancy in Federally-funded planning activities, setting and monitoring performance, and identifying how Federal formula funds can be used smartly and efficiently in support of economic resilience. As with the previous efforts, priority will be placed on directing grants to rural areas, cities, counties, metropolitan areas and states that demonstrate economic need and are committed to building the cross-sector, cross-disciplinary partnerships necessary to tackle the tough decisions that help make places economically competitive. A portion of grant funds will be reserved for small and rural communities and regions.

b. Delta Community Capital Initiative: Administered by HUD's Office of Rural Housing and Economic Development, DCCI is a collaborative effort among three Federal agencies—the Department of Housing and Urban Development (HUD), the Department of the Treasury—Community Development Financial Institutions Fund (CDFI Fund) and the Department of Agriculture—Rural Development (USDA—RD). The DCCI's goal is to increase access to capital for business lending and economic development in the chronically underserved and undercapitalized Lower Mississippi Delta Region. Specifically, it will provide direct investment and technical assistance to community development lending and investing institutions that focus on small business development to benefit the residents of Lower Mississippi Delta Region.

c. Appalachia Economic Development Initiative: Administered by HUD's Office of Rural Housing and Economic Development. AEDI is a collaborative effort among three Federal agencies—the Department of HUD, the CDFI Fund and the USDA—RD. The AEDI's goal is to increase access to capital for business lending and economic development in the chronically underserved and undercapitalized Appalachia Region. Specifically, it will provide investment and technical assistance to State community and/or economic development agencies that apply on behalf of local rural nonprofit organizations or community development corporations that focus on small business development to benefit the residents of the Appalachia Region.

4. Department of Labor, Employment and Training Administration

a. Trade Adjustment Assistance Community College and Career Training Grant Program (TAACCT): The Education and Training Administration's Trade Adjustment Assistance Community College and Career Training Grant Program (TAACCT) provides community colleges and other eligible institutions of higher education with funds to expand and improve their ability to deliver education and career training programs. Through these multi-year grants, the Department of Labor is helping to ensure that our nation's institutions of higher education are helping adults succeed in acquiring the skills, degrees, and credentials needed for high-wage, high-skill employment while also meeting the needs of employers for skilled workers.

5. Department of Transportation

a. Transportation Investment Generating Economic Recovery (TIGER): The U.S. Department of Transportation's Transportation Investment Generating Economic Recovery, or TIGER Discretionary Grant program, provides a unique opportunity for the Department of Transportation to engage directly with states, cities, regional planning organizations, and rural communities through a competitive process that invests in road, rail, transit and port projects that promise to achieve critical national objectives. Each project is multi-modal, multi-jurisdictional or otherwise challenging to fund through existing programs. The TIGER program showcases DOT's use of a rigorous cost-benefit analysis throughout the process to select projects with exceptional benefits, explore ways to deliver projects faster and save on construction costs, and make investments in our Nation's infrastructure that make communities more livable and sustainable. For more information about the TIGER program, please visit *http://www.dot.gov/tiger.*

6. Environmental Protection Agency

a. Targeted Brownfield Assessments (TBA) program is designed to help states, tribes, and municipalities, as well as land clearance authorities, regional redevelopment agencies, and other eligible entities—especially those without other EPA brownfield site assessment resources—minimize the uncertainties of contamination often associated with brownfields, and set the stage for new investment. The TBA program is not a grant program, but a service provided by EPA via a contractor, who conducts environmental assessment activities to address the requestor's needs.

b. Brownfield Site Assessment/cleanup/RLF (RLF) (includes assessment, Revolving Loan Fund, and cleanup grants) can support a range of activities needed to re-deploy properties, including for manufacturing and related uses. Assessment grants provide funding for communities, regional development authorities, and other eligible recipients to inventory, characterize, assess, and conduct planning and community involvement related to brownfield sites. Revolving Loan Fund (RLF) grants provide funding for states, communities, and other eligible recipients to capitalize a locally administered RLF to carry out cleanup activities at brownfield sites; alternatively, recipients may use up to 40% of their capitalization grants to provide subgrants for cleanup purposes. Cleanup grants provide funding to carry out remedial activities at brownfield sites. Cleanup grants require a 20 percent cost share (cash or eligible in-kind), which may be waived based on hardship. An applicant must own the site for which it is requesting funding at time of application. For additional information on brownfield grants, including examples of their use to advance manufacturing activities, please visit *www.epa.gov/brownfields.*

7. National Science Foundation

a. Advanced Technology Education (ATE) (supplemental awards will be awarded only to existing ATE grantees also designated as *Manufacturing Communities* entitled to challenge grants): With an emphasis on two-year colleges, the Advanced Technological Education (ATE) program focuses on the education of technicians for the high-technology fields that drive our nation's economy. The program involves

partnerships between academic institutions and employers to promote improvement in the education of science and engineering technicians at the undergraduate and secondary school levels. The ATE program supports curriculum development; professional development of college faculty and secondary school teachers; career pathways to two-year colleges from secondary schools and from two-year colleges to four-year institutions; and other activities. Another goal is articulation between two-year and four-year programs for K–12 prospective teachers that focus on technological education. The program also invites proposals focusing on research to advance the knowledge base related to technician education.

b. I/UCRC (supplemental awards will be awarded only to existing ATE grantees also designated as *Manufacturing Communities* entitled to challenge grants): The Industry/University Cooperative Research Centers (I/UCRC) program develops long-term partnerships among industry, academe, and government. The centers are catalyzed by a seed investment from the National Science Foundation (NSF) and are primarily supported by industry center members, with NSF taking a supporting role in their development and evolution. Each center is established to conduct research that is of interest to both the industry and the center. An I/UCRC not only contributes to the Nation's research infrastructure base and enhances the intellectual capacity of the engineering and science workforce through the integration of research and education, but also encourages and fosters international cooperation and collaborative projects.

8. Small Business Administration

a. Accelerator Program (pending funding and authority for the program): The Accelerator Program, within the SBA's Office of Investment and Innovation, is comprised of ecosystems that encompass programs which at a high level provide high potential entrepreneurs and fast growing start-ups with three things—in exchange for minority equity stakes: (1) Mentorship—access to people that have "seen the movie" before and whom can be tapped for advice; (2) Access to Capital—access to super-seed cash to jump-start ideas and very young companies; and (3) Space—Sharing office space and co-working to enable both cost savings and idea proliferation in a Keiretsu-type setting. Some of the concrete and specific initiatives at the Accelerator Program include Demo Days (brought accelerators from diverse industries and geographies together to network and share ideas), Start-Up University (an online platform for universities to build and share effective models for fostering student entrepreneurship), and Educate Accelerators (train the trainers type programs).

9. U.S. Department of Agriculture

a. Rural Economic Development Loan and Grant Program (REDLG) REDLG provides loans and grants to local public and nonprofit utilities which use the funds to make zero interest loans to businesses and economic development projects in rural areas that will create and retain employment. Examples of eligible projects include: Purchase or improvement of real estate, buildings, and equipment, working capital and start-up costs; health care facilities and equipment, business incubators; telecommunications/computer networks; educational and job training facilities and services; community facilities and other community development projects. In REDLG a rural area is any area other than a city or town that has a population of greater than 50,000 inhabitants and its contiguous urbanized area.

b. Rural Business Enterprise Grant Program (RBEG): RBEG grants may be made to public bodies and private nonprofit corporations which use the grant funds to assist small and emerging businesses in rural areas. Public bodies include States, counties, cities, townships, and incorporated town and villages, boroughs, authorities, districts, and Indian tribes. Small and emerging private businesses are those that will employ 50 or fewer new employees and have less than $1 million in projected gross revenues. Examples of eligible fund use include: Capitalization of revolving loan funds to finance small and emerging rural businesses; training and technical assistance; job training; community facilities and infrastructure, rural transportation improvement; and project planning and feasibility. In RBEG a rural area is any area other than a city or town that has a population of greater than 50,000 inhabitants and its contiguous urbanized area.

c. Intermediary Relending Program (IRP) IRP loans are provided to intermediaries to establish revolving loan funds which they use to with finance business and economic development activity in rural communities. Private non-profit corporations, public agencies, Indian groups, and cooperatives with at least 51 percent rural membership may apply for intermediary lender status. IRP funding may be used for a variety of business and community development projects located in a rural area. Under the IRP, a rural area is any area that is not inside a city with a population of 25,000 or more according to the latest decennial census. Some examples of eligible projects, related to businesses in the manufacturing sector are: Acquisition of a business, purchase or development of land, buildings, facilities, leases, purchase equipment, leasehold improvements, machinery, supplies; startup costs and working capital. IRP may also finance community and economic development projects.

d. Business & Industry Guaranteed Loan Program (B&I) The B&I Guaranteed Loan Program bolsters existing private credit structure by guaranteeing quality loans aimed at improving the economic and environmental climate in rural communities. A borrower may be a cooperative organization, corporation, partnership, or other legal entity organized and operated on a profit or nonprofit basis; an Indian tribe on a Federal or State reservation or other Federally recognized tribal group; a public body; or an individual. Borrowers must be engaged in a business that will: Provide employment; improve the economic or environmental climate; promote the conservation, development, and use of water for aquaculture; or reduce reliance on nonrenewable energy resources by encouraging the development and construction of solar energy systems and other renewable energy systems.

In addition, each of the 13 IMCP Participating Agencies—the above nine plus the Departments of Commerce, Defense, Education, and Energy—will offer staff time in order that each Manufacturing Community will have access to a POC (assigned from an IMCP Participating Agency) to facilitate access to technical assistance and economic development funds.

III. Eligibility Information

A. Eligible Organizations

Proposals for designation as a Manufacturing Community must be submitted on behalf of the region by a consortium that includes one or more of the eligible organizations discussed in this section. The consortium must designate one of these eligible organizations as lead applicant and one member of that organization to be the primary point of contact for the consortium. Applicants are strongly encouraged to include other key stakeholders, including but not limited to private sector partners, higher education institutions, government entities, economic development and

other community and labor groups, financial institutions and utilities. All members of the consortium must submit letters of commitment or sign a Memorandum of Understanding documenting their contributions to the partnership. Additionally, at a minimum, the applicant must have letters of support from a higher education institution, a private sector partner, and some government entity if not already part of the consortium. Applicants should demonstrate a significant level of regional cooperation in their proposal because only one designation will be made in a particular region.

Eligible lead applicants include a(n):

1. District Organization;

2. Indian Tribe or a consortium of Indian Tribes;

3. State, county, city, or other political subdivision of a State, including a special purpose unit of a State or local government engaged in economic or infrastructure development activities, or a consortium of political subdivisions;

4. Institution of higher education or a consortium of higher education institutions; or

5. Public or private non-profit organization or association acting in cooperation with officials of a political subdivision of a State.[1]

B. Geographic Scope

Applicants may define their regional boundaries of their consortium, though all such regions should have a strong existing manufacturing base. In general, an applicant's region should be large enough to contain critical elements of the key technologies or supply chains (KTS) prioritized by the applicant, but small enough to enable close collaboration (e.g. generally, larger than a city but smaller than a state). The proposed manufacturing community should provide evidence that their community ranks in the top third in the nation for their key manufacturing technology or supply chain by either: Location quotient for employment in the KTS, or location quotient for firms in the KTS.

A key element in evaluating proposals will be the rate of improvement in key indicators that the plan can credibly generate. Thus, both distressed and non-distressed manufacturing regions are encouraged to apply.

[1] See section 3 of (42 U.S.C. 3122) and 13 CFR 300.3.

IV. Application and Submission Information

A. How To Submit an Application

You may submit applications by any of the following methods. All comments must include the title, "Proposals for designation as a Manufacturing Community" and Docket No. 131121981–3981.

Email: IMCP@eda.gov. Include "Proposals for designation as a Manufacturing Community" and Docket No. 131121981–3981 in the subject line of the message.

Fax: (202) 482–2838, Attention: Office of Performance and National Programs.

Please indicate "Proposals for designation as a Manufacturing Community" and Docket No. 131121981–3981 on the cover page.

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FOR FURTHER INFORMATION CONTACT: Ryan Hedgepeth, U.S. Department of Commerce, Economic Development Administration, 1401 Constitution Avenue NW., Suite 78006, Washington, DC 20230 or via email at *rhedgepeth@eda.gov.*

In preparing their applications, communities are urged to consult online resources developed through IMCP, namely (1) a data portal centralizing data available across agencies to enable communities to evaluate their strengths and weaknesses; and (2) a "playbook" that identifies existing Federal planning grant and technical assistance resources and catalogues best practices in economic development. These resources are available at *www.eda.gov/challenges/imcp/.*

B. Content and Form of Application Submission

In order to be considered for designation, applicants must submit a proposal that includes all required elements outlined below. The proposal will be used to determine which communities will receive the manufacturing communities designation. Reviewers will focus on the quality of the analysis described below; the POC awarded to designees will help with identifying appropriate funding streams and fine-tuning the details of proposals to meet the requirements of individual agencies.

Each proposal shall consist of no more than thirty (30) single-sided pages exclusive of cover sheet and/or transmittal letter, and must include the following information:

(a) *Point of Contact:* Name, phone number, email address, and organization address of the respondent's primary point of contact, including specific staff member to be the point of contact;

(b) *Assessment of Local Industrial Ecosystem:* An integrated assessment of the local industrial ecosystem (i.e., the whole range of physical, capital, and human resource components needed for manufacturing activities) as it exists today in the area defined by the applicant and what is missing; and an evidence-based path for developing chosen components of this ecosystem (infrastructure, transit, workforce, etc.) by making specific investments to address gaps and make a region uniquely competitive;

(c) *Implementation Strategy Description:* A description of the proposed investments and implementation strategy that will be used to address gaps in the ecosystem;

(d) *Implementation Strategy Parties:* A description of the local partner organizations/jurisdictions, and their roles and responsibilities, that will carry out the proposed strategy, including letters of commitment or signed a Memorandum of Understanding documenting their contributions to the partnership as attachments that will *not* count against the 30-page limit;

(e) Performance Metrics: A description of metrics, benchmarks and milestones to be tracked and of evaluation methods to be used (experimental design, control groups, etc.) over the course of the implementation to gauge performance of the strategy;

(f) Federal Financial Assistance Experience: Evidence of the intended recipient's ability and authority to manage a Federal financial assistance award;

(g) Geographic Scope: Description of the regional boundaries of their consortium and the basis for determining that their manufacturing concentration ranks in the top third in the nation for their key manufacturing technology or supply chain by either: Location quotient for employment in the KTS, or location quotient for firms in the KTS.

(h) Submitting Official: Documentation that the Submitting Official is authorized by the applicant to submit a proposal and subsequently apply for assistance;

C. Deadlines for Submission

The deadline for receipt of applications is March 14, 2014 at 11:59 p.m. Eastern Time. Proposals received after the closing date and time will not be considered.

V. Application Review and Selection Process

Throughout the review and selection process, the IMCP Participating Agencies reserve the right to seek clarification in writing from applicants whose proposals are being reviewed and considered. IMCP Participating Agencies may ask applicants to clarify proposal materials, objectives, and work plans, or other specifics necessary to comply with Federal requirements. To the extent practicable, the IMCP Participating Agencies encourage applicants to provide data and evidence of the merits of the project in a publicly available and verifiable form.

A. Proposal Narrative Requirements and Selection Criteria

IMCP Participating Agencies will consider each of the following factors as a basis to confer the manufacturing communities designation. (See section V.B. of this notice for weighting).

1. Quality of Assessment/ Implementation Strategy

Applicants should provide a detailed data-driven assessment of the local industrial ecosystem as it exists today, what is missing, and an evidence-based path to development that could make a region uniquely competitive. This description should also explain public good investments needed to realize these plans. The proposed development should involve strong coordination across the subcategories below. Applicants must conduct a thorough cost-benefit analysis of their proposed public good investment and demonstrate that project benefits exceed project costs, similar to analysis required of Department of Transportation TIGER applicants (see *www.dot.gov/sites/dot.dev/files/docs/TIGER%202013%20NOFA_BCA%20Guidance_0.pdf*).

At the outset, applicants should *identify KTS* on which their development plan will focus, and explain how these KTS build on existing regional assets and capabilities. In selecting KTS and in defining the geographic boundaries of the community, applicants should choose areas that are sufficiently focused to ensure a *well-integrated development plan,* but sufficiently broad that resulting development of related capabilities have a *substantial impact on a community's prosperity overall* and achieve broad distribution of benefits. Finally, the applicant should discuss why this community has a *comparative advantage* in building these KTS (e.g., comparative data such as location quotients levels of sales, employment, patents) and how their strategy integrates the following subcategories into a coherent whole, leading to a vibrant manufacturing ecosystem based on these KTS.

We expect that winning applications will include a detailed, integrated, and data-driven assessment of the local industrial ecosystem as it currently exists for their KTS, what is missing, and a path to development that could make a region uniquely competitive. However, we do not expect that applicants will provide detailed budgets and analysis for plans to remedy every gap they identify. Instead, applicants should submit estimated budgets for such projects that they can show would be catalytic.

The following text provides guidance on how we will analyze the composition of a community's industrial ecosystem, and is not meant to be proscriptive.

For *workforce and training,* the applicant should consider:

i. Current capability: What are the requisite skills and average compensation for employees in fields relevant to the KTS? How many people with these or similar skills currently reside in the region? How many employees could be added to the workforce with minimal additional training?

ii. Current institutions for improving capability: What local community colleges, certified apprenticeships, workforce intermediaries, and other training programs exist that either specialize in the KTS or could develop specialties helpful for the KTS? Do these programs result in recognized credentials and pathways for continuous learning that are valued by employers and lead to improved outcomes for employees? To what extent do these institutions currently integrate research and development (R&D) activities and education to best prepare the current and future workforce? To what extent do postsecondary partners engage with feeder programs, such as those in secondary schools? What is the nature of engagement of Workforce Investment Boards, employers, community, and labor organizations?

iii. Gaps: What short- and long-term human resources challenges exist for the local economy along the region's proposed development path? If available, what is the local unemployment rate for key occupations in the KTS? Are any local efforts underway to re-incorporate the long-term unemployed into the workforce that could be integrated into KTS?

iv. Plans: Communities that intend to focus on workforce issues as a priority area in seeking future grants should explain how they intend to build on local assets to improve KTS in areas such as:

a. Linkage (including training, financial and in-kind partnerships) with employers (or prospective employers) in the KTS and labor/community groups to ensure skills are useful, portable, and lead to a career path;

b. Plans to ensure broad distribution of benefits, e.g., through programs to upgrade jobs and wages or support disadvantaged populations;

c. Extent of plan to integrate R&D activities and education to best prepare the current and future workforce as appropriate to the KTS focus specified.

For *supplier networks,* the applicant should consider:

i. Current Capability: What are key firms in the KTS? What parts of the KTS are located inside and outside the region defined by the applicant? How are firms connected to each other? What are the key trade and other associations and what roles do they play? How might customers or suppliers (even outside the region) support suppliers in the region? What are examples of projects/shared assets across these firms? What new KTS products have been launched recently? If your community is participating in SBA Supply Chain Analysis grant, how will you leverage their work?

ii. Current Institutions for Improving Capability: What processes or institutions (foundations, medical or educational institutions, trade associations, etc.) exist to promote innovation or upgrade supplier capability? Please provide performance measures and/or case studies as evidence of these capabilities.

iii. Gaps: What short- and long-term supply chain challenges exist for the local economy along the region's proposed development path? Are there institutions that convene suppliers and customers to discuss improved ways of working together, roadmap complementary investments, etc.?

iv. Plans: Communities that intend to focus on improving supplier networks as a priority area in seeking future grants should explain how they intend to build on local assets to improve KTS in areas such as:

a. Establishing an industrial park conducive to supply chain integration,

including support for convening and upgrading supplier firms of all sizes;

b. Remedying gaps and/or undertaking more intensive supply chain mapping;

c. Measuring and improving supplier capabilities in innovation, problem-solving ability, and systematic operation (e.g. lean, International Organization for Standardization (ISO) certification);

d. Leveraging organizations that work with suppliers, such as Manufacturing Extension Partnership (MEP), U.S. Export Assistance Centers (USEAC), Small Business Development Centers (SBDCs), SCORE chapters and Women Business Centers (WBCs); and

e. Measuring and improving trade association activity, interconnectedness, and support from key customers or suppliers (even if outside the region).

For *research and innovation*, the applicant should consider:

i. Current Capabilities: What are the community's university/research assets in KTS? To what extent do training institutions currently integrate R&D activities and education to best prepare the current and future workforce? Does the community have shared facilities such as incubator space or research centers? What is the community's record for helping the ecosystem develop small businesses and start-ups?

ii. Current Institutions for Improving Capability: How relevant are local institutions' program of research and commercialization for the proposed development path? How robust is the revenue model? What local entities work with new and existing firms to help promote innovation? How integrated are industry and academia (including Federal Laboratories)?

iii. Gaps: What short- and long-term research challenges exist for the local economy along the region's proposed development path?

iv. Plans: Communities that intend to focus on improving local research institutions as a priority area in seeking future grants should explain how they intend to build on local assets to improve KTS in areas such as:

a. Establishing shared space and procuring capital equipment for incubation and research;

b. Developing strategies for negotiating intellectual property rights in ways that balance the goals of rewarding inventors and sharing knowledge;

c. Plans for promoting university research relevant to new industry needs, and arrangements to facilitate adoption of such applied research by industry;

d. Leveraging other Federal innovation initiatives such as the National Network for Manufacturing Innovation, MEP, Manufacturing Technology Accelerator Centers; and

e. Plans to ensure broad distribution of the benefits of public investment, including benefits to disadvantaged populations.

For *infrastructure/site development*, the applicant should consider:

i. Current capability: Describe the quality of existing physical infrastructure and logistical services that support manufacturing and provide analysis of availability of sites prepared to receive new manufacturing investment (including discussion of specific limitations of these cites, i.e., environmental concerns or limited transportation access). Provide detailed analysis on how transportation infrastructure serves KTS in moving people and goods. Do KTS firms contribute significantly to air or water pollution, or sprawl?

ii. Current institutions for improving capability; Is there capability for on-going analysis to identify appropriate sites for new manufacturing activity, and efforts necessary to make them "implementation ready?" Do the applicants control these sites? Are they well-located, requiring readily achievable remedial or infrastructural support to become implementation-ready? Are they easily accessible by potential workers via short commutes or multiple modes of transportation? Are they located in areas where planned uses will not disproportionately impact the health or environment of vulnerable populations? Are they suitable for manufacturing investment in accordance with Brownfield Area-Wide plans, Comprehensive Economic Development Strategies (CEDS), or other plans that focus on economic development outcomes in an area such as those associated with metropolitan planning organizations or regional councils of government? Are there opportunities to improve the environmental sustainability of the KTS?

iii. Gaps: Provide analysis of gaps in existing infrastructure relevant for proposed path to ecosystem development, including barriers and challenges to attracting manufacturing-related investment such as lack of appropriate land or transportation use planning, and explains how plans will address them. To what extent have firms indicated interest in investing in the region if infrastructure gaps are addressed?

iv. Plans: Communities that intend to focus on infrastructure development as a priority area in seeking future grants should explain how they intend to build on local assets to improve KTS in areas such as:

a. Transportation projects that contribute to economic competitiveness of the region and United States as a whole by (i) improving efficiency, reliability, sustainability and/or cost-competitiveness in the movement of workers or goods in the KTS, and (ii) creating jobs in the KTS;

b. Site development for manufacturing to take advantage of existing transportation and other infrastructure and facilitate worker access to new manufacturing jobs;

c. Infrastructure and site reuse that will generate cost savings over the long term and efficiency in use of public resources; and

d. Improvement of production methods and locations so as to reduce environmental pollution and sprawl.

For *trade and international investment*, the applicant should consider:

i. Current capability: What is the current level and rate of change of the community's exports of products or services in the KTS? Identify existing number of international KTS firms, inward investment flow, outward investment flow, export and import figures, KTS trends in the region and internationally.

ii. Current institutions for improving export capability and support: What local public sector, public-private partnership, or nonprofit programs have been developed to promote exports of products or services from the KTS?

iii. Gaps: What are the barriers to increasing KTS exports? Identify strategic needs or gaps to fully implement a program to attract foreign investment (e.g. outreach missions, marketing materials, infrastructure, data or research, missing capabilities).

iv. Plans: Communities that intend to focus on exports or foreign direct investment as a priority area in seeking future grants should explain how they intend to build on local assets to improve KTS in areas such as:

a. Developing global business-to-business matching services; regional advisory services for engaging international markets and international trade officials, or planning and implementing trade missions.

b. Location (investment) promotion in target markets and within target sectors to build the KTS; Investment Missions; business accelerators or soft landing sites to support new investors; marketing materials; or organizational capacity to support investment strategy implementation.

For operational improvement *and capital access*, the applicant should consider:

i. Current capability: For the KTS, what data is available about business operational costs and local capital access? The applicant can provide general description of what is available, and more detailed description of key areas of comparative advantage or of concern. How does industry partner with utility companies to achieve efficient energy distribution and delivery and/or more energy efficient manufacturing operations? What (if any) local institutions exist to help companies reduce business operational costs while maintaining or increasing performance? What (if any) sources of capital and infrastructure are available (public and private) to businesses to expand or locate in a community? What evidence exists regarding their performance?

ii. Gaps: What improvements or new institutions (including financial institutions and foundations) are key for promoting continuous improvement in KTS business operational capability?

iii. Plans: Communities that intend to focus on operational improvements and/or capital access as a priority area in seeking future grants should explain how they intend to build on local assets to improve KTS in areas such as:

a. Reducing manufacturers' production costs by reducing waste management costs, enhancing efficiency, and promoting resilience establishing mechanisms to help firms measure and minimize life-cycle costs (e.g., improving firms' access to innovative financing mechanisms for energy efficiency projects, such as a revolving energy efficiency loan fund or state green bank);

b. Building concerted local efforts and capital projects that facilitate industrial energy efficiency, combined heat and power, and commercial energy retrofits (applicants should detail strategies for capturing these opportunities in support of local manufacturing/business competitiveness); and

c. Developing public-private partnerships that provide capital to commercialize new technology, and develop/equip production facilities in the KTS.

2. Capacity To Carry Out Implementation Strategy

Applications will be judged in part on the quality of the evidence they provide, including the following information:

i. Overall leadership capacity—lead organization's capacity to carry out planned investments in public goods, e.g., prior leadership of similar efforts, prior success attracting outside investment, prior success identifying and managing local and regional partners, and ability to manage, share, and use data for evaluation and continuous improvement.

ii. Sound partnership structure, e.g., clear identification of project lead, clarity of partner responsibilities for executing plan, and appropriateness of partners designated for executing each component; clarity of partnership governance structure; and strength of accountability mechanisms, including contractual measures and remedies for non-performance, as reflected in letters of commitment or Memorandum of Understanding among consortium members. As discussed in Section III.A. of this notice, the partnership (a) must include an EDA-eligible lead applicant (district organization; Indian tribe; state, county, city, or political subdivision of state, institution of higher education, or nonprofit); and (b) should include other key stakeholders, including but not limited to private sector partners, higher education institutions, government entities, economic development and other community and labor groups, financial institutions and utilities. At a minimum, the applicant must have letters of support from a higher education institution, a private sector partner, and some government entity if not already part of the consortium.

iii. Partner capacity to carry out planned investments in public goods and attract companies, as measured by prior stewardship of Federal, state, and/or private dollars received and prior success at achieving intended outcomes.

iv. State of ecosystem's institutions (associated with the six subcategories under Section I. of this notice) and readiness of industry, nonprofit, and public sector facilities to improve the way they facilitate innovation, development, production, and sale of products, as well as train/educate a corresponding workforce.

v. Depth and breadth of communities' short, medium and long term development and employment goals, plans to utilize high-quality data and rigorous methods to evaluate progress, and demonstration that the probability of achieving these goals is realistic.

Competitive applications will have clearly defined goals and impacts that are aligned with IMCP objectives. Over the long term (5–10 years), plans should lead to significant improvements in community's economic activity, environmental sustainability, and quality of life. Thus, every applicant should provide credible evidence that their KTS development plan will lead over the next 5- 10 years to significant but reasonably attainable increases in private investment in the sector, creation of well-paying jobs, increased median income, increased exports and improved environmental quality. We expect that every applicant will track these long-term outcomes, for either the community as a whole or only for their KTS.

In addition, applications will be evaluated on the extent to which applicants present practical and clear metrics for nearer-term evaluations. For the short and medium term (next 2–3 years), applicants should develop milestones (targets they expect to achieve in this time frame) and metrics (measurements toward the selected milestones and long-term goals) that measure the extent to which the chosen catalytic projects are successfully addressing the ecosystem gaps identified in their assessment and contributing to improving the long-term metrics above.

These intermediate metrics will vary according to the plan; for example, a community that has identified a weakness in supplier quality may track improvements in supplier quality systems, while a community that has identified a desire to increase university-industry collaboration might track invention disclosures filed by faculty and business. To the extent feasible, communities should also plan to statistically evaluate the individual programs as well as the effects of the bundle of programs taken together. For example, communities might choose randomly from among qualified applicants if job training programs are oversubscribed, and track job creation outcomes for both treatment and control groups.

A key element in evaluating proposals will be the rate of improvement in key indicators that the plan can credibly generate. Thus, both distressed and non-distressed manufacturing regions are encouraged to apply.

3. Verifiable Commitment From Existing and Prospective Stakeholders—Both Private and Public—To Executing a Plan and Investing in a Community.[2]

i. *Cohesion of partnership.* This may be shown in part by evidence of prior

[2] Such commitments may range in intensity and duration. Lead applicants are responsible for overall coordination, reporting, and delivery of results. Consortium members have ongoing roles that should be specified in the proposal. Other partners may take on less intensive commitments such as in-kind donations of the use of meeting space, equipment, telecommunications services, or staffing for particular functions; letters or other expressions of support for IMCP activities and applications for resources; participation in steering committees or

Continued

collaboration between the IMCP lead applicant, applicant consortium members, and other key community stakeholders (local government, anchor institutions, community, business and labor leaders and local firms, etc.) that includes specific examples of past projects/activities.

ii. *Strength/extent of partnership commitment* (not contingent upon receipt or specific funding stream) to coordinate work and investment to execute plan and strategically invest in identified public goods. Documented match for current project and evidence of past investments can help serve to demonstrate this commitment.

iii. *Breadth of commitment to the plan from diverse institutions*, including local anchor institutions (e.g., hospitals, colleges/universities, labor and community organizations, major employers small business owners and other business leaders, national and community foundations) and local, state and regional government officials.

iv. *Investment commitments.* Extent to which applicants can demonstrate commitments from public and private sectors to invest in public goods identified by the plan, or investments that directly lead to high-wage jobs in manufacturing or related sectors. Letters of intent from prospective investors to support projects, with detailed descriptions of the extent of their financial and time commitment, can serve to demonstrate this commitment. These commitments should be classified into two groups: those that are not contingent on receipt of a specific Federal economic development funding stream, and those that are contingent on the availability of such a Federal economic development funding stream. In the latter case, applicants should aim to show that each dollar of their proposed Federally-funded public investments will be matched over the next 5–10 years by at least two dollars of other investment, which may be private or public (non-Federal).

B. Review Process

All proposals submitted for the manufacturing communities designation will be reviewed on their individual merits by an interagency panel. The interagency panel will judge applications against the evaluation criteria enumerated in section V.A. of this notice, and score applications on a scale of 100 points. The maximum number of points that may be awarded to each criterion is as follows:

1. Quality of Implementation Strategy: 50 points

i. Quality of analysis of workforce, supplier network, innovation, infrastructure, trade, and costs (6 points per element)—36 points

ii. Bonus weight (applicant selects one of the elements in section V.B.1.i. for extra weighting)—6 points

iii. Quality of integration of the six elements—8 points;

2. Capacity: 25 points

i. Leadership capacity, partnership structure, partner capacity, readiness of institutions (4 points per element)—16 points

ii. Quality of goal-setting and evaluation plan—9 points; and

3. Commitment: 25 points

i. Cohesion, strength, and breadth of partnership—14 points

ii. Credibility and size of investments not tied to future Federal economic development funding—7 points

iii. Credibility and size of match tied to IMCP funding—4 points.

Following the scoring of applications, the interagency panel will rank the applications according to their respective scores and present the ranking to the Assistant Secretary for Economic Development (who will serve as the selecting official for the manufacturing community designations made by EDA pursuant to this notice). In determining the issuance of manufacturing community designations, the Assistant Secretary for Economic Development will take into consideration the ranking and supporting justifications provided by the interagency review panel, as well as the applicant's ability to successfully carryout the public policy and program priorities outlined in this notice. The decision of the Assistant Secretary for Economic Development is final; however, if the Assistant Secretary for Economic Development decides to make a manufacturing communities designation that differs from the recommendation of the interagency review panel, the Assistant Secretary for Economic Development will document the rationale for such a determination.

C. Transparency

The agencies and bureaus involved in this initiative are committed to conducting a transparent competition and publicizing information about investment decisions. Applicants are advised that their respective applications and information related to their review, evaluation, and project progress may be shared publicly. For further information on how proprietary, confidential commercial/business, and personally identifiable information will be protected see Section VI.A. of this notice.

VI. Other Information

A. Freedom of Information Act Disclosure

The Freedom of Information Act (5 U.S.C. 552) (FOIA) and DOC's implementing regulations at 15 CFR part 4 set forth the rules and procedures to make requested material, information, and records publicly available. Unless prohibited by law and to the extent permitted under FOIA, contents of applications submitted by applicants may be released in response to FOIA requests. In the event that an application contains information or data that the applicant deems to be confidential commercial information, that information should be identified, bracketed, and marked as "Privileged, Confidential, Commercial or Financial Information." Based on these markings, the confidentiality of the contents of those pages will be protected to the extent permitted by law.

B. Intergovernmental Review

Applications submitted under this announcement are subject to the requirements of Executive Order (EO) 12372, "Intergovernmental Review of Federal Programs," if a State has adopted a process under EO 12372 to review and coordinate proposed Federal financial assistance and direct Federal development (commonly referred to as the "single point of contact review process"). All applicants must give State and local governments a reasonable opportunity to review and comment on the proposed Project, including review and comment from area-wide planning organizations in metropolitan areas.[3] To find out more about a State's process under EO 12372, applicants may contact their State's Single Point of Contact (SPOC). Names and addresses of some States' SPOCs are listed on the Office of Management and Budget's home page at *www.whitehouse.gov/omb/grants_spoc.* Section A.11. of Form ED–900 provides more information and allows applicants to demonstrate compliance with EO 12372.

VII. Contact Information

For questions concerning this solicitation, or more information about the IMCP Participating Agencies

other advisory bodies; permanent donations of funding, land, equipment, facilities or other resources; or the provision of other types of support without taking on a formal role in the day-to-day operations and advancement of the overall strategy; stronger applications will also specify these commitments.

[3] As provided for in 15 CFR part 13.

programs, you may contact the appropriate IMCP Participating Agency's representative listed below.

1. Appalachian Regional Commission

a. Local Access Road Program: Jason Wang, (202) 884–7725, *jwang@arc.gov*
b. Area Development Program: David Hughes, (202) 884–7740, *dhughes@arc.gov*

2. Delta Regional Authority

a. States' Economic Development Assistance Program (SEDAP): Kemp Morgan, (662) 483–8210, *kmorgan@dra.gov*

3. Department of Housing and Urban Development

a. Office of Sustainable Housing and Communities (OSHC) grant: Salin Geevarghese, (202) 402–6412, *salin.g.geeverarghese@hud.gov*
b. Delta Community Capital Initiative: Jackie Williams, (202) 402–4611, *Jackie.L.Williams@hud.gov*
c. Appalachia Economic Development Initiative: (202) 402–4611, *Jackie.L.Williams@hud.gov*

4. Department of Labor, Employment and Training Administration

a. Trade Adjustment Assistance Community College and Career Training (TAACCCT): Robin Fernkas, (202) 693–3177, *Fernkas.Robin@dol.gov*

5. Department of Transportation

a. Transportation Investment Generating Economic Recovery (TIGER): Thomas Berry, (202) 366–4829, *thomas.berry@dot.gov*

6. Environmental Protection Agency

a. Targeted Brownfield Assessments (TBA): Debra Morey, (202) 566–2735, *morey.debi@epa.gov*
b. Brownfield Grants: Debra Morey, (202) 566–2735, *morey.debi@epa.gov*

7. National Science Foundation

a. Advanced Technology Education: Susan Singer, (703) 292–5111, *srsinger@nsf.gov*
b. I/UCRC: Grace Wang, (703) 292–5111 *jiwang@nsf.gov*

8. Small Business Administration

a. Accelerator Program: Pravina Ragavan, (202) 205–6988, *pravina.raghavan@sba.gov*; Javier Saade, (202) 205–6513, *javier.saade@sba.gov*

9. U.S. Department of Agriculture

a. Rural Economic Development Loan and Grant Program (REDLG): Mark Brodziski, (202) 720–1394, *mark.brodziski@wdc.usda.gov*
b. Rural Business Enterprise Grant Program (RBEG): Mark Brodziski, (202) 720–1394, *mark.brodziski@wdc.usda.gov*
c. Intermediary Relending Program (IRP): Mark Brodziski, (202) 720–1394, *mark.brodziski@wdc.usda.gov*
d. Business & Industry Guaranteed Loan Program (B&I): John Broussard, (202) 720–1418, *john.broussard@wdc.usda.gov*

10. U.S. Department of Commerce

Michael Jackson, (202) 482–3639, *mjackson@doc.gov*

Dated: December 5, 2013.

Thomas Guevara,

Deputy Assistant Secretary for Regional Affairs.

[FR Doc. 2013–29422 Filed 12–9–13; 8:45 am]

BILLING CODE 3510–WH–P

DEPARTMENT OF COMMERCE

International Trade Administration

[C–570–993, C–560–827]

Monosodium Glutamate From the People's Republic of China and the Republic of Indonesia: Postponement of Preliminary Determination in the Countervailing Duty Investigations

AGENCY: Enforcement and Compliance, formerly Import Administration, International Trade Administration, Department of Commerce.

FOR FURTHER INFORMATION CONTACT: Jun Jack Zhao at (202) 482–1396 (the People's Republic of China (PRC)); Nicholas Czajkowski at (202) 482–1395 (the Republic of Indonesia (Indonesia)), AD/CVD Operations, Enforcement and Compliance, International Trade Administration, U.S. Department of Commerce, 14th Street and Constitution Avenue NW., Washington, DC 20230.

SUPPLEMENTARY INFORMATION:

Background

On October 23, 2013, the Department of Commerce (the Department) initiated the countervailing duty investigations of monosodium glutamate from Indonesia and the PRC.[1] Currently, the preliminary determinations are due no later than December 27, 2013.

Postponement of Due Date for the Preliminary Determination

Section 703(b)(1) of the Tariff Act of 1930, as amended (the Act), requires the Department to issue the preliminary determination in a countervailing duty investigation within 65 days after the date on which the Department initiated the investigation. However, if the Department concludes that the parties concerned in the investigation are cooperating and determines that the investigation is extraordinarily complicated, section 703(c)(1)(B) of the Act allows the Department to postpone making the preliminary determination until no later than 130 days after the date on which the administering authority initiated the investigation.

The Department has determined that the parties involved in these proceedings are cooperating, and that the investigations are extraordinarily complicated.[2] Specifically, the Department is investigating numerous alleged subsidy programs in both Indonesia and the PRC; these programs include loans, grants, tax incentives, and the provision of goods and services for less than adequate remuneration. Due to the number and complexity of the alleged countervailable subsidy practices being investigated, we determine that these investigations are extraordinarily complicated. Therefore, in accordance with section 703(c)(1)(B) of the Act, we are postponing the due date for the preliminary determinations to not later than 130 days after the day on which the investigations were initiated. Thus, the deadline for completion of the preliminary determinations is now March 2, 2014. Because the deadline falls on a non-business day, in accordance with the Department's practice, the deadline will become the next business day, March 3, 2014.[3]

This notice is issued and published pursuant to section 703(c)(2) of the Act and 19 CFR 351.205(f)(1).

Dated: December 3, 2012.

Paul Piquado,

Assistant Secretary for Enforcement and Compliance.

[FR Doc. 2013–29458 Filed 12–9–13; 8:45 am]

BILLING CODE 3510–DS–P

[1] *See Monosodium Glutamate from the People's Republic of China and the Republic of Indonesia: Initiation of Countervailing Duty Investigations*, 78 FR 65269 (October 31, 2013).

[2] *See* section 703(c)(1)(B) of the Act.

[3] *See Notice of Clarification: Application of "Next Business Day" Rule for Administrative Determination Deadlines Pursuant to the Tariff Act of 1930, as Amended*, 70 FR 24533 (May 10, 2005).

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

RIN 0648–XD018

Endangered and Threatened Species; Take of Anadromous Fish

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

ACTION: Notice; availability of hatchery plans and request for comment.

SUMMARY: Notice is hereby given that the Oregon Department of Fish and Wildlife (ODFW) has submitted four Hatchery and Genetic Management Plans (HGMPs) pursuant to the protective regulations promulgated for Pacific salmon and steelhead under the Endangered Species Act (ESA). The HGMPs specify the operations of four hatchery programs rearing salmon and steelhead in the Sandy River subbasin within the State of Oregon. This document serves to notify the public of the availability of the HGMPs for comment prior to a decision by NMFS whether to approve the proposed hatchery programs.

DATES: Comments must be received at the appropriate address or fax number (see **ADDRESSES**) no later than 5 p.m. Pacific time on January 9, 2014.

ADDRESSES: Written comments on the application should be addressed to the NMFS Sustainable Fisheries Division, 1201 NE. Lloyd Boulevard, Suite 1100, Portland, OR 97232, or faxed to 503–872–2737. Comments may be submitted by email. The mailbox address for providing email comments is: *SandyHatcheries2013.wcr@noaa.gov*. Include in the subject line of the email comment the following identifier: Comments on Oregon's 2013 Sandy hatchery plans.

FOR FURTHER INFORMATION CONTACT: Rich Turner, at phone number: (503) 736–4737, or via email: *Rich.Turner@noaa.gov*.

SUPPLEMENTARY INFORMATION:

Species Covered in This Notice

Chinook salmon (*Oncorhynchus tshawytscha*): Threatened, naturally produced and artificially propagated Lower Columbia River.

Chum salmon (*O. keta*): Threatened, naturally produced and artificially propagated Columbia River.

Coho salmon (*O. kisutch*): Threatened, naturally produced and artificially propagated Lower Columbia River.

Steelhead (*O. mykiss*): Threatened, naturally produced and artificially propagated Lower Columbia River.

Pacific eulachon (*Thaleichthys pacificus*): Threatened, naturally produced southern distinct population segment.

ODFW has previously submitted to NMFS four HGMPs describing hatchery programs that release salmon and steelhead into the Sandy River that were found, in a September 28, 2012, determination, to comply with requirements of the ESA under limit 5 of the 4(d) Rule. These programs were designed to meet mitigation responsibilities related to impacts from development in the Sandy River and Columbia River basins by providing hatchery fish to support fishing opportunities while minimizing potential risks to natural-origin spring Chinook salmon, coho salmon, and winter steelhead populations, consistent with Oregon's Lower Columbia River Conservation and Recovery Plan for Oregon Populations of Salmon and Steelhead. The September 28, 2012, determination remains in effect.

Since the determination, ODFW has identified changes it wishes to make to its hatchery operations and has submitted to NMFS four revised HGMPs describing changes to the current hatchery programs. The revised Spring Chinook Salmon HGMP includes the incorporation of natural-origin Chinook salmon into the broodstock, a reduction in the number of juveniles released, and changes in rearing locations. The revised Winter Steelhead Program HGMP includes the incorporation of natural-origin winter steelhead into the broodstock. The revised Coho Salmon Program and the Summer Steelhead Program HGMPs include changes to rearing locations. Submittal of these four revised HGMPs constitutes the proposed action and the revised HGMPs are the subject of this notice.

As specified in the July 10, 2000, ESA 4(d) rule for salmon and steelhead (65 FR 42422) and updated June 28, 2005 (70 FR 37160), NMFS may approve an HGMP if it meets criteria set forth in 50 CFR 223.203(b)(5)(i)(A) through (K). Prior to final approval of an HGMP, NMFS must publish notification announcing its availability for public review and comment.

Authority

Under section 4 of the ESA, the Secretary of Commerce is required to adopt such regulations as he deems necessary and advisable for the conservation of species listed as threatened. The ESA salmon and steelhead 4(d) rule (65 FR 42422, July 10, 2000, as updated in 70 FR 37160, June 28, 2005) specifies categories of activities that contribute to the conservation of listed salmonids and sets out the criteria for such activities. Limit 5 of the updated 4(d) rule (50 CFR 223.203(b)(5)) further provides that the prohibitions of paragraph (a) of the updated 4(d) rule (50 CFR 223.203(a)) do not apply to activities associated with artificial propagation programs provided that an HGMP has been approved by NMFS to be in accordance with the salmon and steelhead 4(d) rule (65 FR 42422, July 10, 2000, as updated in 70 FR 37160, June 28, 2005).

Dated: December 4, 2013.

Angela Somma,

Chief, Endangered Species Division, Office of Protected Resources, National Marine Fisheries Service.

[FR Doc. 2013–29399 Filed 12–9–13; 8:45 am]

BILLING CODE 3510–22–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

RIN 0648–XD019

Endangered and Threatened Species; Take of Anadromous Fish

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

ACTION: Notice of receipt and request for comment.

SUMMARY: Notice is hereby given that NMFS has received three applications for direct take permits for spring Chinook salmon, in the form of Hatchery and Genetic Management Plans (HGMPs), pursuant to the Endangered Species Act of 1973, as amended (ESA). One application is from the Public Utility District No. 1 of Douglas County (Douglas PUD), the Public Utility District of Grant County (Grant PUD), and the Washington Department of Fish and Wildlife (WDFW) for the operation of the Methow spring Chinook salmon program. Another application is from the U.S. Fish and Wildlife Service (USFWS) and U.S. Bureau of Reclamation (Reclamation) for the Winthrop National Fish Hatchery (WNFH) spring Chinook salmon program. The third application is from the Confederated Colville Tribes (CCT); this program is funded by the Bonneville Power Administration (BPA) and operates in close coordination with the USFWS and Reclamation WNFH spring Chinook program. All applicants

are seeking ESA section 10(a)(1)(A) permits. This document serves to notify the public of the availability of the permit applications and addenda for public review, comment, and submission of written data, views, arguments, or other relevant information. All comments and other information received will become part of the public record and will be available for review pursuant to section 10(c) of the ESA.

DATES: Comments and other submissions must be received at the appropriate address or fax number (see **ADDRESSES**) no later than 5 p.m. Pacific time on January 9, 2014.

ADDRESSES: Written responses to the application should be sent to Craig Busack, National Marine Fisheries Services, Sustainable Fisheries Division, 1201 NE. Lloyd Boulevard, Suite 1100, Portland, OR 97232. Comments may also be submitted by email to: *MethowOkanoganPlans.wcr@noaa.gov*. Include in the subject line of the email comment the following identifier: Comments on Methow, Winthrop, and Okanogan spring Chinook salmon HGMPs. Comments may also be sent via facsimile (fax) to (503) 872–2737. Requests for copies of the permit applications should be directed to the National Marine Fisheries Services, Sustainable Fisheries Division, 1201 NE. Lloyd Boulevard, Suite 1100, Portland, OR 97232. The documents are also available on the Internet at *www.westcoast.fisheries.noaa.gov*. Comments received will also be available for public inspection, by appointment, during normal business hours by calling (503) 230–5418.

FOR FURTHER INFORMATION CONTACT: Craig Busack at (503) 230–5412 or via email at *craig.busack@noaa.gov*.

SUPPLEMENTARY INFORMATION:

Species Covered in This Notice

Chinook salmon (*Oncorhynchus tshawytscha*): endangered, naturally-produced and artificially-propagated Upper Columbia River spring-run.

Steelhead (*Oncorhynchus mykiss*): threatened, naturally-produced and artificially-propagated Upper Columbia River summer-run.

Background

Section 9 of the ESA and Federal regulations prohibit the "taking" of a species listed as endangered or threatened. The term "take" is defined under the ESA to mean harass, harm, pursue, hunt, shoot, wound, kill, trap, capture, or collect, or to attempt to engage in any such conduct. NMFS may issue permits to take listed species for any act otherwise prohibited by section 9 for scientific purposes or to enhance the propagation or survival of the affected species, under section 10(a)(1)(A) of the ESA. NMFS regulations governing permits for threatened and endangered species are promulgated at 50 CFR 222.307.

On November 13, 2012, NMFS received an application from the Douglas PUD, the Grant PUD, and the WDFW for an ESA section 10(a)(1)(A) permit for the direct take of ESA-listed Upper Columbia River spring Chinook salmon in order to carry out an artificial propagation (hatchery) program at the Methow Fish Hatchery (MFH) and associated facilities to enhance the species. The application included a HGMP (dated February 12, 2010; previously submitted on March 3, 2010) and a supplemental document titled *Supporting Information Submitted to National Marine Fisheries Service Regarding the Methow Fish Hatchery Spring Chinook HGMP*. The Douglas and Grant PUD-funded and WDFW Methow spring Chinook salmon program serves two purposes: (1) Mitigation for passage losses caused by operation of the Wells, Priest Rapids, and Wanapum Dams, and (2) act as a conservation program for Methow spring Chinook salmon. The current release goal is 163,000 yearling smolts annually.The proposed hatchery program complies with the terms and conditions of the Wells Anadromous Fish Agreement and Habitat Conservation Plan (HCP) and the Priest Rapids anadromous fish settlement agreement, and is consistent with the 2008–2017 *U.S.* v. *Oregon* Management Agreement.

On November 21, 2012, NMFS received an application from the USFWS and Reclamation for the WNFH spring Chinook salmon program. The application included an HGMP and a supplemental document entitled *Supporting Information Submitted to National Marine Fisheries Service Regarding the Winthrop National Fish Hatchery Spring Chinook HGMP*. The purpose of this program is to mitigate for the losses caused by the construction of Grand Coulee Dam. The WNFH spring Chinook salmon program serves two purposes: (1) Provides a "safety-net" program for the MFH conservation program operated by the WDFW, and (2) provides a biologically appropriate source of juvenile fish for a proposed spring Chinook salmon reintroduction program in the Okanogan subbasin. The current release goal is 600,000 juveniles annually. The proposed hatchery program complies with the 2008–2017 *U.S.* v *.Oregon* Management Agreement.

On May 13, 2013, NMFS received an application from the CCT for an ESA section 10(a)(1)(A) permit for the direct take of ESA-listed Upper Columbia River spring Chinook salmon in order to carry out an artificial propagation (hatchery) program at the Chief Joseph Hatchery and associated facilities for development of a non-essential experimental Okanogan spring Chinook salmon population. The purpose of this program is to restore natural spawning spring Chinook salmon in historical habitats of the Okanogan subbasin. The long-term vision is to restore ceremonial and subsistence fishing for the CCT throughout their usual and accustomed fishing grounds. However, the short-term focus is on conservation—the program is expected to expand the spatial structure of the UCR Spring Chinook Salmon ESU, and no harvest activities will occur within the 5- to 10-year time frame of this HGMP. The CCT's Chief Joseph Hatchery spring Chinook salmon program releases would establish a nonessential experimental spring Chinook salmon population in the Okanogan River under section 10(j) of the ESA, using Methow composite spring Chinook salmon from the WNFH in place of Carson-stock spring Chinook salmon.

All HGMPs and supporting documents are available for public review and comment as part of the permit application packages.

Authority

This notice is provided pursuant to section 10(c) of the ESA. NMFS will evaluate each application, associated documents, and comments submitted thereon to determine whether the applications meet the requirements of section 10(a)(1)(A) of the ESA. If it is determined that the requirements are met, permits will be issued to the USFWS along with the WDFW and the Douglas and Grant PUDs as co-permittees for the purpose of carrying out the Methow spring Chinook salmon program. Permits will also be issued to the USFWS and the CCT for the purpose of carrying out the Okanogan spring Chinook salmon hatchery program. NMFS will publish a record of its final action in the **Federal Register**.

Dated: December 4, 2013.

Angela Somma,

Chief, Endangered Species Division, Office of Protected Resources, National Marine Fisheries Service.

[FR Doc. 2013–29400 Filed 12–9–13; 8:45 am]

BILLING CODE 3510–22–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

RIN 0648–XD015

Fisheries of the Gulf of Mexico; Southeast Data, Assessment, and Review (SEDAR) Assessments of Gag (Mycteroperca microlepis) and Greater Amberjack (Seriola dumerili); Public Meetings

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

ACTION: Notice of SEDAR 33 Gulf of Mexico Gag and Greater Amberjack webinars.

SUMMARY: The SEDAR 33 assessment of the Gulf of Mexico stocks of gag and greater amberjack will consist of two workshops and a series of webinars: a Data Workshop, an Assessment process conducted via webinars, and a Review Workshop. This series of workshops and webinars will be referred to as SEDAR 33. This notice is for additional Assessment Workshop webinars. See **SUPPLEMENTARY INFORMATION.**

DATES: Additional Assessment Workshop webinars are scheduled for January 8, 2014 and January 15, 2014. See **SUPPLEMENTARY INFORMATION.**

ADDRESSES:

Meeting address: The Assessment Workshop webinars will be held via GoToWebinar. All workshops and webinars are open to members of the public. Those interested in participating should contact Ryan Rindone at SEDAR (see **FOR FURTHER INFORMATION CONTACT**) to request an invitation providing pertinent information. Please request meeting information at least 24 hours in advance.

SEDAR address: 4055 Faber Place Drive, Suite 201, N. Charleston, SC 29405

FOR FURTHER INFORMATION CONTACT: Ryan Rindone, SEDAR Coordinator; telephone: (813) 348–1630; email: *ryan.rindone@gulfcouncil.org*

SUPPLEMENTARY INFORMATION: The Gulf of Mexico, South Atlantic, and Caribbean Fishery Management Councils, in conjunction with NOAA Fisheries and the Atlantic and Gulf States Marine Fisheries Commissions have implemented the Southeast Data, Assessment and Review (SEDAR) process, a multi-step method for determining the status of fish stocks in the Southeast Region. SEDAR is a three-step process including: (1) Data Workshop; (2) Assessment Process including a workshop and webinars; and (3) Review Workshop. The product of the Data Workshop is a data report which compiles and evaluates potential datasets and recommends which datasets are appropriate for assessment analyses. The product of the Assessment Process is a stock assessment report which describes the fisheries, evaluates the status of the stock, estimates biological benchmarks, projects future population conditions, and recommends research and monitoring needs. The assessment is independently peer reviewed at the Review Workshop. The product of the Review Workshop is a Consensus Summary documenting panel opinions regarding the strengths and weaknesses of the stock assessment and input data. Participants for SEDAR Workshops are appointed by the Gulf of Mexico, South Atlantic, and Caribbean Fishery Management Councils and NOAA Fisheries Southeast Regional Office and Southeast Fisheries Science Center. Participants include: data collectors and database managers; stock assessment scientists, biologists, and researchers; constituency representatives including fishermen, environmentalists, and non-governmental organizations (NGOs); international experts; and staff of Councils, Commissions, and state and federal agencies.

SEDAR 33 Assessment Workshop Schedule:

January 8, 2014 and January 15, 2014; SEDAR 33 Assessment Workshop Webinars

All webinars will begin at 1 p.m. eastern time, will last approximately four hours, and will be conducted using GoToWebinar. Participants will review modeling efforts, suggest sensitivity analyses, and decide on an appropriate model run or set of model runs to put forward to the Review Workshop for each species.

Although non-emergency issues not contained in this agenda may come before this group for discussion, 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 and any issues arising after publication of this notice that require emergency action under section 305(c) of the Magnuson-Stevens Fishery Conservation and Management Act, provided the public has been notified of the intent to take final action to address the emergency.

Special Accommodations

These meetings are accessible to people with disabilities. Requests for auxiliary aids should be directed to the SEDAR office (see **ADDRESSES**) at least 10 business days prior to the meeting.

Note: The times and sequence specified in this agenda are subject to change.

Authority: 16 U.S.C. 1801 *et seq.*

Dated: December 5, 2013.

Tracey L. Thompson,

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

[FR Doc. 2013–29418 Filed 12–9–13; 8:45 am]

BILLING CODE 3510–22–P

DEPARTMENT OF DEFENSE

Office of the Secretary

[Docket ID: DoD–2013–OS–0227]

Proposed Collection; Comment Request

AGENCY: Office of the Secretary of Defense, DoD.

ACTION: Notice.

SUMMARY: In compliance with Section 3506(c)(2)(A) of the *Paperwork Reduction Act of 1995,* the Defense Security Service (DSS) announces a proposed public information collection and seeks public comment on the provisions thereof. Comments are invited on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed information collection; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the information collection on respondents, including through the use of automated collection techniques or other forms of information technology.

DATES: Consideration will be given to all comments received by February 10, 2014.

ADDRESSES: You may submit comments, identified by docket number and title, by any of the following methods:

- *Federal eRulemaking Portal: http://www.regulations.gov.* Follow the instructions for submitting comments.
- *Mail:* Federal Docket Management System Office, 4800 Mark Center Drive, East Tower, Suite 02G09, Alexandria, VA 22350–3100.

Instructions: All submissions received must include the agency name, docket number and title for this **Federal Register** document. The general policy for comments and other submissions from members of the public is to make these submissions available for public

viewing on the Internet at *http://www.regulations.gov* as they are received without change, including any personal identifiers or contact information.

FOR FURTHER INFORMATION CONTACT: To request more information on this proposed information collection or to obtain a copy of the proposal and associated collection instruments, please write to: Defense Security Service, ATTN: Mr. Helmut Hawkins, Industrial Policy and Programs—A&E Division, 27130 Telegraph Road, Quantico, VA 22134.

SUPPLEMENTARY INFORMATION:

Title; Associated Form; and OMB Number: Personnel Security Investigation Projection for Industry Survey; DSS Form 232; OMB Number 0704–0417.

Needs and Uses: Executive order (EO) 12829, "National Industrial Security Program (NISP)," stipulates that the Secretary of Defense shall serve as the Executive Agent for inspecting and monitoring the contractors, licensees, and grantees who require or will require access to classified information; and for determining the eligibility for access to classified information of contractors, licensees, and grantees and their respective employees. The Under Secretary of Defense for Intelligence assigned Defense Security Service (DSS) the responsibility for central operational management of DoD personnel security investigation (PSI) workload projections, and for monitoring of PSI funding and investigation quality issues for DoD components. This responsibility includes managing workload projections, along with funding and quality oversight matters related to PSIs conducted for employees and consultants of contractors cleared under the NISP. Prior to 2001, DSS compared historical PSI data for budget formulation. Since 2001, DSS conducted an annual survey of cleared contractors to more accurately assess personnel security and trustworthiness investigation requirements. In this annual collection of information, DSS asks the Facility Security Officers of cleared contractor entities to provide for each of three fiscal years (e.g., 2015, 2016, 2017): Projections of the numbers and types of personnel security investigations (PSIs) required; a description of methodology used for the projections; and estimates of the numbers and types of cleared contractor's PSI projections that are separately attributable to DoD contracts and the contracts of non-DoD agencies. The data will be incorporated into DSS's budget submissions and will be used to track against cleared contractors' actual PSI submissions.

The Office of Personnel Management (OPM) has responsibility for conducting PSIs and the subsequent periodic reinvestigations (PRs) in accordance with the Code of Federal Regulations, Title 5, Part 736.

Cleared contractors, representatives of various industry associations, the National Industrial Security Program Policy Advisory Committee (NISPPAC), various components of the Department of Defense (including the Military Departments) and other Federal Government agencies are familiar with the annual survey.

Affected Public: Business or other for profit; Not-for-profit institutions under Department of Defense Security Cognizance.

Annual Burden Hours: 17,801.

Number of Respondents: 13,351.

Responses per Respondent: 1.

Average Burden per Response: 80 minutes.

Frequency: Annually.

The execution of the DSS Form 232 is an essential element of DSS' ability to project the PSI needs of cleared contractor entities. This collection of information requests the assistance of the Facility Security Officer to provide projections of the numbers and types of PSIs. The data will be incorporated into DSS's budget submissions and used to track against actual PSI submissions. The form will be distributed electronically via a web-based commercial survey tool. The form will display OMB approval number 0704–0417.

Dated: December 5, 2013.

Aaron Siegel,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 2013–29451 Filed 12–9–13; 8:45 am]

BILLING CODE 5001–06–P

DEPARTMENT OF DEFENSE

Office of the Secretary

Department of Defense Task Force on the Care, Management, and Transition of Recovering Wounded, Ill, and Injured Members of the Armed Forces; Notice of Federal Advisory Committee Meeting

AGENCY: Office of the Assistant Secretary of Defense, DoD.

ACTION: Meeting notice.

SUMMARY: The Department of Defense is publishing this notice to announce the following Federal Advisory Committee meeting of the Department of Defense Task Force on the Care, Management, and Transition of Recovering Wounded, Ill, and Injured Members of the Armed Forces (subsequently referred to as the Task Force).

DATES: Monday, January 27, 2014, from 8:30 a.m. to 5:15 p.m. EST–Tuesday, January 28, 2014, from 8:30 a.m. to 5:00 p.m. EST.

ADDRESSES: DoubleTree by Hilton Hotel Washington, DC—Crystal City, 300 Army Navy Drive, Arlington, VA 22202 (Washington Ball Room).

FOR FURTHER CONTACT INFORMATION: Mail Delivery service through Recovering Warrior Task Force, Hoffman Building II, 200 Stovall St., Alexandria, VA 22332–0021 "Mark as Time Sensitive for January Meeting". Email correspondence to *rwtf@mail.mil.* Denise F. Dailey, Designated Federal Officer; Telephone (703) 325–6640. Fax (703) 325–6710.

SUPPLEMENTARY INFORMATION: This meeting is being held under the provisions of the Federal Advisory Committee Act of 1972 (5 U.S.C., Appendix, as amended), the Government in the Sunshine Act of 1976 (5 U.S.C. 552b, as amended), and 41 CFR 102–3.150.

Purpose of the Meeting: The purpose of the meeting is for the Task Force Members to convene and gather data from panels and briefers on the Task Force's topics of inquiry.

Agenda: (Refer to *http://rwtf.defense.gov* for the most up-to-date meeting information).

Day One: Monday, January 27, 2014

8:30 a.m.–8:45 a.m. Welcome, Member Introductions
8:45 a.m.–9:45 a.m. Installation Visit After Action Review
9:45 a.m.–10:45 a.m. Vision Center of Excellence (VCE) Briefing
10:45 a.m.–11:00 a.m. Break
11:00 a.m.–12:00 p.m. National Intrepid Center of Excellence (NICoE) Briefing
12:00 p.m.–1:00 p.m. Break for Lunch
1:00 p.m.–3:00 p.m. Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE PH & TBI) Briefing
3:00 p.m.–3:15 p.m. Break
3:15 p.m.–4:15 p.m. Recommendations of Major Committees on Wounded, Ill, and Injured
4:15 p.m.–5:00 p.m. The Veteran Metrics Initiative Briefing
5:00 p.m.–5:15 p.m. Wrap Up

Day Two: Tuesday, January 28, 2014

8:30 a.m.–8:45 a.m. Welcome
8:45 a.m.–9:00 a.m. Public Forum

9:00 a.m.–10:00 a.m. Office of the Assistant Secretary of Defense for Health Affairs Briefing
10:00 a.m.–10:15 a.m. Break
10:15 a.m.–11:00 a.m. Wounded Warrior Project Technical Training Academy Briefing
11:00 a.m.–12:00 p.m. Interagency Program Office (IPO) Briefing
12:00 p.m.–1:00 p.m. Break for Lunch
1:00 p.m.–2:00 p.m. Job Training, Employment Skills Training, Apprenticeships, and Internships Update
2:00 p.m.–3:00 p.m. Health Net Federal Services and United Healthcare Military & Veterans Warrior Navigation and Assistance Program (WNAP) Briefing
3:00 p.m.–3:15 p.m. Break
3:15 p.m.–4:45 p.m. Non-Profits Panel
4:45 p.m.–5:00 p.m. Wrap Up

Public's Accessibility to the Meeting: Pursuant to 5 U.S.C. 552b and 41 CFR 102–3.140 through 102–3.165, and the availability of space, this meeting is open to the public. Seating is on a first-come basis.

Pursuant to 41 CFR 102–3.105(j) and 102–3.140, and section 10(a)(3) of the Federal Advisory Committee Act of 1972, the public or interested organizations may submit written statements to the Department of Defense Task Force on the Care, Management, and Transition of Recovering Wounded, Ill, and Injured Members of the Armed Forces about its mission and functions. If individuals are interested in making an oral statement during the Public Forum, a written statement for a presentation of two minutes must be submitted as stated in this notice and it must be identified as being submitted for an oral presentation by the person making the submission. Identification information must be provided and, at a minimum, must include a name and a phone number. Individuals may visit the Task Force Web site at *http://rwtf.defense.gov* to view the Charter. Individuals making presentations will be notified by Wednesday, January 22, 2014. Oral presentations will be permitted only on Tuesday, January 28, 2014 from 8:45 a.m. to 9:00 a.m. e.s.t. before the Task Force. The number of oral presentations will not exceed ten, with one minute of questions available to the Task Force members per presenter. Presenters should not exceed their two minutes.

Written statements in which the author does not wish to present orally may be submitted at any time or in response to the stated agenda of a planned meeting of the Department of Defense Task Force on the Care, Management, and Transition of Recovering Wounded, Ill, and Injured Members of the Armed Forces.

All written statements shall be submitted to the Designated Federal Officer for the Task Force through the contact information in the **FOR FURTHER INFORMATION CONTACT** section, and this individual will ensure that the written statements are provided to the membership for their consideration.

Statements, either oral or written, being submitted in response to the agenda mentioned in this notice must be received by the Designated Federal Officer at the address listed in the **FOR FURTHER INFORMATION CONTACT** section no later than 5:00 p.m. e.s.t., Tuesday, January 21, 2014 with the subject of this notice. Statements received after this date may not be provided to or considered by the Task Force until its next meeting. Please mark mail correspondence as "Time Sensitive for January Meeting."

The Designated Federal Officer will review all timely submissions with the Task Force Co-Chairs and ensure they are provided to all members of the Task Force before the meeting that is the subject of this notice.

Reasonable accommodations will be made for those individuals with disabilities who request them. Requests for additional services should be directed to Ms. Heather Moore, (703) 325–6640, by 5:00 p.m. EST, Wednesday, January 22, 2014.

Dated: December 5, 2013.

Aaron Siegel,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 2013–29442 Filed 12–9–13; 8:45 am]

BILLING CODE 5001–06–P

DEPARTMENT OF DEFENSE

Office of the Secretary

Meeting of the Uniform Formulary Beneficiary Advisory Panel

AGENCY: Assistant Secretary of Defense (Health Affairs), DoD.

ACTION: Notice of meeting.

SUMMARY: The Department of Defense (DoD) is publishing this notice to announce the following Federal Advisory Committee Meeting of the Uniform Formulary Beneficiary Advisory Panel (hereafter referred to as the Panel).

DATES: Thursday, January 9, 2014, from 9:00 a.m. to 1:00 p.m.

ADDRESSES: Naval Heritage Center Theater, 701 Pennsylvania Avenue NW., Washington, DC 20004.

FOR FURTHER INFORMATION CONTACT: CDR Joseph Lawrence, DFO, Uniform Formulary Beneficiary Advisory Panel, 4130 Stanley Road, Suite 208, Building 1000, San Antonio, TX 78234–6012. Telephone: (210) 295–1271. Fax: (210) 295–2789. Email Address: *Baprequests@tma.osd.mil.*

SUPPLEMENTARY INFORMATION: This meeting is being held under the provisions of the Federal Advisory Committee Act of 1972 (Title 5, United States Code (U.S.C.), Appendix, as amended) and the Government in the Sunshine Act of 1976 (Title 5, U.S.C., Section (Sec.) 552b, as amended).

Purpose of Meeting: The Panel will review and comment on recommendations made to the Director of TRICARE Management Activity, by the Pharmacy and Therapeutics Committee, regarding the Uniform Formulary.

Meeting Agenda

1. Sign-In
2. Welcome and Opening Remarks
3. Public Citizen Comments
4. Scheduled Therapeutic Class Reviews (Comments will follow each agenda item)
   a. Pulmonary Agent-1
   1. Combinations
   2. Short Actions Beta Agonists
   b. Antilipidemics-1
   c. Benign Prostatic Hyperplasia Agents
   d. Designated Newly Approved Drugs in Already-Reviewed Classes
   e. Pertinent Utilization Management Issues
5. Panel Discussions and Vote

Meeting Accessibility: Pursuant to 5 U.S.C. 552b, as amended, and 41 CFR 102–3.140 through 102–3.165, and the availability of space, this meeting is open to the public. Seating is limited and will be provided only to the first 220 people signing-in. All persons must sign-in legibly.

Administrative Work Meeting: Prior to the public meeting, the Panel will conduct an Administrative Work Meeting from 8:00 a.m. to 9:00 a.m. to discuss administrative matters of the Panel. The Administrative Work Meeting will be held at the Naval Heritage Center, 701 Pennsylvania Avenue NW., Washington, DC 20004. Pursuant to 41 CFR 102–3.160, the Administrative Work Meeting will be closed to the public.

Written Statements: Pursuant to 41 CFR 102–3.105(j) and 102–3.140, the public or interested organizations may submit written statements to the membership of the Panel at any time or in response to the stated agenda of a

planned meeting. Written statements should be submitted to the Panel's Designated Federal Officer (DFO). The DFO's contact information can be obtained from the General Services Administration's Federal Advisory Committee Act Database at *http://facasms.fido.gov/*.

Written statements that do not pertain to the scheduled meeting of the Panel may be submitted at any time. However, if individual comments pertain to a specific topic being discussed at a planned meeting, then these statements must be submitted no later than 5 business days prior to the meeting in question. The DFO will review all submitted written statements and provide copies to all the committee members.

Public Comments: In addition to written statements, the Panel will set aside 1 hour for individuals or interested groups to address the Panel. To ensure consideration of their comments, individuals and interested groups should submit written statements as outlined in this notice; but if they still want to address the Panel, then they will be afforded the opportunity to register to address the Panel. The Panel's DFO will have a "Sign-Up Roster" available at the Panel meeting for registration on a first-come, first-serve basis. Those wishing to address the Panel will be given no more than 5 minutes to present their comments, and at the end of the 1 hour time period, no further public comments will be accepted. Anyone who signs-up to address the Panel, but is unable to do so due to the time limitation, may submit their comments in writing; however, they must understand that their written comments may not be reviewed prior to the Panel's deliberation.

To ensure timeliness of comments for the official record, the Panel encourages that individuals and interested groups consider submitting written statements instead of addressing the Panel.

Dated: December 5, 2013.

Aaron Siegel,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 2013–29445 Filed 12–9–13; 8:45 am]

BILLING CODE 5001–06–P

DEPARTMENT OF DEFENSE

Office of the Secretary

TRICARE, Formerly Known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); Fiscal Year 2014 Mental Health Rate Updates

AGENCY: Department of Defense.

ACTION: Notice of Updated Mental Health Rates for FY 2014.

SUMMARY: This notice provides the updated regional per-diem rates for low-volume mental health providers; the update factor for hospital-specific per-diems; the updated cap per-diem for high-volume providers; the beneficiary per-diem cost-share amount for low-volume providers; and, the updated per-diem rates for both full-day and half-day TRICARE Partial Hospitalization Programs for FY 2014.

DATES: *Effective Date:* The FY 2014 rates contained in this notice are effective for services on or after October 1, 2013.

ADDRESSES: TRICARE Management Activity (TMA), Medical Benefits and Reimbursement Branch, 16401 East Centretech Parkway, Aurora, CO 80011–9066.

FOR FURTHER INFORMATION CONTACT: Elan Green, Medical Benefits and Reimbursement Branch, TMA, telephone (303) 676–3907.

SUPPLEMENTARY INFORMATION: The final rule published in the **Federal Register** (FR) on September 6, 1988 (53 FR 34285) set forth reimbursement changes that were effective for all inpatient hospital admissions in psychiatric hospitals and exempt psychiatric units occurring on or after January 1, 1989. The final rule published in the **Federal Register** on July 1, 1993 (58 FR 35400) set forth maximum per-diem rates for all partial hospitalization admissions on or after September 29, 1993. Included in these final rules were provisions for updating reimbursement rates for each federal FY. As stated in the final rules, each per-diem shall be updated by the Medicare update factor for hospitals and units exempt from the Medicare Prospective Payment System (i.e., this is the same update factor used for the inpatient prospective payment system). For FY 2014, the market basket rate is 2.5 percent. This year, Medicare applied two reductions to its market basket amount: (1) A 0.5 percent reduction for economy-wide productivity required by section 3401(a) of the Patient Protection and Affordable Care Act (PPACA) which amended section 1886(b)(3)(B) of the Social Security Act, and (2) a 0.3 percent point adjustment as required by section 1886(b)(3)(B)(xii) of the Act as added and amended by sections 3401 and 10319(a) of the PPACA. These two reductions do not apply to TRICARE. Hospitals and units with hospital-specific rates (hospitals and units with high TRICARE volume) and regional-specific rates for psychiatric hospitals and units with low TRICARE volume will have their TRICARE rates for FY 2014 updated by 2.5 percent.

Partial hospitalization rates for full-day programs also will be updated by 2.5 percent for FY 2014. Partial hospitalization rates for programs of less than 6 hours (with a minimum of three hours) will be paid a per diem rate of 75 percent of the rate for a full-day program.

The cap amount for high-volume hospitals and units also will be updated by the 2.5 percent for FY 2014.

The beneficiary cost share for low-volume hospitals and units also will be updated by the 2.5 percent for FY 2014.

Per 32 CFR 199.14, the same area wage indexes used for the CHAMPUS Diagnosis-Related Group (DRG)-based payment system shall be applied to the wage portion of the applicable regional per-diem for each day of the admission. The wage portion shall be the same as that used for the CHAMPUS DRG-based payment system. For wage index values greater than 1.0, the wage portion of the regional rate subject to the area wage adjustment is 69.6 percent for FY 2014. For wage index values less than or equal to 1.0, the wage portion of the regional rate subject to the area wage adjustment is 62.0 percent.

Additionally, 32 CFR 199.14 requires that hospital specific and regional per-diems shall be updated by the Medicare update factor for hospitals and units exempt from the Medicare prospective payment system.

The following reflect an update of 2.5 percent for FY 2014.

REGIONAL—SPECIFIC RATES FOR PSYCHIATRIC HOSPITALS AND UNITS WITH LOW TRICARE VOLUME FOR FY 2014

United States census region	Regional rate
Northeast:	
New England	$827
Mid-Atlantic	797
Midwest:	
East North Central	689
West North Central	650
South:	
South Atlantic	820
East South Central	877
West South Central	747
West:	

REGIONAL—SPECIFIC RATES FOR PSYCHIATRIC HOSPITALS AND UNITS WITH LOW TRICARE VOLUME FOR FY 2014—Continued

United States census region	Regional rate
Mountain	746
Pacific	882
Puerto Rico	563

Beneficiary cost-share: Beneficiary cost-share (other than dependents of Active Duty members) for care paid on the basis of a regional per-diem rate is the lower of $218 per day or 25 percent of the hospital billed charges effective for services rendered on or after October 1, 2013. Cap Amount: Updated cap amount for hospitals and units with high TRICARE volume is $1,040 per day for services on or after October 1, 2013.

The following reflects an update of 2.5 percent for FY 2014 for the full day partial hospitalization rates. Partial hospitalization rates for programs of less than 6 hours (with a minimum of three hours) will be paid a per diem rate of 75 percent of the rate for a full-day program.

PARTIAL HOSPITALIZATION RATES FOR FULL-DAY AND HALF-DAY PROGRAMS

[FY 2014]

United States census region	Full-day rate (6 hours or more)	Half-day rate (3–5 hours)
Northeast:		
New England (Maine, N.H., Vt., Mass., R.I., Conn.)	$331	$248
Mid-Atlantic:		
(N.Y., N.J., Penn.)	361	271
Midwest:		
East North Central (Ohio, Ind., Ill., Mich., Wis.)	318	239
West North Central:		
(Minn., Iowa, Mo., N.D., S.D., Neb., Kan.)	318	239
South:		
South Atlantic (Del., Md., DC, Va., W.Va., N.C., S.C., Ga., Fla.)	339	254
East South Central:		
(Ky., Tenn., Ala., Miss.)	368	276
West South Central:		
(Ark., La., Texas, Okla.)	368	276
West:		
Mountain (Mon., Idaho, Wyo., Col., N.M., Ariz., Utah, Nev.)	371	278
Pacific (Wash., Ore., Calif., Alaska, Hawaii)	365	274
Puerto Rico	237	178

The above rates are effective for services rendered on or after October 1, 2013.

Dated: December 5, 2013.

Aaron Siegel,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 2013–29438 Filed 12–9–13; 8:45 am]

BILLING CODE 5001–06–P

DEPARTMENT OF DEFENSE

Department of the Air Force

[Docket ID: USAF–2013–0038]

Privacy Act of 1974; System of Records

AGENCY: Department of the Air Force, DoD.

ACTION: Notice to alter a System of Records.

SUMMARY: The Department of the Air Force proposes to alter a system of records notice, F024 AF IL C, entitled "Motor Vehicle Operators' Records", in its existing inventory of records systems subject to the Privacy Act of 1974, as amended. This system will be used to create and maintain records of motor vehicle operators and licenses. In addition, records are created and maintained on Air Force personnel required to drive government owned or leased vehicles that exceed 10,000 pounds gross vehicle weight and are used for emergency response and/or are equipped with four-wheel-drive. The data is used to create a printed vehicle operator identification card.

DATES: This proposed action will be effective on January 10, 2014 unless comments are received which result in a contrary determination. Comments will be accepted on or before January 9, 2014.

ADDRESSES: You may submit comments, identified by docket number and title, by any of the following methods:

- *Federal Rulemaking Portal: http://www.regulations.gov.* Follow the instructions for submitting comments.
- *Mail:* Federal Docket Management System Office, 4800 Mark Center Drive East Tower, 2nd Floor, Suite 02G09, Alexandria, VA 22350–3100.

Instructions: All submissions received must include the agency name and docket number for this **Federal Register** document. The general policy for comments and other submissions from members of the public is to make these submissions available for public viewing on the Internet at *http://www.regulations.gov* as they are received without change, including any personal identifiers or contact information.

FOR FURTHER INFORMATION CONTACT: Mr. Charles J. Shedrick, Department of the Air Force, Air Force Privacy Office, Office of Warfighting Integration and Chief Information Officer, ATTN: SAF/CIO A6, 1800 Air Force Pentagon, Washington, DC 20330–1800, or by phone at (571) 256–2515.

SUPPLEMENTARY INFORMATION: The Department of the Air Force's notices for systems of records subject to the Privacy Act of 1974 (5 U.S.C. 552a(r)), as amended, have been published in the **Federal Register** and are available from the address in **FOR FURTHER INFORMATION CONTACT** or from the Defense Privacy and Civil Liberties Office Web site at *http://dpclo.defense.gov/privacy/SORNs/component/airforce/index.html.*

The proposed systems reports, as required by 5 U.S.C. 552a(r) of the Privacy Act of 1974, as amended, were submitted on September 23, 2013 to the

House Committee on Oversight and Government Reform, the Senate Committee on Homeland Security and Governmental Affairs, and the Office of Management and Budget (OMB) pursuant to paragraph 4c of Appendix I to OMB Circular No. A–130, "Federal Agency Responsibilities for Maintaining Records About Individuals," dated February 8, 1996 (February 20, 1996, 61 FR 6427).

Dated: December 5, 2013.

Aaron Siegel,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

F024 AF IL C

SYSTEM NAME:

Motor Vehicle Operator's Records (December 30, 2008, 73 FR 79849).

CHANGES:

* * * * *

CATEGORIES OF INDIVIDUALS COVERED BY THE SYSTEM:

Delete entry and replace with "Air Force Active duty, Reserve, National Guard, civilians and nonappropriated funds employees who are required to operate a government motor vehicle on or off post."

CATEGORIES OF RECORDS IN THE SYSTEM:

Delete entry and replace with "Name, rank, date of birth, gender, eye color, hair color, height, weight, state issued driver's license number and any restrictions listed on the driver's license."

AUTHORITY FOR MAINTENANCE OF THE SYSTEM:

Delete entry and replace with "10 U.S.C. 8013, Secretary of the Air Force; DoD 4500.36–R, Management, Acquisition, and Use of Motor Vehicles; Air Force Policy Directive 24–3, Management, Operations and Use of Transportation Vehicles; and Air Force Instruction 24–301, Transportation, Vehicle Operations."

PURPOSE(S):

Delete entry and replace with "To create and maintain records of motor vehicle operators and licenses. In addition, records are created and maintained on Air Force personnel required to drive government owned or leased vehicles exceeding 10,000 pounds gross vehicle weight and are used for emergency response and/or are equipped with four-wheel-drive. The data is used to create a printed vehicle operator identification card."

* * * * *

STORAGE:

Delete entry and replace with "Electronic storage media."

RETRIEVABILITY:

Delete entry and replace with "Individual's name and/or driver's license number."

SAFEGUARDS:

Delete entry and replace with "Driver's records are maintained only in electronic form. Access to records is limited to members responsible for adding new driver's information to the database or updating existing records in the performance of their official duties. The On-line Vehicle Interactive Management System (OLVIMS) Licensing Module is only accessible through the Air Force Portal, Global Combat Support System (GCSS–AF). This system's software uses Primary Key Infrastructure (PKI)/Common Access Card (CAC) authentication to prevent unauthorized access."

RETENTION AND DISPOSAL:

Delete entry and replace with "Retained in licensing database until discharge or separation of the individual. Upon request, a printed copy will be provided to the individual when discharged or separated."

SYSTEM MANAGER(S) AND ADDRESS:

Delete entry and replace with "AFLCMC/HIAR (OLVIMS Program Office) 200 E Moore Street, Suite 1016, Maxwell AFB, Gunter Annex, AL 36114–3004."

NOTIFICATION PROCEDURE:

Delete entry and replace with "Individuals seeking to determine whether information about themselves is contained in this system of records should address written inquiries to AF A4LE, Pentagon, Washington, DC 20330–1040.

For verification purposes, individual should provide their full name and any details which may assist in locating records, and their signature.

In addition, the requester must provide a notarized statement or an unsworn declaration made in accordance with 28 U.S.C. 1746, in the following format:

If executed outside the United States: 'I declare (or certify, verify, or state) under penalty of perjury under the laws of the United States of America that the foregoing is true and correct. Executed on (date). (Signature)'.

If executed within the United States, its territories, possessions, or commonwealths: 'I declare (or certify, verify, or state) under penalty of perjury that the foregoing is true and correct. Executed on (date). (Signature)'."

Record access procedures:

Delete entry and replace with "Individuals seeking access to information about themselves contained in this system of records should address written inquiries to AF A4LE, Pentagon, Washington, DC 20330–1040.

For verification purposes, individual should provide their full name and any details which may assist in locating records, and their signature.

In addition, the requester must provide a notarized statement or an unsworn declaration made in accordance with 28 U.S.C., 1746, in the following format:

If executed outside the United States: 'I declare (or certify, verify, or state) under penalty of perjury under the laws of the United States of America that the foregoing is true and correct. Executed on (date). (Signature)'.

If executed within the United States, its territories, possessions, or commonwealths: 'I declare (or certify, verify, or state) under penalty of perjury that the foregoing is true and correct. Executed on (date). (Signature)'."

* * * * *

RECORD SOURCE CATEGORIES:

Delete entry and replace with "Information obtained from the individual, medical institutions, police and investigating officers, motor vehicles bureaus, state or local governments, witnesses, and Department of Transportation."

* * * * *

[FR Doc. 2013–29407 Filed 12–9–13; 8:45 am]

BILLING CODE 5001–06–P

DEPARTMENT OF EDUCATION

[Docket No. ED–2013–ICCD–0127]

Agency Information Collection Activities; Submission to the Office of Management and Budget for Review and Approval; Comment Request; Special Education—Personnel Preparation To Improve Services and Results for Children with Disabilities

AGENCY: Department of Education (ED), Office of Special Education and Rehabilitative Services (OSERS).

ACTION: Notice.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. chapter 3501 *et seq.*), ED is proposing an extension of an existing information collection.

DATES: Interested persons are invited to submit comments on or before January 9, 2014.

ADDRESSES: Comments submitted in response to this notice should be submitted electronically through the Federal eRulemaking Portal at *http://*

www.regulations.gov by selecting Docket ID number ED–2013–ICCD–0127 or via postal mail, commercial delivery, or hand delivery. Please note that comments submitted by fax or email and those submitted after the comment period will not be accepted. Written requests for information or comments submitted by postal mail or delivery should be addressed to the Director of the Information Collection Clearance Division, U.S. Department of Education, 400 Maryland Avenue SW., LBJ, Room 2E115 Washington, DC 20202–4537.

FOR FURTHER INFORMATION CONTACT: For questions related to collection activities or burden, please call Tomakie Washington, 202–401–1097 or electronically mail *ICDocketMgr@ed.gov*. Please do not send comments here. We will only accept comments in this mailbox when the regulations.gov site is not available to the public for any reason.

SUPPLEMENTARY INFORMATION: The Department of Education (ED), in accordance with the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3506(c)(2)(A)), provides the general public and Federal agencies with an opportunity to comment on proposed, revised, and continuing collections of information. This helps the Department assess the impact of its information collection requirements and minimize the public's reporting burden. It also helps the public understand the Department's information collection requirements and provide the requested data in the desired format. ED is soliciting comments on the proposed information collection request (ICR) that is described below. The Department of Education is especially interested in public comment addressing the following issues: (1) Is this collection necessary to the proper functions of the Department; (2) will this information be processed and used in a timely manner; (3) is the estimate of burden accurate; (4) how might the Department enhance the quality, utility, and clarity of the information to be collected; and (5) how might the Department minimize the burden of this collection on the respondents, including through the use of information technology. Please note that written comments received in response to this notice will be considered public records.

Title of Collection: Special Education—Personnel Preparation to Improve Services and Results for Children with Disabilities.

OMB Control Number: 1820–0622.

Type of Review: Extension without change of an existing collection of information.

Respondents/Affected Public: Individuals or households, private sector.

Total Estimated Number of Annual Responses: 2,520.

Total Estimated Number of Annual Burden Hours: 3,600.

Abstract: The data collection under this request are governed by 34 CFR 304.1–304.32 regulations that implement section 673(h) of the Individuals with Disabilities Education Act, which requires that individuals who receive a scholarship through the Personnel Preparation Program funded under the Act subsequently provide special education and related services to children with disabilities for a period of two years for every year for which assistance was received. Scholarship recipients who do not satisfy the requirements of the regulations must repay all or part of the cost of assistance in accordance with regulations issued by the Secretary. These regulations implement requirements governing among other things, the service obligation for scholars, oversight by grantees, and repayment of scholarship. In order for the Federal government to ensure the goals of the program are achieved; the collection of data, record keeping, and documentation are necessary.

Dated: December 4, 2013.

Tomakie Washington,

Acting Director, Information Collection Clearance Division, Privacy, Information and Records Management Services, Office of Management.

[FR Doc. 2013–29374 Filed 12–9–13; 8:45 am]

BILLING CODE 4000–01–P

DEPARTMENT OF EDUCATION

[Docket No. ED–2013–ICCD–0149]

Agency Information Collection Activities; Comment Request; G5 System Post Award Budget Drawdown e-Form

AGENCY: Department of Education (ED), Office of Innovation and Improvement (OII).

ACTION: Notice.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. chapter 3501 *et seq.*), ED is proposing a new information collection.

DATES: Interested persons are invited to submit comments on or before February 10, 2014.

ADDRESSES: Comments submitted in response to this notice should be submitted electronically through the Federal eRulemaking Portal at *http://www.regulations.gov* by selecting Docket ID number ED–2013–ICCD–0149 or via postal mail, commercial delivery, or hand delivery. Please note that comments submitted by fax or email and those submitted after the comment period will not be accepted. Written requests for information or comments submitted by postal mail or delivery should be addressed to the Director of the Information Collection Clearance Division, U.S. Department of Education, 400 Maryland Avenue SW., LBJ, Room 2E115, Washington, DC 20202–4537.

FOR FURTHER INFORMATION CONTACT: For questions related to collection activities or burden, please call Tomakie Washington, 202–401–1097 or electronically mail *ICDocketMgr@ed.gov*. Please do not send comments here. We will only accept comments in this mailbox when the regulations.gov site is not available to the public for any reason.

SUPPLEMENTARY INFORMATION: The Department of Education (ED), in accordance with the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3506(c)(2)(A)), provides the general public and Federal agencies with an opportunity to comment on proposed, revised, and continuing collections of information. This helps the Department assess the impact of its information collection requirements and minimize the public's reporting burden. It also helps the public understand the Department's information collection requirements and provide the requested data in the desired format. ED is soliciting comments on the proposed information collection request (ICR) that is described below. The Department of Education is especially interested in public comment addressing the following issues: (1) Is this collection necessary to the proper functions of the Department; (2) will this information be processed and used in a timely manner; (3) is the estimate of burden accurate; (4) how might the Department enhance the quality, utility, and clarity of the information to be collected; and (5) how might the Department minimize the burden of this collection on the respondents, including through the use of information technology. Please note that written comments received in response to this notice will be considered public records.

Title of Collection: G5 System Post Award Budget Drawdown e-Form.

OMB Control Number: 1855—NEW.

Type of Review: A new information collection.

Respondents/Affected Public: Private Sector, State, Local, or Tribal Governments.

Total Estimated Number of Annual Responses: 30,496.

Total Estimated Number of Annual Burden Hours: 30,496.

Abstract: In response to grant monitors need for a better reporting mechanism for grantee budgets, the G5 team developed a new electronic budget form for grantees to complete. This new electronic form requires grantees to detail the budget categories from which they are expending funds in order for Department grant monitors to track more carefully the drawdowns and financial management systems of grantees. Although this form may be used by all grantees, at this time only grantees on cost reimbursement or route payment status will be required to use this form when reporting their budget, requesting funds, and accessing funds.

Current Department regulations sections 74.20–74.28 and 74.50–74.53 address the financial management and reporting requirements of grantees. The new form developed in G5 serves as the mechanism for grantees to report expenditures and track their spending in order to ensure compliance with Department regulations. The currently used budget form, the SF 524, is not comprehensive enough to meet the needs of grant monitors to efficiently and effectively monitor this sub-set of grantees. This new data collection will enhance the ability of grant monitors to track the budgeting of grantees and the management of their funds.

Dated: December 4, 2013.

Tomakie Washington,

Acting Director, Information Collection Clearance Division, Privacy, Information and Records Management Services, Office of Management.

[FR Doc. 2013–29376 Filed 12–9–13; 8:45 am]

BILLING CODE 4000–01–P

DEPARTMENT OF EDUCATION

[Docket No. ED–2013–ICCD–0147]

Agency Information Collection Activities; Comment Request; Measuring Educational Gain in the National Reporting System for Adult Education

AGENCY: Department of Education (ED), Office of Vocational and Adult Education (OVAE).

ACTION: Notice.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. chapter 3501 *et seq.*), ED is proposing an extension of an existing information collection.

DATES: Interested persons are invited to submit comments on or before February 10, 2014.

ADDRESSES: Comments submitted in response to this notice should be submitted electronically through the Federal eRulemaking Portal at *http://www.regulations.gov* by selecting Docket ID number ED–2013–ICCD–0147 or via postal mail, commercial delivery, or hand delivery. Please note that comments submitted by fax or email and those submitted after the comment period will not be accepted. Written requests for information or comments submitted by postal mail or delivery should be addressed to the Director of the Information Collection Clearance Division, U.S. Department of Education, 400 Maryland Avenue SW., LBJ, Room 2E115, Washington, DC 20202–4537.

FOR FURTHER INFORMATION CONTACT: For questions related to collection activities or burden, please call Tomakie Washington, 202–401–1097 or electronically mail *ICDocketMgr@ed.gov*. Please do not send comments here. We will only accept comments in this mailbox when the *regulations.gov* site is not available to the public for any reason.

SUPPLEMENTARY INFORMATION: The Department of Education (ED), in accordance with the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3506(c)(2)(A)), provides the general public and Federal agencies with an opportunity to comment on proposed, revised, and continuing collections of information. This helps the Department assess the impact of its information collection requirements and minimize the public's reporting burden. It also helps the public understand the Department's information collection requirements and provide the requested data in the desired format. ED is soliciting comments on the proposed information collection request (ICR) that is described below. The Department of Education is especially interested in public comment addressing the following issues: (1) Is this collection necessary to the proper functions of the Department; (2) will this information be processed and used in a timely manner; (3) is the estimate of burden accurate; (4) how might the Department enhance the quality, utility, and clarity of the information to be collected; and (5) how might the Department minimize the burden of this collection on the respondents, including through the use of information technology. Please note that written comments received in response to this notice will be considered public records.

Title of Collection: Measuring Educational Gain in the National Reporting System for Adult Education.

OMB Control Number: 1830–0567.

Type of Review: An extension of an existing information collection.

Respondents/Affected Public: State, Local, or Tribal Governments.

Total Estimated Number of Annual Responses: 15.

Total Estimated Number of Annual Burden Hours: 600.

Abstract: Title 34 of the Code of Federal Regulations part 462 establishes procedures the Secretary uses to consider literacy tests for use in the National Reporting System (NRS) for adult education. This information is used by the Secretary to determine the suitability of published literacy tests to measure and report educational gain under the NRS.

Dated: December 4, 2013.

Tomakie Washington,

Acting Director, Information Collection Clearance Division, Privacy, Information and Records Management Services, Office of Management.

[FR Doc. 2013–29375 Filed 12–9–13; 8:45 am]

BILLING CODE 4000–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Project No. 2851–020]

Cellu Tissue Corporation; Notice of Application for Amendment of Licenses and Soliciting Comments, Motions To Intervene, and Protests

Take notice that the following hydroelectric application has been filed with the Commission and is available for public inspection:

a. *Application Type:* Amendment of License.

b. *Project No:* 2851–020.

c. *Date Filed:* October 30, 2013.

d. *Applicant:* Cellu Tissue Corporation.

e. *Name of Project:* Natural Dam Project.

f. *Location:* The Natural Dam Project is located on the Oswegatchie River in St. Lawrence County, New York.

g. *Filed Pursuant to:* Federal Power Act, 16 U.S.C. 791a–825r.

h. *Applicant Contact:* Jason George, Gomez and Sullivan Engineers, P.C., P.O. Box 2179, Henniker, NH 03242, (603) 428–4960.

i. *FERC Contact:* Christopher Chaney, (202) 502–6778, or *christopher.chaney@ferc.gov.*

j. *Deadline for filing comments, motions to intervene, and protests:* 30

days from issuance date of this notice by the Commission.

The Commission strongly encourages electronic filing. Please file any motion to intervene, protest, comments, and/or recommendations using the Commission's eFiling system at *http://www.ferc.gov/docs-filing/efiling.asp*. Commenters can submit brief comments up to 6,000 characters, without prior registration, using the eComment system at *http://www.ferc.gov/docs-filing/ecomment.asp*. You must include your name and contact information at the end of your comments. For assistance, please contact FERC Online Support at *FERCOnlineSupport@ferc.gov*, (866) 208–3676 (toll free), or (202) 502–8659 (TTY). In lieu of electronic filing, please send a paper copy to: Secretary, Federal Energy Regulatory Commission, 888 First Street NE., Washington, DC 20426. The first page of any filing should include docket number P–2851–020.

k. *Description of Request:* Cellu Tissue Corporation proposes to amend the Stream Flow and Water Level Monitoring Plan to reflect recent upgrades to the three turbine-generator units at the project, and to modify the impoundment elevation limits. Specifically, the licensee proposes to meet the run-of-river operation through manual control of all three units, instead of installing automatic control equipment on Unit 1. Additionally, the impoundment elevation would decrease from the current elevation of 396.2 feet (crest of the fully-inflated rubber dam) to 395.8 feet, while the fluctuation range would remain unchanged at 0.35 feet.

l. *Locations of the Application:* This filing may be viewed on the Commission's Web site at *http://www.ferc.gov/docs-filing/elibrary.asp*. Enter the docket number P–2851 in the docket number field to access the document. You may also register online at *http://www.ferc.gov/docs-filing/esubscription.asp* to be notified via email of new filings and issuances related to this or other pending projects. For assistance, call 1–866–208–3676 or email *FERCOnlineSupport@ferc.gov*, for TTY, call (202) 502–8659. A copy is also available for inspection and reproduction at the address in item (h) above and at the Commission's Public Reference Room, located at 888 First Street NE., Room 2A, Washington, DC 20426, or by calling (202) 502–8371.

m. Individuals desiring to be included on the Commission's mailing list should so indicate by writing to the Secretary of the Commission.

n. *Comments, Protests, or Motions to Intervene:* Anyone may submit comments, a protest, or a motion to intervene in accordance with the requirements of Rules of Practice and Procedure, 18 CFR 385.210, .211, .214, respectively. In determining the appropriate action to take, the Commission will consider all protests or other comments filed, but only those who file a motion to intervene in accordance with the Commission's Rules may become a party to the proceeding. Any comments, protests, or motions to intervene must be received on or before the specified comment date for the particular application.

o. *Filing and Service of Responsive Documents:* Any filing must (1) bear in all capital letters the title "COMMENTS", "PROTEST", or "MOTION TO INTERVENE" as applicable; (2) set forth in the heading the name of the applicant and the project number of the application to which the filing responds; (3) furnish the name, address, and telephone number of the person protesting or intervening; and (4) otherwise comply with the requirements of 18 CFR 385.2001 through 385.2005. All comments, motions to intervene, or protests must set forth their evidentiary basis and otherwise comply with the requirements of 18 CFR 4.34(b). All comments, motions to intervene, or protests should relate to project works that are the subject of the license amendment. Agencies may obtain copies of the application directly from the applicant. A copy of any protest or motion to intervene must be served upon each representative of the applicant specified in the particular application. If an intervener files comments or documents with the Commission relating to the merits of an issue that may affect the responsibilities of a particular resource agency, they must also serve a copy of the document on that resource agency. A copy of all other filings in reference to this application must be accompanied by proof of service on all persons listed in the service list prepared by the Commission in this proceeding, in accordance with 18 CFR 4.34(b) and 385.2010.

Dated: December 4, 2013.

Kimberly D. Bose,

Secretary.

[FR Doc. 2013–29403 Filed 12–9–13; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

Combined Notice of Filings #1

Take notice that the Commission received the following electric rate filings:

Docket Numbers: ER11–3980–003; ER10–2294–004; ER11–3808–003; ER13–534–003.

Applicants: ORNI 18, LLC, ORNI 39, LLC, Mammoth One LLC, ORNI 14 LLC.

Description: Notice of Non-Material Change-in-Status of the ORNI Companies.

Filed Date: 12/3/13.

Accession Number: 20131203–5142.

Comments Due: 5 p.m. ET 12/24/13.

Docket Numbers: ER14–336–001.

Applicants: Sunwave USA Holdings, Inc.

Description: Sunwave USA Holdings, Inc. submits Amendment to MBR Tariff Filing to be effective 12/1/2013.

Filed Date: 12/3/13.

Accession Number: 20131203–5046.

Comments Due: 5 p.m. ET 12/24/13.

Docket Numbers: ER14–509–000.

Applicants: PJM Interconnection, L.L.C.

Description: PJM Interconnection, L.L.C. submits Queue Position T77; Original Service Agreement No. 3669 to be effective 10/31/2013.

Filed Date: 12/2/13.

Accession Number: 20131202–5190.

Comments Due: 5 p.m. ET 12/23/13.

Docket Numbers: ER14–510–000.

Applicants: ISO New England Inc., New England Power Pool Participants Committee.

Description: ISO New England Inc. and New England Power Pool Participants Committee submit Installed Capacity Requirement, Hydro Quebec Interconnection Capability Credits and Related Values for the 2014/2015, 2015/2016 and 2016/2017.

Filed Date: 12/3/13.

Accession Number: 20131203–5052.

Comments Due: 5 p.m. ET 12/24/13.

Docket Numbers: ER14–511–000.

Applicants: GenOn Energy Management, LLC.

Description: GenOn Energy Management, LLC submits Compliance Filing to MBR Tariff to be effective 12/4/2013.

Filed Date: 12/3/13.

Accession Number: 20131203–5055.

Comments Due: 5 p.m. ET 12/24/13.

Docket Numbers: ER14–512–000.

Applicants: NRG Power Marketing LLC.

Description: NRG Power Marketing LLC submits tariff filing per 35:

Compliance Filing for MBR Tariff to be effective 12/4/2013.

Filed Date: 12/3/13.

Accession Number: 20131203–5065.

Comments Due: 5 p.m. ET 12/24/13

Docket Numbers: ER14–513–000.

Applicants: NRG Solar Avra Valley LLC.

Description: NRG Solar Avra Valley LLC submits Compliance Filing for MBR Tariff to be effective 12/4/2013.

Filed Date: 12/3/13.

Accession Number: 20131203–5067.

Comments Due: 5 p.m. ET 12/24/13.

Docket Numbers: ER14–514–000.

Applicants: NRG Solar Borrego I LLC.

Description: NRG Solar Borrego I LLC submits Compliance Filing for MBR Tariff to be effective 12/4/2013.

Filed Date: 12/3/13.

Accession Number: 20131203–5068.

Comments Due: 5 p.m. ET 12/24/13.

Docket Numbers: ER14–515–000.

Applicants: NRG Solar Roadrunner LLC.

Description: NRG Solar Roadrunner LLC submits Compliance Filing for MBR Tariff to be effective 12/4/2013.

Filed Date: 12/3/13.

Accession Number: 20131203–5069.

Comments Due: 5 p.m. ET 12/24/13.

Docket Numbers: ER14–516–000.

Applicants: Midcontinent Independent System Operator, Inc.

Description: Midcontinent Independent System Operator, Inc. submits 12–02–2013 SA 2606 OTP–CPEC T–L L13–02 Benedict to be effective 12/4/2013.

Filed Date: 12/3/13.

Accession Number: 20131203–5081.

Comments Due: 5 p.m. ET 12/24/13.

Take notice that the Commission received the following electric securities filings:

Docket Numbers: ES14–3–000; ES14–9–000.

Applicants: FirstEnergy Service Company.

Description: Supplemental Filing and Request for 10-Day Comment Period of FirstEnergy Service Company.

Filed Date: 12/2/13.

Accession Number: 20131202–5201.

Comments Due: 5 p.m. ET 12/12/13.

Take notice that the Commission received the following electric reliability filings:

Docket Numbers: RR13–3–001.

Applicants: North American Electric Reliability Corporation.

Description: Compliance Filing of the North American Electric Reliability Corporation in Response to Order Approving Amendments to the Rules of Procedure Appendix 4D.

Filed Date: 12/2/13.

Accession Number: 20131202–5161.

Comments Due: 5 p.m. ET 12/23/13.

The filings are accessible in the Commission's eLibrary system by clicking on the links or querying the docket number.

Any person desiring to intervene or protest in any of the above proceedings must file in accordance with Rules 211 and 214 of the Commission's Regulations (18 CFR 385.211 and 385.214) on or before 5:00 p.m. Eastern time on the specified comment date. Protests may be considered, but intervention is necessary to become a party to the proceeding.

eFiling is encouraged. More detailed information relating to filing requirements, interventions, protests, service, and qualifying facilities filings can be found at: *http://www.ferc.gov/docs-filing/efiling/filing-req.pdf.* For other information, call (866) 208–3676 (toll free). For TTY, call (202) 502–8659.

Dated: December 3, 2013.

Nathaniel J. Davis, Sr.,

Deputy Secretary.

[FR Doc. 2013–29401 Filed 12–9–13; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. ID–7277–000]

Beam, D. Richard; Notice of Filing

Take notice that on November 27, 2013, D. Richard Beam submitted for filing, an application for authority to hold interlocking positions, pursuant to section 305(b) of the Federal Power Act (FPA), 16 U.S.C. 825d(b), Part 45 of the Federal Energy Regulatory Commission's (Commission) Rules of Practice and Procedure, 18 CFR part 45, and Order No. 664.[1]

Any person desiring to intervene or to protest this filing must file in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211, 385.214). Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a notice of intervention or motion to intervene, as appropriate. Such notices, motions, or protests must be filed on or before the comment date. On or before the comment date, it is not necessary to serve motions to intervene or protests on persons other than the Applicant.

The Commission encourages electronic submission of protests and interventions in lieu of paper using the "eFiling" link at *http://www.ferc.gov.* Persons unable to file electronically should submit an original and 5 copies of the protest or intervention to the Federal Energy Regulatory Commission, 888 First Street NE., Washington, DC 20426.

This filing is accessible on-line at *http://www.ferc.gov,* using the "eLibrary" link and is available for review in the Commission's Public Reference Room in Washington, DC. There is an "eSubscription" link on the Web site that enables subscribers to receive email notification when a document is added to a subscribed docket(s). For assistance with any FERC Online service, please email *FERCOnlineSupport@ferc.gov,* or call (866) 208–3676 (toll free). For TTY, call (202) 502–8659.

Comment Date: 5:00 p.m. Eastern Time on December 18, 2013.

Dated: November 29, 2013.

Kimberly D. Bose,

Secretary.

[FR Doc. 2013–29402 Filed 12–9–13; 8:45 am]

BILLING CODE 6717–01–P

[1] *Commission Authorization to Hold Interlocking Positions,* 112 FERC ¶ 61,298 (2005) (Order No. 664); *order on reh'g,* 114 FERC ¶ 61,142 (2006) (Order No. 664–A).

ENVIRONMENTAL PROTECTION AGENCY

[EPA–HQ–RCRA–2013–0737, FRL–9903–95–OSWER]

Agency Information Collection Activities; Proposed Collection; Comment Request; Land Disposal Restrictions

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: The Environmental Protection Agency is planning to submit an information collection request (ICR), Land Disposal Restrictions (EPA ICR No. 1442.22, OMB Control No. 2050–0085) to the Office of Management and Budget (OMB) for review and approval in accordance with the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*). Before doing so, EPA is soliciting public comments on specific aspects of the proposed information collection as described below. This is a proposed extension of the ICR, which is currently approved through March 31, 2014. An Agency may not conduct or sponsor and a person is not required to respond to a collection of information unless it

displays a currently valid OMB control number.

DATES: Comments must be submitted on or before February 10, 2014.

ADDRESSES: Submit your comments, referencing by Docket ID No. EPA–HQ–RCRA–2013–0737, online using *www.regulations.gov* (our preferred method), by email to *rcra-docket@epa.gov*, or by mail to: EPA Docket Center, Environmental Protection Agency, Mail Code 28221T, 1200 Pennsylvania Ave. NW., Washington, DC 20460.

EPA's policy is that all comments received will be included in the public docket without change including any personal information provided, unless the comment includes profanity, threats, information claimed to be Confidential Business Information (CBI) or other information whose disclosure is restricted by statute.

FOR FURTHER INFORMATION CONTACT: Peggy Vyas, Environmental Protection Agency, 1200 Pennsylvania Ave. NW., Washington, DC 20460; telephone number: 703–308–5477; fax number: 703–308–8433; email address: *vyas.peggy@epa.gov*.

SUPPLEMENTARY INFORMATION: Supporting documents which explain in detail the information that the EPA will be collecting are available in the public docket for this ICR. The docket can be viewed online at *www.regulations.gov* or in person at the EPA Docket Center, EPA West, Room 3334, 1301 Constitution Ave. NW., Washington, DC. The telephone number for the Docket Center is 202–566–1744. For additional information about EPA's public docket, visit *http://www.epa.gov/dockets*.

Pursuant to section 3506(c)(2)(A) of the PRA, EPA is soliciting comments and information to enable it to: (i) Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the Agency, including whether the information will have practical utility; (ii) evaluate the accuracy of the Agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used; (iii) enhance the quality, utility, and clarity of the information to be collected; and (iv) minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submission of responses. EPA will consider the comments received and amend the ICR as appropriate. The final ICR package will then be submitted to OMB for review and approval. At that time, EPA will issue another **Federal Register** notice to announce the submission of the ICR to OMB and the opportunity to submit additional comments to OMB.

Abstract: Section 3004 of the Resource Conservation and Recovery Act (RCRA), as amended, requires that EPA develop standards for hazardous waste treatment, storage, and disposal as may be necessary to protect human health and the environment. Subsections 3004(d), (e), and (g) require EPA to promulgate regulations that prohibit the land disposal of hazardous waste unless it meets specified treatment standards described in subsection 3004(m).

The regulations implementing these requirements are codified in the *Code of Federal Regulations* (CFR) Title 40, Part 268. EPA requires that facilities maintain the data outlined in this ICR so that the Agency can ensure that land disposed waste meets the treatment standards. EPA strongly believes that the recordkeeping requirements are necessary for the agency to fulfill its congressional mandate to protect human health and the environment.

Form Numbers: None.

Respondents/affected entities: Private sector and State, Local, or Tribal governments.

Respondent's obligation to respond: Mandatory (40 CFR part 268).

Estimated number of respondents: 194,560.

Frequency of response: On occasion.

Total estimated burden: 1,208,382 hours. Burden is defined at 5 CFR 1320.03(b)

Total estimated cost: $161,734,819 includes $64,195,885 annualized labor costs and $97,538,934 annualized capital or O&M costs.

Changes in Estimates: The burden hours are likely to stay substantially the same.

Dated: November 26, 2013.

Barnes Johnson,

Director, Office of Resource Conservation and Recovery.

[FR Doc. 2013–29449 Filed 12–9–13; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[FRL–9903–97-Region-5]

Proposed CERCLA Administrative Cost Recovery Settlement; Cadie Auto Salvage Site, Belvidere, Boone County, Illinois

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice; request for public comment.

SUMMARY: In accordance with the Comprehensive Environmental Response, Compensation, and Liability Act, as amended ("CERCLA"), notice is hereby given of a proposed administrative settlement for recovery of past response costs concerning the Cadie Auto Salvage Site in Belvidere, Boone County, Illinois with the following settling parties: UOP, LLC; Allied Chemical Corporation; Honeywell International, Inc.; S.J. Smith Company Inc.; United States Department of Energy/Argonne National Laboratory; United States Department of Energy/Sandia National Laboratories; United States Department of Energy/Mound Facility; and Defense Logistics Agency. The settlement requires the non-owner Settling Parties to pay a total of $85,898, plus any interest accrued between the date of receipt of notice by the Settling Parties that EPA has signed the CERCLA Settlement Agreement (Agreement) and the Effective Date of the Agreement, to the Hazardous Substance Superfund through an escrow account to be established by the Settling Party. The settlement includes a covenant not to sue the Settling Parties pursuant to Section 107(a) of CERCLA, and contribution protection for the Settling Parties. For thirty (30) days following the date of publication of this notice, the Agency will receive written comments relating to the settlement. The Agency will consider all comments received and may modify or withdraw its consent to the settlement if comments received disclose facts or considerations which indicate that the settlement is inappropriate, improper, or inadequate. The Agency's response to any comments received will be available for public inspection at the EPA, Region 5, Records Center, 77 W. Jackson Blvd., 7th Fl., and Chicago, Illinois 60604.

DATES: Comments must be submitted on or before January 9, 2014.

ADDRESSES: The proposed settlement is available for public inspection at the EPA, Region 5, Records Center, 77 W. Jackson Blvd., 7th Fl., Chicago, Illinois 60604. A copy of the proposed

settlement may be obtained from Peter Felitti, Assoc. Regional Counsel, EPA, Office of Regional Counsel, Region 5, 77 W. Jackson Blvd., mail code: C–14J, Chicago, Illinois 60604. Comments should reference the Cadie Auto Salvage Site, Belvidere, Boone County, Illinois and EPA Docket No. and should be addressed to Peter Felitti, Assoc. Regional Counsel, EPA, Office of Regional Counsel, Region 5, 77 W. Jackson Blvd., mail code: C–14J, Chicago, Illinois 60604.

FOR FURTHER INFORMATION CONTACT: Peter Felitti, Assoc. Regional Counsel, EPA, Office of Regional Counsel, Region 5, 77 W. Jackson Blvd., mail code: C–14J, Chicago, Illinois 60604.

SUPPLEMENTARY INFORMATION: The Cadie Auto Salvage Superfund Site is located in Belvidere, Boone County, Illinois. After EPA received a request from the Illinois Environmental Protection Agency, U.S. EPA conducted an assessment of the Site and conducted a removal action. A total of 248 compressed gas cylinders on the Site were shipped off site for disposal as well as approximately 733 gallons of flammable liquids, two oz. of metallic mercury, ten tons of empty drums, eight tons of non-hazardous soil, 18 tons of hazardous soil, and fifty cans of waste aerosols. The work was completed on December 1, 2010. U.S. EPA issued a General Notice Letter to the Settling Parties in June 2011. Between June 2011 and August 2013, EPA and the Settling Parties negotiated the present proposed Administrative Settlement.

Dated: November 21, 2013.

Richard C. Karl,

Director, Superfund Division.

[FR Doc. 2013–29454 Filed 12–9–13; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[FRL 9903–96–OARM; EPA–HQ–OA–2013–0122]

National Advisory Council for Environmental Policy and Technology

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice of Advisory Committee Video/Teleconference.

SUMMARY: Under the Federal Advisory Committee Act, Public Law 92463, EPA gives notice of a public teleconference of the National Advisory Council for Environmental Policy and Technology (NACEPT). NACEPT provides advice to the EPA Administrator on a broad range of environmental policy, technology, and management issues. NACEPT members represent academia, industry, non-governmental organizations, and local, state, and tribal governments. *Purpose of Video/Teleconference*: NACEPT will discuss draft recommendations regarding EPA's FY2014–2018 Draft Strategic Plan. The agenda and meeting materials will be available at *http://www.epa.gov/ofacmo/nacept/cal-nacept.htm* and *http://www.regulations.gov* under Docket ID: EPA–HQ–OA–2013–0122.

DATES: NACEPT will hold a public video/teleconference on Thursday, December 19, 2013, from 12:00 p.m. to 4:00 p.m. Eastern Standard Time. EPA is announcing this teleconference with less than 15 calendar days public notice due to the limited amount of time available to review and comment on the FY 2014–2018 Draft Strategic Plan.

ADDRESSES: The meeting will be held at U.S. EPA, William Jefferson Clinton East Building, 1201 Constitution Ave. NW., Room 1132, Washington, DC 20004.

FOR FURTHER INFORMATION CONTACT: Mark Joyce, Acting Designated Federal Officer, *joyce.mark@epa.gov*, (202) 564–2130, U.S. EPA, Office of Diversity, Advisory Committee Management and Outreach (1601M), 1200 Pennsylvania Avenue NW., Washington, DC 20460.

SUPPLEMENTARY INFORMATION: Requests to make oral comments or to provide written comments to NACEPT should be sent to Eugene Green at *green.eugene@epa.gov* by Friday, December 13, 2013. The meeting is open to the public, with limited seating on a first-come, first-served basis. Members of the public wishing to participate in the video/teleconference should contact Eugene Green at *green.eugene@epa.gov* or (202) 564–2432 by December 13, 2013.

Meeting Access: Concerns regarding accessibility and/or accommodations for individuals with disabilities should be directed to Eugene Green at *green.eugene@epa.gov* or (202) 564–2432. To ensure adequate time for processing, please make requests for accommodations at least 7 days prior to the meeting.

Dated: November 27, 2013.

Mark Joyce,

Acting Designated Federal Officer.

[FR Doc. 2013–29446 Filed 12–9–13; 8:45 am]

BILLING CODE 6560–50–P

FEDERAL MARITIME COMMISSION

Sunshine Act Meeting

AGENCY: Federal Maritime Commission.

DATES: December 10, 2013.

PLACE: 800 N. Capitol Street NW., First Floor Hearing Room, Washington, DC.

STATUS: The meeting will be held in Closed Session.

MATTERS TO BE CONSIDERED:

Closed Session

1. Commission interview of applicants for the position of Inspector General.

CONTACT PERSON FOR MORE INFORMATION: Karen V. Gregory, Secretary (202) 523 5725.

Karen V. Gregory,

Secretary.

[FR Doc. 2013–29464 Filed 12–6–13; 11:15 am]

BILLING CODE 6730–01–P

FEDERAL RESERVE SYSTEM

Change in Bank Control Notices; Acquisitions of Shares of a Bank or Bank Holding Company

The notificants listed below have applied under the Change in Bank Control Act (12 U.S.C. 1817(j)) and § 225.41 of the Board's Regulation Y (12 CFR 225.41) to acquire shares of a bank or bank holding company. The factors that are considered in acting on the notices are set forth in paragraph 7 of the Act (12 U.S.C. 1817(j)(7)).

The notices are available for immediate inspection at the Federal Reserve Bank indicated. The notices also will be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing to the Reserve Bank indicated for that notice or to the offices of the Board of Governors. Comments must be received not later than December 26, 2013.

A. Federal Reserve Bank of San Francisco (Gerald C. Tsai, Director, Applications and Enforcement) 101 Market Street, San Francisco, California 94105–1579:

1. *John Jung Hun Chang, Wellwish Investment LLC, Ellis Eunrok Chang, all of Garden Grove, California, and Ellen Eunmi Chang*, Bellevue, Washington; to retain voting shares of U & I Financial Corp., and thereby indirectly retain voting shares of UniBank, both in Lynnwood, Washington.

Board of Governors of the Federal Reserve System, December 5, 2013.

Michael J. Lewandowski,

Associate Secretary of the Board.

[FR Doc. 2013–29426 Filed 12–9–13; 8:45 am]

BILLING CODE 6210–01–P

FEDERAL RESERVE SYSTEM

[Docket No. OP–1472]

Federal Reserve Policy on Payment System Risk; Procedures for Measuring Daylight Overdrafts

AGENCY: Board of Governors of the Federal Reserve System.

ACTION: Policy Statement; request for comment.

SUMMARY: The Board of Governors of the Federal Reserve System (Board) is requesting comment on multiple changes to part II of the Federal Reserve Policy on Payment System Risk (PSR policy) related to the procedures for measuring balances intraday in institutions' accounts at the Federal Reserve Banks (Reserve Banks). The proposed changes relate to the Board's procedures for posting debit and credit entries to institutions' Federal Reserve accounts for automated clearing house (ACH) debit and commercial check transactions. Elsewhere in the **Federal Register** under Docket No. R–1473, the Board is also proposing necessary related changes to the Board's Regulation J regarding the timing of when paying banks settle for check transactions presented to them by the Reserve Banks. Additionally, in this notice, the Board is requesting comment on a set of principles for establishing future posting rules for the Reserve Banks' same-day ACH service. The Board is also requesting comment on a change in language in section II.G.3 of the PSR policy intended to clarify the Reserve Banks' administration of the policy for U.S. branches and agencies of foreign banking organizations.

DATES: Comments on the proposed changes must be received on or before February 10, 2014.

ADDRESSES: You may submit comments, identified by Docket No. OP–1472, by any of the following methods:

Agency Web site: http://www.federalreserve.gov. Follow the instructions for submitting comments at *http://www.federalreserve.gov/apps/foia/proposedregs.aspx.*

- *Federal eRulemaking Portal: http://www.regulations.gov.* Follow the instructions for submitting comments.
- *Email: regs.comments@federalreserve.gov.* Include docket number in the subject line of the message.
- *FAX:* (202) 452–3819 or (202) 452–3102.
- *Mail:* Robert deV. Frierson, Secretary, Board of Governors of the Federal Reserve System, 20th Street and Constitution Avenue NW., Washington, DC 20551.

All public comments are available from the Board's Web site at *http://www.federalreserve.gov/apps/foia/proposedregs.aspx* as submitted, except as necessary for technical reasons. Accordingly, your comments will not be edited to remove any identifying or contact information. Public comments may also be viewed electronically or in paper in Room MP–500 of the Board's Martin Building (20th and C Streets NW.) between 9:00 a.m. and 5:00 p.m. on weekdays.

FOR FURTHER INFORMATION CONTACT: Susan V. Foley, Senior Associate Director (202) 452–3596, Jeffrey Walker, Assistant Director (202) 721–4559, or Michelle D. Olivier, Financial Services Analyst (202) 452–2404, Division of Reserve Bank Operations and Payment Systems, Board of Governors of the Federal Reserve System; for users of Telecommunications Device for the Deaf (TDD) only, contact (202) 263–4869.

SUPPLEMENTARY INFORMATION:

I. Background

Technology and processing improvements have enabled payment systems and institutions to achieve significant efficiencies relative to twenty years ago when the Board's procedures for measuring institutions' intraday Federal Reserve account balances were established. Payment innovations have enabled both the introduction of new payment services and networks and the enhancement of legacy payment systems (such as checks and ACH). In particular, interbank check-processing has undergone a remarkable period of change, from few checks being exchanged electronically 10 years ago to virtually 100 percent today. The ACH system has also recently made progress in defining same-day clearing and settlement, and the Reserve Banks are now offering a same-day service on a limited basis.[1]

The Federal Reserve believes that ongoing innovation is necessary to ensure safe, efficient, and accessible payment systems in a changing economic environment. In support of this broad objective, the Board is currently working to align and modernize the procedures for measuring account balances associated with ACH and check transactions to reflect enhancements in technology and the Reserve Banks' current operations and processing times. The Board's PSR policy establishes the procedures, referred to as posting rules, for the settlement of debits and credits to institutions' Federal Reserve accounts for different payment types.[2] The application of these posting rules determines an institution's intraday account balance and whether it has incurred a negative balance (daylight overdraft).

Under the current posting rules for commercial and government ACH transactions established in 1994, ACH debit transactions post at 11:00 a.m. Eastern time (ET), and ACH credit transactions post at 8:30 a.m. ET.[3] The Board delayed the posting of ACH debit transactions to allow receiving institutions time to obtain funds after the opening of the Reserve Banks' Fedwire Funds Service, which at that time opened at 8:30 a.m. Since then, the Fedwire Funds Service opening has been moved earlier, first in 1997 and again in 2005, and the service now opens at 9:00 p.m. the previous evening. Continuing the practice of delaying the settlement of ACH debit transactions until 11:00 a.m. is no longer necessary and may retard efforts by institutions to expedite funds settlements.

In 2008, the Board requested comment on moving the posting time of ACH debit transactions from 11:00 a.m. to 8:30 a.m. to coincide with the posting of ACH credit transactions but decided not to pursue the change because of economic conditions at the time and the additional costs and liquidity pressures that could be placed on some institutions.[4] Commenters' concerns included the costs associated with funding their accounts earlier in the day, the loss of interest income from holding higher overnight account balances rather than investing in the market, and the additional staffing costs that might be incurred to manage accounts before normal business hours, particularly for small institutions outside of the eastern time zone.[5]

[1] The Reserve Banks currently offer a same-day ACH service that allows institutions to opt-in to send and receive ACH credit or debit transactions during the processing day in addition to the overnight cycle. In section III of this notice, the Board proposes a set of principles for establishing future posting rules for the Reserve Banks' same-day ACH service. The Board does not contemplate that it would ordinarily request comment on changes to the ACH posting rules that are consistent with these principles.

[2] The Board's PSR policy is available at *www.federalreserve.gov/paymentsystems/psr_policy.htm.*

[3] All times are eastern time unless otherwise specified.

[4] The request for comment and the subsequent notice of the Board's decision not to pursue the proposed changes can be found, respectively, at 73 FR 12443 (Mar. 7, 2008) and 73 FR 79127 (Dec. 24, 2008).

[5] Institutions have the option either to hold higher balances overnight or to arrange for sufficient funding before 8:30 a.m. for any transactions that process overnight and post early in the morning; eligible institutions may also incur daylight overdrafts.

Although it chose not to pursue the simultaneous posting of ACH debit and credit transactions in 2008, the Board said that it would reconsider the proposed posting rule change in the future because it believed that the simultaneous posting of ACH credit and debit transactions at 8:30 a.m. would enhance the efficiency of the payment system in the long run. The Board also recognized that the potential burden of the posting rule change on institutions would be reduced through the payment of interest on Federal Reserve account balances and the implementation of a proposed (at that time) PSR policy change that would allow institutions eligible to incur intraday credit to collateralize all or a portion of their daylight overdrafts to reduce or eliminate any daylight overdraft fees.[6]

Since the initial 2008 proposal, the payment of interest on Federal Reserve account balances and the proposed PSR policy changes have been implemented, and the economic climate has improved. Interest on Federal Reserve account balances reduces institutions' costs of holding higher account balances overnight to fund an earlier posting of ACH debits.[7] The current PSR policy, implemented in March 2011, allows eligible institutions to collateralize their daylight overdrafts to reduce or eliminate any daylight overdraft fees associated with the proposed posting rule change. In addition, for each two-week reserve maintenance period, institutions receive a $150 fee waiver, reducing the burden on institutions that incur small amounts of uncollateralized daylight overdrafts. Although these changes alleviate the potential burden of the proposed ACH posting rule change for eligible institutions, for those institutions whose account balances may be adversely affected by the posting rule change and are ineligible for intraday credit and interest on balances in Federal Reserve accounts, the effect of moving to an 8:30 a.m. posting time for ACH debit transactions has not changed since the Board's proposal in 2008, and these institutions would need to hold higher balances overnight or manage their accounts before 8:30 a.m.

Currently, the Board's posting rules for commercial check transactions reflect a presumption that banks generally handle checks in paper form and do not reflect banks' widespread use of electronic check-processing methods.[8] As a consequence, the Board's posting rules align with the processing of less than one-tenth of 1 percent of checks that the Reserve Banks handle. The Board believes that settlement practices should reflect the speed of clearing as well as the timing of deposits and presentments, and that its posting rules should be updated to align with today's electronic check-processing environment.

The Reserve Banks' check-processing is almost 100 percent electronic today. Indeed, more than 99.9 percent of checks that depositary banks sent to the Reserve Banks are now sent electronically, and more than 99.9 percent of checks the Reserve Banks presented to paying banks are presented electronically.[9] The Board, however, last revised its posting rules for commercial check transactions in 2002, before the effective date of the Check Clearing for the 21st Century Act (Check 21 Act).[10] In 2002, the Board was interested in removing barriers that might discourage institutions from agreeing to accept electronic check presentments. The posting rules were modified to allow debits associated with electronic check presentments to begin posting at 1:00 p.m. local time rather than 11:00 a.m. to ensure that institutions would not be debited earlier for electronic check presentments than for paper check presentments.[11]

The posting rules for commercial check presentments also allow for at least a one-hour window between presentment and posting of the associated debits to allow institutions time for limited verification of cash letters (batches of checks).[12] The Board adopted the current one-hour window between presentment and settlement in 1992 when the Reserve Banks presented paper to paying banks. Electronic delivery of checks and computerized handling within institutions should facilitate a paying institution's ability to verify the receipt of cash letters sooner than when presentment was predominately in paper form.

The Board also recognizes that there may be certain Reserve Bank operational processes that need modification to eliminate exceptions to faster clearing and settlement. In particular, the Reserve Banks have worked with institutions over the years to develop

[6] Edge and agreement corporations, bankers' banks that have not waived their exemption from reserve requirements, limited-purpose trust companies, government-sponsored enterprises including Federal Home Loan Banks (FHLBs), and international organizations do not have regular access to the discount window and are not permitted to incur daylight overdrafts in their Federal Reserve accounts. Voluntary collateralization of daylight overdrafts and the $150 fee waiver are not available to these institutions.

[7] Payment of interest on Federal Reserve account balances was implemented in October 2008. FHLBs are not eligible to earn interest on balances in Federal Reserve accounts, but can act as pass-through correspondents. As set out in Regulation D (12 CFR 204.10), in cases of balances maintained by pass-through correspondents that are not interest-eligible institutions, Reserve Banks shall pay interest only on the balances maintained to satisfy a reserve balance requirement of one or more respondents, and the correspondents shall pass back to its respondents interest paid on balances in the correspondent's account.

[8] Commercial check transactions include all non-government check transactions. Treasury checks, postal money orders, local Federal Reserve Bank checks, and savings bond redemptions in separately sorted deposits already post at 8:30 a.m. and are not affected by the posting rules proposed in today's **Federal Register** notice.

The posting rules reflect a paper-processing era in which collecting banks, such as the Reserve Banks, generally had multiple daily paper deposit deadlines and in which banks used airplanes and couriers specifically dedicated to delivering paper checks. Today, by contrast, the Reserve Banks have only one paper deposit deadline per day but multiple electronic deadlines, and paper checks are generally delivered to banks by U.S. mail or other common carrier.

[9] Statistics are for forward deposits and presentments only. In September 2013, over 98 percent of returned checks were deposited electronically, and over 96 percent of returned checks were delivered electronically by the Reserve Banks. A depositary bank is the bank into which a check is deposited; a paying bank is the bank on which a check is drawn.

[10] In 2002, depositary banks sent virtually all checks to the Reserve Banks in paper form, and the Reserve Banks, in turn, delivered about 75 percent of checks to paying banks in paper form. The Reserve Banks presented less than 25 percent of their check volume electronically by agreement with the paying bank.

The Check 21 Act, which became effective in October 2004, was designed to enhance payment system efficiency by reducing legal impediments to processing checks electronically. The Check 21 Act facilitated processing checks electronically by creating a new type of paper instrument, called a substitute check, which is the legal equivalent of the original check for all purposes. As a result, a collecting bank could receive an electronic file and create substitute checks from check images in the file to present to paying banks that did not accept electronic check presentment.

[11] Before the change, debits associated with all commercial check transactions, whether paper or electronic, were posted on the next clock hour that was at least one hour after presentment, beginning at 11:00 a.m. Because Reserve Banks generally delivered electronic check presentment files early in the morning, the corresponding debits would occur at 11:00 a.m. for many institutions, earlier than the posting times associated with paying banks receiving paper check presentments. The Board was concerned that this timing difference may have created modest and undesirable incentives for paying banks to continue to require that checks be presented in paper form.

[12] The one-hour window between presentment and settlement is also specified in subpart A of Regulation J. Elsewhere in the **Federal Register**, the Board is proposing necessary related changes to this and another provision in the Board's Regulation J.

The one-hour window allowed the paying bank to verify that the cash letter had been received, but was not intended to allow the paying bank to examine individual checks prior to settling for the cash letter. Cash letters include a group of checks packaged as paper items or electronic records that are presented to the paying bank. A cash letter includes physical documentation or electronic records containing the depositor routing number, a list detailing the amount of each check, and the total amount and the number of all checks in the cash letter.

flexible electronic file presentment schedules. These schedules covered the timing and frequency of electronic check presentments and were designed to encourage banks to accept electronic presentments. For some institutions, the Reserve Banks have been creating a single file that includes all of the institution's check activity for the day that is presented late in the day (but before 2:00 p.m. local time of the institution).[13] The Reserve Banks, however, have taken a recent step in advancing the speed of check clearing that now will likely result in all institutions receiving multiple presentment files beginning January 2, 2014.[14] Any posting rule change to align settlement with today's clearing practices would also likely result in multiple presentments, and such presentments would begin early in the day. If not, those institutions that receive all check activity in a late day presentment file would be able to gain an intraday liquidity advantage by delaying presentment and consequently debits, while benefiting from the earlier availability of credits from deposited checks. To mitigate the effects of these changes, institutions may choose for business or other reasons not to access presentment files made available until specific times in the day, but the Reserve Banks would still settle those transactions based on presentment having been made.[15]

II. Discussion of Proposed Changes

1. Commercial and Government ACH Debit Transactions

Consistent with its proposal in 2008, the Board proposes to move the posting times for ACH debit transactions processed overnight to 8:30 a.m. from 11:00 a.m. to coincide with the posting time for ACH credit transactions processed overnight. Other types of ACH transactions, including same-day ACH and certain ACH return items, would not be affected and would continue to post at 5:00 p.m.

Posting ACH debit transactions according to the proposed posting rules would

- Simplify account management by allowing institutions to fund the net of all ACH activity at a single posting time, rather than funding debit and credit transactions separately
- Increase liquidity early in the day for institutions that originate ACH debit transactions over the FedACH network, and for those institutions that originate ACH debit transactions over the Electronic Payments Network (EPN), the other ACH operator, but have transactions delivered to receiving institutions over the FedACH network (inter-operator transactions)[16]
- Align the Reserve Banks' FedACH settlement times with those of the other ACH operator, EPN
- Increase the efficiency of the ACH by aligning the processing of ACH debit transactions with settlement

The proposed ACH posting rules would also better conform to the Board's principles for measuring daylight overdrafts, which the Board developed in the early 1990s to guide the development of posting rules.

By posting ACH credit and debit transactions simultaneously to Federal Reserve accounts, institutions' balances would increase or decrease by only the net amount of funds from daily ACH settlements. Debits associated with the receipt of ACH debit transactions could be simultaneously offset by credits from the receipt of ACH credit transactions, and vice versa. Among other benefits, the netting of ACH credit and debit transactions would enhance the efficiency of the payment system by reducing the potential for intraday liquidity demands from institutions with a concentration of activity in certain types of ACH transactions. Additionally, simultaneously posting the majority of ACH activity at 8:30 a.m. would reduce the burden of separately monitoring and funding net ACH credit transactions and net ACH debit transactions at 8:30 a.m. and 11:00 a.m., respectively.

As a consequence of the proposed change, institutions that originate debit transactions would benefit from the earlier availability of credits associated with ACH debit transactions. For example, an institution that originates a large value of ACH credit and debit transactions may be net positive for daily ACH activity but under current posting rules may require intraday credit between 8:30 a.m. and 11:00 a.m. to fund the earlier posting of ACH credit transactions. Although only approximately 2 percent of institutions, or roughly 75 institutions, are net receivers of funds from ACH debit transactions, the impact on liquidity of the later posting of ACH debit transactions can be significant because of the large value of debit transactions that they originate.

The existing later settlement time of ACH debit transactions also introduces the possibility of a competitive disparity between the Reserve Banks' FedACH service and EPN, because EPN's practice is to post both ACH credit and debit transactions at 8:30 a.m., which may be a more attractive service for large originators. Aligning the settlement times between FedACH and EPN would remove any resulting competitive disparities related to settlement times between the two ACH operators. Although most commenters in 2008 believed that FedACH's disadvantage relative to EPN was minimal, the competitive landscape between the operators continues to evolve, and the Board is interested in ensuring that its posting rules do not create a competitive disadvantage for either operator.

When considering changes to the posting rules, the Board evaluates proposals against its principles for measuring daylight overdrafts. These principles were formalized in the early 1990s to guide the development of the posting rules to measure daylight overdrafts and continue to be relevant today.

The four principles are:

(1) To the extent possible, the measurement procedures should not provide intraday float to participants.

(2) The measurement procedures should reflect the times at which payor institutions are obligated to pay for transfers.

(3) The users of payment services should be able to control their use of intraday credit.

(4) The Reserve Banks should not obtain any competitive advantage from the measurement procedures.

In evaluating the proposed posting rule change against its principles for measuring daylight overdrafts, the Board notes that neither the existing nor the proposed posting rules provide intraday float, because both the credit and debit entries associated with each type of ACH transaction post simultaneously. However, the earlier posting time of 8:30 a.m. for ACH debit transactions would conform more closely with the second principle that

[13] For most institutions, the Reserve Banks make available multiple electronic check presentments beginning early in the morning.

[14] On October 3, 2013, the Reserve Banks announced a new product that will likely result in institutions receiving an additional presentment file. Specifically, the Reserve Banks will be adding an additional FedReturn image cash letter deposit deadline at 12:30 p.m. beginning on January 2, 2014. Any FedReturn file deposited with the Reserve Banks before 12:30 p.m. will be delivered to the depositary bank by 2:00 p.m. local time. For more information, see *http://www.frbservices.org/files/communications/pdf/check/100313_deposit_deadline.pdf.*

[15] The Reserve Banks send institutions presentment notifications with the value of presentments by FedMail or make them available on FedLine Web. Institutions also have access to information through Account Management Information.

[16] Liquidity refers to balances in Federal Reserve accounts to make payments. An increase in liquidity involves higher account balances, which could result in fewer daylight overdrafts.

posting times should reflect the time at which the payor institution is obligated to pay. The purpose of the second principle is to minimize as much as possible the period between when the payments are delivered to the institution and when the payment is settled. The Reserve Banks' FedACH processing day extends from 3:00 a.m. to 2:59 a.m. on the next calendar day. The FedACH payments settling on a given processing day are usually processed by 4:00 a.m., and payment advices are sent to institutions by 6:00 a.m. By moving the posting time of ACH debit transactions from 11:00 a.m. to 8:30 a.m., the posting rules would reduce the window between when receivers of ACH debit transactions receive ACH debit files and when they are obligated to settle these payments.

The third principle specifies that institutions should be able to control their use of intraday credit and monitor their accounts to comply with limits and other restrictions related to daylight overdrafts. As discussed previously, this principle motivated the later posting of ACH debit transactions to allow institutions time to fund their ACH debit activity over Fedwire. Because the Fedwire Funds Service now opens at 9:00 p.m. the previous calendar day, institutions have the operational ability to fund ACH debit activity before 8:30 a.m. Lastly, the proposed posting rules for ACH debit transactions align with the fourth principle that the Reserve Banks should not obtain a competitive advantage from the measurement procedures, because the proposed settlement time of 8:30 a.m. for ACH debit transactions is within the settlement window available to private-sector operators using the National Settlement Service (NSS) service.[17]

Despite the benefits associated with the earlier posting of ACH debit transactions, because of the concentration of ACH debit origination activity, most institutions are receivers of ACH debit transactions, and, as a result, the Board recognizes that the posting rule change would reduce, on average, account balances between 8:30 and 10:59 a.m. for most FedACH participants. Based on second-quarter 2013 payment data, 98 percent of approximately 3,300 participants on average would experience lower balances over the quarter.[18] The average change in balances on days with affected payments for institutions eligible and ineligible to receive intraday credit would be $5 million and $76 million, respectively.[19] Out of those institutions that would experience lower balances, less than one-half of 1 percent, only 13 institutions, would incur overdraft fees in any of the six two-week reserve maintenance periods (RMP) within the quarter analyzed.[20]

Nine of the 13 institutions that would incur higher fees are eligible to incur daylight overdrafts. The average increase in fees over the quarter would be $33 per RMP, and the largest average fee increase per RMP for an institution was estimated at $132.[21] To avoid fee increases, these institutions could pledge on average $7 million of (additional) collateral.[22] Alternatively, they could hold higher balances and receive interest on their Federal Reserve balances, or arrange early morning funding.

Additionally, 4 of the 13 institutions are ineligible to receive intraday credit and would incur overdrafts under the proposed rules. To avoid violating the PSR policy and incurring fees, these institutions would need to increase funding in their accounts on average by $33 million either overnight or through early morning funding.[23] These institutions include bankers' banks and Federal Home Loan Banks, and not all would be eligible to earn interest on their Federal Reserve balances.

Overall, the Board believes that accelerating the settlement of ACH debits from 11:00 a.m. to 8:30 a.m. promotes the efficiency of the ACH network and strategically aligns the payment system for future advancements in the speed of clearing and settlement. The Board also believes that the reduction in potential liquidity extensions by the Reserve Banks to large originators, simplified account management, the alignment of settlement times between FedACH and EPN, and the improvement gained in measuring daylight overdrafts relative to the Board's principles provide benefits that outweigh the increase in funding costs or overdraft fees that may be incurred by less than one-half of 1 percent of affected institutions. Additionally, the Board believes that the majority of these institutions could avoid increased fees by pledging (additional) collateral, and for most institutions that choose to hold higher balances, interest paid on balances in Federal Reserve accounts would reduce the costs associated with doing so.

Questions

In response to the Board's proposal to change the posting times for ACH debit transactions, the Board requests comment on the benefits and drawbacks. In particular,

(1) What additional costs would institutions expect to incur in order to fund their Federal Reserve accounts by 8:30 a.m. for ACH debit transactions? Are there significant differences in the anticipated effect on those institutions eligible and ineligible to receive intraday credit or earn interest on balances in Federal Reserve accounts?

(2) What are the expected benefits from posting ACH debit transactions earlier?

(3) Would the proposed changes affect the availability of funds to institutions' customers' accounts? Would the proposed changes affect the debiting of funds from institutions' customers' accounts?

(4) What additional costs would institutions expect to incur if ACH credit and debit transactions were posted between 6:00 a.m. and 8:30 a.m.? If the Reserve Banks' NSS operating hours did not open before 8:30 a.m.

[17] NSS is a multilateral settlement service owned and operated by the Reserve Banks. The service is offered to institutions that settle for participants in clearinghouses, financial exchanges, and other clearing and settlement groups. Settlement agents, acting on behalf of those institutions in a settlement arrangement, electronically submit settlement files to the Reserve Banks. Files are processed upon receipt, and entries are automatically posted to the institutions' Federal Reserve accounts. The NSS operating hours are currently 8:30 a.m. to 5:00 p.m.

[18] Although most institutions with master accounts are involved in both ACH and commercial check activity, approximately half of these participants settle their activity to a correspondent rather than their own master account.

Analysis in this notice is intended to be illustrative only and reflect activity at the master account level from the second quarter 2013. All institutions should consider their own historical payment activity when evaluating the effect of the proposed posting rule changes.

[19] Ninety-seven percent of these institutions are community banks and credit unions with assets of less than $10 billion. These data are similar to the results for the proposed commercial check posting rules discussed later in the notice.

The average balance calculation only includes days in the second quarter of 2013 for which institutions had ACH debit transactions. The simulation of balances under the proposed posting rules focuses only on balances held at 8:30 a.m., while the analysis of fees and collateral takes into account balances held and collateral pledged over the entire 21.5-hour Fedwire operating day.

[20] In response to the Board's 2008 proposal to post ACH debit transactions at 8:30 a.m., several commenters, although generally supportive of the proposals, raised concerns about institutions located in western time zones that would likely incur costs associated with the proposed change. Based on the current data analysis, the institutions that would incur increased fees are not disproportionally located in any single time zone. These data are similar to the results for the proposed commercial check posting rules discussed later in the notice.

[21] The average calculation includes all RMPs in the quarter.

[22] The average calculation only includes RMPs for which institutions required (additional) collateral.

[23] These institutions are not eligible to collateralize daylight overdrafts. The average additional funding relates only to RMPs for which institutions required additional funds.

would that create a competitive disadvantage for private-sector operators?

2. Commercial Check Transactions

Under the current posting rules, commercial check credits post according to one of two options: (1) All credits post at a single, float-weighted posting time, or (2) fractional credits post between the hours of 11:00 a.m. and 6:00 p.m., depending on the institution's preference.[24] Both crediting options are based on surveys of check presentment times and vary across time zones. Commercial check debits are posted on the next clock hour at least one hour after presentment beginning at 11:00 a.m. for paper checks and 1:00 p.m. local time for electronic checks, and ending at 3:00 p.m. local time.

In order to reflect today's electronic check-processing environment, the Board proposes to post commercial check transactions, both credits and debits, at 8:30 a.m., 1:00 p.m., and 5:30 p.m., with the specific posting time depending on when the check was deposited with the Reserve Banks (for credits) or presented by the Reserve Banks (for debits).[25] Credits associated with any commercial checks received by the Reserve Banks' deposit deadlines would post on a rolling basis at the next available posting time at least 30 minutes after receipt by the Reserve Banks.[26] Currently, the Reserve Banks' electronic check deposit deadlines are 9:00 p.m. on the previous business day, and 1:00 a.m., 5:00 a.m. and 10:00 a.m. on the settlement day. The paper check deposit deadline is 7:00 p.m. on the previous business day. As a result, depositary banks could expect credit for all electronic items deposited for the 9:00 p.m., 1:00 a.m., and 5:00 a.m. deposit deadlines to post at 8:30 a.m., and credit for electronic items deposited for the 10:00 a.m. deadline to post at 1:00 p.m. Paper items deposited by 7:00 p.m. on the previous day would post at 8:30 a.m.

Similarly, debits associated with electronic check transactions would post on a rolling basis at the next available posting time that is at least 30 minutes after presentment to the paying bank. Paper presentments are made to institutions by mail or courier, and delivered one to two business days after leaving the Reserve Banks, usually before 2:00 p.m. local time. To accommodate the extra time required to make paper presentments, the few remaining paper commercial check debit transactions, which account for less than one-tenth of 1 percent of checks processed by the Reserve Banks, would post at the final posting time of 5:30 p.m. on the day the paper check is presented to the paying bank.[27]

Under the current posting rules and Regulation J, at least one hour (versus the proposed 30 minutes) must elapse between presentment and posting to allow limited verification of cash letters. In September 2013, almost 100 percent of checks were presented electronically by the Reserve Banks, and 98 percent of routing numbers received forward check presentments electronically.[28] As a result of the widespread use of electronic check-handling methods and the extremely small value of paper presentments, the Board believes 30 minutes is now sufficient for institutions to verify cash letters.[29]

The Reserve Banks would present multiple electronic files per day to institutions that receive electronic presentments, with the first presentment by 8:00 a.m. for settlement at 8:30 a.m. and subsequent presentment files made based on an institution's check activity for the day.[30] Although checks are available for presentment today by 8:00 a.m., as discussed earlier, the Reserve Banks have been holding back presentment for some institutions until later in the day to accumulate all check activity into one presentment file. That file is often made available after 12:00 p.m. local time. The proposed posting rules would likely result in the first presentment file received by institutions to be by 8:00 a.m. Other changes already announced by the Reserve Banks will likely result in institutions receiving multiple files per day and would eliminate the exception arrangements of only one presentment file. For business, technology, or other reasons, institutions may choose not to access these presentment files until a specific time in the day. The Reserve Banks, however, would continue to settle those transactions based on presentment having been made, and institutions would need to manage their Federal Reserve accounts accordingly.

The Board is also proposing to revise the posting rules for large-value check corrections and adjustments. Currently, corrections and credit adjustments amounting to $1 million or more post at 11:00 a.m. and hourly thereafter, coinciding with the current posting rules for commercial checks, while large-value debit adjustments post after the close of the Fedwire Funds Service. In alignment with the proposed posting times for commercial check transactions, the Board proposes to move the settlement of large-value credit corrections and adjustments to begin at 8:30 a.m. and hourly thereafter on the half-hour. Moving the settlement of large-value credit corrections and adjustments to 8:30 a.m. in combination with the earlier posting of commercial check transactions would ensure prompt credit for any discrepancies detected by the Reserve Banks or an institution. The Board also proposes to post large-value debit corrections at the same time as large-value debit adjustments after the close of the Fedwire Funds Service. Posting debit corrections after the close of Fedwire Funds would ensure that institutions would only benefit intraday from detected processing errors and that an institution would not receive a large-value debit correction before the associated check transaction posted.

[24] The first option allows an institution to receive all of its check credits at a single time for each type of cash letter. This time may not necessarily fall on the clock hour. The second option lets the institution receive a portion of its available check credits on the clock hours between 11:00 a.m. and 6:00 p.m. The option selected applies to all check deposits posted to an institution's account. Reserve Banks calculate crediting fractions and float-weighted posting times for each time zone based on surveys.

[25] Foreign checks are not affected by the proposed posting rules for commercial check transactions, and credits for foreign checks deposited and debits to subsequent collecting banks into which the Reserve Banks deposit would continue to post after the close of Fedwire. Additionally, as is the case today, credit to institutions for foreign checks deposited may be delayed until these checks clear depending on the value and point of origination of the check. To clarify treatment of foreign checks, the posting rule for transactions that post after the close of the Fedwire Funds Service has been updated to include a reference to foreign checks.

[26] Immediate credit would not be passed for deferred-availability deposit products. Customer availability for files deposited for these services would be the same as if the file were received at a deposit deadline before 8:00 a.m. the next business day.

[27] The posting of electronic presentments earlier than paper check presentments may contribute marginally to a given paying bank's incentive to require that checks be presented to it in paper form. Electronic check presentment is now pervasive, however, and the Board does not believe that a paying bank that receives presentments electronically would be swayed by the later posting time to return to paper presentment.

Credits for checks presented in paper form would not be delayed to accommodate the extra time required for presentment, and would post at the next available posting time at least 30 minutes after receipt by the Reserve Banks.

[28] Although some participants only have one routing number, other participants may have multiple (in some cases more than 100) routing numbers to facilitate their payments processing.

[29] The Board is also issuing a separate notice requesting comment on proposed changes to Regulation J, under which a paying bank would be required to settle for an item by as early as 8:30 a.m. and as soon as one half-hour after it receives the item from the Reserve Banks.

[30] The timing and frequency of presentments is subject to change by the Reserve Banks to align better with processing advancements and product type.

The magnitude of the proposed change would be minimal because of the limited occurrences of large-value check corrections in Reserve Bank processing. For example, in June 2013, 7 large-value debit corrections were initiated for a total value of $4.5 million.

Posting commercial check transactions according to the proposed posting rules would:

- Give earlier availability for items deposited with the Reserve Banks based on an institution's deposit behavior as well as provide earlier credit for adjustments and corrections identified
- simplify the posting rules structure and, as a result, reduce its administrative burden to institutions and Reserve Banks
- reduce the amount of intraday float currently provided by the Reserve Banks based on posting rules that do not reflect current processing
- align the posting rules with the significant shift over the past decade to electronic check clearing

The commercial check posting rules would also better conform to the Board's principles for measuring daylight overdrafts, which the Board uses to guide the development of posting rules.

Under the proposed posting rules, institutions would benefit from the prompt availability of credits from check activity. The availability of funds from checks also would reflect individual institutions' deposit behavior. According to recent data on deposits received by the Reserve Banks, almost all check credits would post at the 8:30 a.m. posting time.

By posting credits and debits at the next available posting time at least 30 minutes after deposit or presentment, commercial check posting rules would be conceptually much simpler and would allow institutions to identify more easily the value and posting time of check credits and debits. All check credits and debits would post at one of the three set posting times regardless of time zone, with the vast majority posting at 8:30 a.m., reflecting actual deposit and processing activity. An institution could easily determine the time at which funds associated with commercial check transactions would be made available, either 8:30 a.m. or 1:00 p.m., based on current deposit deadlines. Additionally, the proposed rules would be operationally less burdensome because the Reserve Banks would not need to survey periodically check presentment times to determine when check credits would post, and any evolution in typical deposit behavior by institutions or presentment cycles at the Reserve Banks would be automatically accounted for by the proposed rules.

As with all posting rule changes, the Board evaluated this posting rule proposal against its principles for measuring daylight overdrafts. With regard to the first principle that the measurement procedures do not provide intraday float, under the current posting rules, check credits and paper check debits begin posting at 11:00 a.m., whereas electronic check debits begin posting at 1:00 p.m. local time. As a result, the current measurement procedures provide intraday float during the day, which has increased over time as electronic deposits and presentments have expanded. Under the proposed posting rules, the likelihood of intraday float would be minimized by facilitating the prompt, largely simultaneous settlement of both check credits and debit entries at each posting time. Minimal intraday float may be generated because of operational delays in presentments. Additionally, the Board estimates that the Reserve Banks would incur a de minimis amount of overnight float per day, representing about 0.3 percent of the value of checks that the Reserve Banks process each day, because of paper presentments, presentments to regions over the International Date Line, and priced presentment products offered by the Reserve Banks.[31]

With respect to the Board's second principle, the proposal would, overall, decrease the time between presentment of checks and the paying bank's obligation to settle. The current posting rules for commercial check continue to reflect the time required to physically process and present checks, and do not take into consideration the efficiencies gained from electronic processing and presentment. Furthermore, the rules allow for relatively long lags between when checks are processed and when the associated transactions settle, including the delayed 1:00 p.m. local time posting of electronic debits and a minimum one-hour window between presentment and posting of debits. On average, over 90 percent of the value of forward electronic checks is available to be presented by 8:00 a.m., but the associated debits do not begin to settle until 1:00 p.m. local time.[32] Likewise, check credits associated with these transactions do not begin posting until 11:00 a.m. By crediting and debiting institutions at 8:30 a.m. for the bulk of daily check activity and reducing the window between presentment and posting to 30 minutes, the proposed posting rules would align much more closely with when the Reserve Banks are able to process and present commercial checks to paying banks.

Both the current and proposed posting rules conform to the third principal that users of intraday credit should be able to manage their usage of intraday credit by establishing set posting times when institutions can expect to be credited or debited. Under the proposed rules, institutions would have the ability to determine when they would receive credits by choosing to deposit at an earlier or later deposit deadline. Institutions could readily calculate the value of credits or debits that would post to their Federal Reserve accounts at each of the three posting times by the value of check deposits made or presentments received at least 30 minutes before the next posting time. Similar to the earlier proposed posting time for ACH debit transactions, institutions may need to adjust their account management due to the earlier posting of check transactions. To estimate their potential liquidity need at 8:30 a.m. and throughout the day, institutions could consider their historical deposit patterns and presentment times.[33] Ultimately, some institutions may need to hold higher balances overnight, arrange early morning funding, or incur daylight overdrafts, if eligible, to fund the earlier posting of check transactions.

Lastly, the fourth principle requires that Reserve Banks do not obtain a competitive advantage from the measurement procedures. Under Regulation J, the Reserve Banks have the legal and operational ability to debit paying banks for paper presentments of checks earlier in the day than private-sector collecting banks and, in turn, pass credits for deposited checks earlier in the day without incurring significant intraday float. In March 1998, the Board requested comment on whether these legal differences between the Reserve Banks and the private sector provided the Reserve Banks with a competitive advantage and, if so, whether these legal differences should be reduced or

[31] For example, an institution that provides corporate cash management services may opt for a premium presentment service that allows the institution to establish a morning cutoff time for its presentments. All presentments to be made to the institution after the cutoff time would be held and presented to the institution on the following business day. Credit to the depositary bank, however, would be passed on the current business day. The Board expects that very few checks would be held over as a result of such services.

[32] Actual value of check presentments made by 8:00 a.m. is approximately 82 percent because some institutions do not have presentment arrangements before 8:00 a.m.

[33] In assessing the effect of the proposed posting rules, institutions receiving only one presentment file per day today would need to adjust their current presentment times to reflect the earlier posting time and receipt of multiple files.

eliminated. Based on the analysis of the comments received, the Board concluded then and continues to believe that these legal disparities do not materially affect the efficiency of or competition in the check-collection system. Furthermore, the vast majority of check activity is now electronic, and banks have the ability to directly exchange checks electronically with banks with which they have agreements to do so. As part of these agreements, depositary and paying banks may determine the timing and method of settlement. Additionally, private-sector check clearinghouses have the option to use NSS to effect settlement of checks or may settle by directing their members to initiate funds transfers over the Reserve Banks' Fedwire Funds Service. NSS's operating hours extend from 8:30 a.m. to 5:00 p.m.; Fedwire Funds operating hours begin at 9:00 p.m. the previous calendar day and end at 6:30 p.m. The Reserve Banks today settle commercial check transactions (including corrections and adjustments) from 11:00 a.m. to 6:30 p.m. within the Fedwire Funds operating day. From a payment system risk perspective, the Board has traditionally encouraged the use of NSS for multilateral settlement arrangements and is seeking comment on whether the Reserve Banks should consider extending NSS hours to accommodate a somewhat later settlement time by private-sector clearinghouses. Lastly, the earlier posting of check credits and debits may be viewed as more or less advantageous depending on an institution's net check activity for the day, but it is unlikely to be a material consideration because of its minimal effect on Federal Reserve account balances and variability over time. As a result, the Board believes the fourth principle would continue to be met.

By posting check debits and credits according to the proposed posting rules, most institutions could expect that the value of checks credited and debited at 8:30 a.m. would largely reflect their net daily check activity. For approximately 36 percent of the 3,100 check participants, account balances at 8:30 a.m. would be higher on average under the proposed rules due to the earlier availability of funds received from checks.[34] For the 64 percent of participants with lower average balances at 8:30 a.m. under the proposed rules, the average change in balances for institutions eligible and ineligible to receive intraday credit would be $5 million and $21 million, respectively. Only 22 institutions, however, would incur overdraft fees in any of the six RMPs within the quarter analyzed.

Twenty-one of the 22 institutions that would incur higher fees are eligible to incur daylight overdrafts. The average increase in fees over the quarter would be $104 per RMP; these data include one institution whose average RMP fee increase was estimated at $1,027, $756 higher than the institution with the next largest average RMP fee increase.[35] To avoid fee increases, these institutions could pledge on average $14 million of (additional) collateral.[36] Alternatively, they could hold higher balances and receive interest on Federal Reserve account balances, or arrange for early morning funding.

Additionally, 1 of the 22 institutions is ineligible to receive intraday credit and would incur overdrafts under the proposed rules. To avoid violating the PSR policy and incurring fees, the institution would need to increase funding in its account on average by $24 million either overnight or through early morning funding.[37] This institution would be eligible to receive interest on Federal Reserve account balances.

Overall, the Board believes that the proposed posting rules for check transactions are necessary to reflect the speed of electronic check-processing and to remove antiquated provisions based on the previous environment of paper processing. Furthermore, the proposed posting rules will position the Reserve Banks to make further enhancements to the speed of processing by aligning the clearance and settlement of check payments. In addition, the posting rules would benefit participants by providing earlier availability of funds that reflect their deposit behavior and reduce the administrative burden of the current regime. The Board believes these benefits outweigh the increase in funding costs or overdraft fees that may be incurred by less than three-quarters of 1 percent of affected institutions. Additionally, the Board believes that these institutions could avoid increased fees by pledging (additional) collateral or holding higher balances, which would receive interest on Federal Reserve account balances.

Questions

In response to the Board's proposals to change the posting times for commercial check transactions and large-value corrections and credit adjustments, the Board requests comment on the benefits and drawbacks. In particular,

(1) What additional costs would institutions expect to incur in order to fund their Federal Reserve accounts by 8:30 a.m. for commercial check transactions? Are there significant differences in the anticipated effect on those institutions eligible and ineligible to receive intraday credit or earn interest on balances in Federal Reserve accounts?

(2) What are the expected benefits from posting commercial check transactions earlier?

(3) Would the proposed changes affect the availability of funds to institutions' customers' accounts? Would the proposed changes impact the debiting of funds from institutions' customers' accounts?

(4) Would posting check debits at 5:30 p.m., after the current close of NSS, give the Reserve Banks a material competitive advantage relative to private-sector clearinghouses? Should the Reserve Banks consider expanding the operating hours of NSS to 5:30 p.m. to support the needs of private-sector clearinghouses or collecting banks?

(5) For those institutions receiving paper presentments, would a posting time after the close of the Fedwire Funds Service be better than 5:30 p.m.?[38] What are the reasons?

(6) What additional costs would institutions expect to incur if commercial check transactions posted between 6:00 a.m. and 8:30 a.m.? Would NSS hours need to expand to ensure that the earlier posting would not result in a material competitive disparity

[34] The average balance calculation only includes days in the second quarter of 2013 for which institutions had commercial check payment activity. The simulation of balances under the proposed posting rules focuses only on balances held at 8:30 a.m., while the analysis of fees and collateral takes into account balances held and collateral pledged over the entire 21.5-hour Fedwire Funds operating day.

[35] The average calculation includes all RMPs in the quarter. The average increase in fees over the quarter would be $58 per RMP if the data excluded that one institution.

[36] The average calculation only includes RMPs for which institutions required (additional) collateral.

[37] This institution is not eligible to collateralize daylight overdrafts. The average additional funding relates only to RMPs for which the institution required additional funds.

[38] Because of operational limitations and for account management reasons, the operating hours for NSS could not be extended to 6:30 p.m. for a comparable settlement option. The operating hours for NSS would need to close sufficiently before 6:00 p.m. to ensure that the Fedwire Funds 6:00 p.m. third-party close and the Fedwire Funds 6:30 p.m. settlement close would not be delayed. In addition, historically, NSS has closed well before the Fedwire Funds third-party close to allow for contingency settlement on Fedwire Funds in the event that normal settlement procedures on NSS were unsuccessful. Posting debits for paper presentments after the close of Fedwire would be consistent with the posting of foreign checks, which is a paper-based process.

between the Reserve Banks and private-sector operators?

(7) Although Reserve Banks are already making changes that will result in paying banks receiving at least two presentment files per day, would adding one, two, three, or more additional presentment files increase costs materially?

(8) Would 15 minutes, rather than the 30 minutes proposed for limited verification of cash letters, be sufficient time given that most cash letters are processed electronically? For consistency, should the Reserve Banks establish in their Operating Circular a minimum 15- or 30-minute window between established distribution times for ACH debit transaction files and posting to ensure institutions can view the amount settling in their accounts before it is debited?[39]

(9) Would the earlier posting of electronic presentments materially incent institutions to accept only paper presentments?

Combined Effect of Proposed Posting Rules for ACH Debit and Commercial Check Transactions

The Board assessed the combined effect of the changes to both the ACH debit and commercial check transaction posting rules on institutions' account balances and daylight overdraft fees. Most institutions would experience an increase in settlement activity at 8:30 a.m. Overall, the combined posting rule proposals would reduce, on average, account balances held in Federal Reserve accounts at 8:30 a.m. for most institutions, but the vast majority of those institutions would not incur daylight overdraft fees as a result. The low incidence of fees can be attributed to the current levels of pledged collateral and collateralized daylight overdrafts receiving a zero fee, the $150 fee waiver covering modest amounts of uncollateralized overdrafts, and the historically high balances held in Federal Reserve accounts.

TABLE—COMBINED EFFECT OF PROPOSALS ON INSTITUTIONS' BALANCES[40]

Institution type	Change in balances at 8:30 a.m.	Number of institutions	Average change (millions)
Eligible to incur daylight overdrafts	Higher	200	55
	Lower	3,251	−7
	Daylight overdrafts incurred	919	−10
Ineligible to incur daylight overdrafts	Higher	4	1,611
	Lower	23	−81
	Daylight overdrafts incurred	5	−102

As indicated in the table, approximately 200 institutions (6 percent) would incur an increase in available cash balances in their Federal Reserve accounts at 8:30 a.m. from the combined posting rule changes. The earlier credit for commercial check transactions is a large contributor to the higher balances at 8:30 a.m. for most of these institutions; large originators of ACH debit transactions also benefit (on average balances increase approximately $163 million) from the earlier posting of these transactions. At the same time, almost 3,300 institutions (94 percent) of the approximate 3,500 participants in ACH and commercial check on average would experience lower balances at 8:30 a.m.[41] The primary driver for this reduction is that the vast majority of these institutions are community banks or credit unions with assets of less than $10 billion that receive rather than originate most ACH debit transactions.[42] Those institutions' accounts would be debited earlier in the day than the current posting rules. The average change in balances for institutions with lower balances at 8:30 a.m. would be $7 million for institutions eligible to receive intraday credit and $81 million for ineligible institutions.

Of the 23 institutions that would incur lower balances and are ineligible to receive intraday credit, only 5 would incur daylight overdrafts under the proposed posting rules. On average these 5 institutions would incur daylight overdrafts in four of the six RMPs in the quarter analyzed. These 5 institutions would need to make account management changes to either increase funding held in their Federal Reserve accounts overnight or arrange for early morning funding. Some, but not all, of these institutions would be eligible to earn interest on Federal Reserve balances for higher balances held overnight.

In addition, of the 3,250 institutions that would experience lower balances and are eligible to incur daylight overdrafts, approximately 919 would also incur daylight overdrafts or incur them at higher levels. At the same time, less than 1 percent, only 28 institutions, would incur any daylight overdraft fees associated with the proposed posting rules in any of the six RMPs within the quarter.

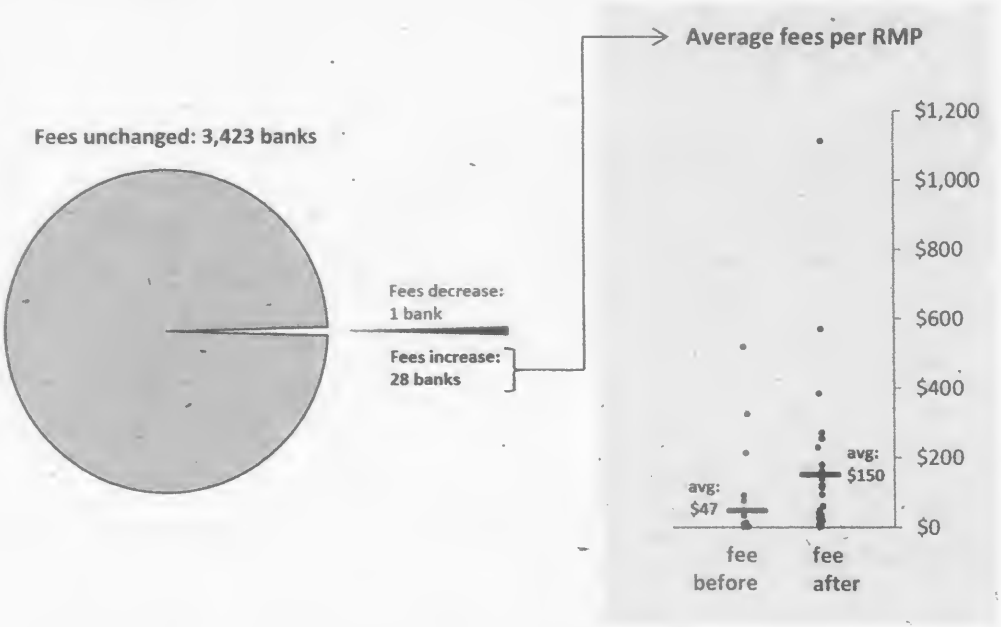
[39] Operating Circular 4 applies to the clearing and settlement of commercial ACH credit and debit transactions for the Reserve Banks' ACH service.

[40] All data presented are based on the second quarter 2013. The balances for one institution eligible to incur daylight overdrafts were unchanged at 8:30 a.m. between the current and proposed posting rules.

[41] The average balance calculation only includes days in the second quarter of 2013 for which institutions had ACH debit or commercial check payment activity. The simulation of balances under the proposed posting rules focuses only on balances held at 8:30 a.m., while the analysis of fees and collateral takes into account balances held and collateral pledged over the entire 21.5-hour Fedwire Funds operating day.

[42] Of these institutions with lower balances, 97 percent are small banking organizations (assets of $500 million or less) or community banks or credit unions with assets between $500 million and $10 billion.

Figure – Combined effect on fees for institutions eligible to incur daylight overdrafts[43]



As illustrated in the figure, 3,423 institutions that are eligible to incur daylight overdrafts would not incur an increase in fees charged, while 28 institutions would incur higher fees. These 28 institutions would incur increased fees on average in three of the six RMPs in the quarter analyzed. The average increase in fees over the quarter would be $103 per RMP (the difference between the current and potential average fees); these data include one institution whose average RMP fee increase was estimated at $1,035, $764 higher than the institution with the next largest average RMP fee increase.[44] The average increase in fees over the quarter would be $68 per RMP if the data excluded that one institution. Some of these institutions (about 43 percent) are already incurring fees under the current posting rules. In addition, almost all of these institutions have a *de minimis* or self-assessed net debit cap, permitting these institutions to incur daylight overdrafts up to 40 percent of their capital if *de minimis* or multiples of their capital if self-assessed.[45] Only one institution has an exempt cap, which is the lowest level of daylight overdraft capacity available to institutions. Of the 28 institutions that would incur higher fees, 23 are community banks and credit unions with assets between $500 million and $10 billion, and 3 are small banking organizations with assets of $500 million or less. To avoid fee increases, these 28 institutions could pledge on average $15 million of (additional) collateral.[46] Alternatively, they could hold higher balances and receive interest on Federal Reserve account balances, or arrange for early morning funding.

Institutions that would incur higher fees are evenly distributed across time zones, including the Pacific time zone. In an earlier proposal, commenters raised concerns that institutions located in western time zones might incur disproportional higher costs associated with earlier posting times. Of the 28 institutions with higher fees, the greatest concentration is located in the Eastern time zone.

The Board recognizes that a limited number of institutions would need to take proactive steps to manage their Federal Reserve accounts to minimize increased fees or to avoid daylight overdrafts (if ineligible for intraday credit). These institutions might incur increased costs related to managing their Federal Reserve accounts under the proposed posting rules. Most of these institutions, however, would be able to take actions to avoid increased fees through posting (additional) collateral or holding higher balances, and interest on balances in Federal Reserve accounts would help compensate most institutions (91 percent) that choose to increase balances held overnight in their Federal Reserve accounts. Three institutions would be the most adversely affected as they are not eligible for intraday credit or interest on balances in Federal Reserve accounts. Ultimately, the Board believes that it is no longer appropriate to maintain posting rules that reflect outdated practices and do not strategically position the payment system for the future of faster clearing and settlement. The Board believes these changes are necessary for the long-run efficiency of the payment system.

Implementation of Proposed Posting Rules for ACH Debit and Commercial Check Transactions

Adoption of an earlier posting time for ACH debit transactions and check transactions could be implemented

[43] Different institutions incurred the highest average fees per RMP under the current and proposed posting rules.

[44] The average calculation includes all RMPs in the quarter.

[45] The PSR policy establishes a limit on the amount of intraday credit that an institution may incur during any given day; this limit is called a net debit cap.

[46] The average calculation only includes RMPs for which institutions required (additional) collateral.

relatively quickly by the Reserve Banks. The Board, however, understands that a small number of institutions might need to make account management changes to arrange for sufficient funding or to pledge (additional) collateral, if eligible. The Board proposes an effective date six months from the final rule to give institutions sufficient time to make any necessary changes.

Questions

In response to the Board's proposals to implement changes to the PSR policy related to the procedures for posting debit and credit entries for ACH debit and commercial check transactions, the Board requests comment on the collective benefits and drawbacks. In particular,

(1) Are there any additional costs as a result of the combined effect of the ACH debit and commercial check posting rule proposals that institutions would expect to incur in order to fund their Federal Reserve accounts by 8:30 a.m.?

(2) Are there any additional expected benefits from the combined effect of the ACH debit and commercial check posting rule proposals?

(3) What additional costs as a result of the combined effect of the ACH debit and commercial check posting rule proposals would institutions expect to incur if both ACH and commercial check transactions posted between 6:00 a.m. and 8:30 a.m.?

(4) Is six months sufficient lead time for implementation? If not, why not? What lead time would be needed if greater than six months? Alternatively, is less implementation time, such as three months, sufficient?

(5) Are there any additional posting rules in the PSR policy that would benefit from changes or that need clarification?

III. Other Revisions to the PSR Policy

Principles for Future Posting Rules for the Reserve Banks' Same-Day ACH Service

Advancements in technology and business processes will continue to enable improvements in the ACH system and institutions' back-end processing capabilities and infrastructures. The ACH system has already begun to see changes, albeit on a limited basis, in faster clearing and settlement. In 2010, the Reserve Banks began offering a limited, voluntary, same-day service for certain ACH debit transactions and recently expanded that service to allow for almost all credit and debit transaction types.[47] The Board expects that this service will evolve over time, with the potential establishment of additional processing cycles that require new posting times for settlement.[48]

The Board proposes to establish a set of principles that would be applied to any new same-day ACH posting rules. The Board does not contemplate that it would ordinarily request public comment on changes to the posting rules that conform to such principles, but would request comment should it consider implementing posting rules that deviate from the principles. Such principles would apply to the Reserve Banks' voluntary (opt-in), same-day ACH service and to any future same-day ACH service, such as a universal same-day ACH service that may be incorporated into NACHA rules.[49] These proposed principles, which would apply in addition to the current four posting-rules principles formulated in the 1990s, are as follows:[50]

(1) For each same-day ACH transmission deadline, the Reserve Banks will establish expected distribution times for the same-day ACH files.

a. The Reserve Banks will post settlement for same-day ACH debit transactions no earlier than 15 minutes after the Reserve Banks' expected distribution times for the associated same-day ACH file.

b. The Reserve Banks will post settlement for ACH credit and debit transactions associated with a particular same-day ACH file distribution time at the same time.

(2) The Reserve Banks will not post settlement for same-day ACH transactions between 6:30 p.m. and 8:30 a.m. the next processing day.

(3) The Reserve Banks will post settlement for same-day ACH transactions exchanged with another operator to support universal same-day ACH during the operating hours for the Reserve Banks' NSS.

The first principle is intended to ensure that institutions have sufficient time to view the amount settling in their Federal Reserve accounts for ACH debit transactions before their account is debited. The principle does not address ACH credit transactions because the originating depository financial institution, whose Federal Reserve account is debited, has full information about the amount and timing of settlement when they initiate the transaction. The principle would also ensure that credit and debit transactions post simultaneously, offsetting the liquidity needed to settle for those same-day ACH transactions.[51] This principle conforms to the Board's current measurement principles that posting rules should reflect the times at which payor institutions are obligated to pay for transfers.

The second principle requires that the same-day ACH posting rules fall within certain business hours, mitigating the potential burden of institutions, especially smaller, West Coast institutions, related to monitoring and funding their account balances outside of these hours. This principle is consistent with the Board's current principle that users of payment services should be able to control their use of intraday credit.

The third principle applies to a potential future state when multiple operators provide same-day ACH services and need to exchange items to support universal same-day ACH.[52] To ensure competitive equality between these operators, the private-sector operator(s) should have the ability to settle for same-day ACH transactions, using the Reserve Banks' NSS, at the same times the Reserve Banks post such transactions.[53] Because the Reserve Banks are the only provider of a same-

[47] The Reserve Banks' service is voluntary in the sense that both the sending institution and the receiving institution must have "opted in" to the Reserve Banks' service in order for the Reserve Banks to treat an eligible ACH transaction as a same-day transaction. The same-day ACH service includes all types of ACH credit and debit transactions with the exception of international ACH transactions and certain check truncation transactions.

[48] The current processing schedule has a 2:00 p.m. deadline for submitting same-day, forward transactions for settlement at 5:00 p.m. Return transactions post at 5:30 p.m.

[49] NACHA is a not-for-profit association that manages the development, administration, and governance of the ACH network for participating depository institutions. In 2011, NACHA proposed amendments to its operating rules to enable ACH debit and credit transfers to be cleared and settled on the same day that they are originated. The expedited service would require the participation of all receiving institutions in the ACH network, going beyond the Reserve Banks' voluntary service. Although the majority of NACHA's voting members were in favor of the proposal, NACHA did not receive the 75 percent positive vote required for passage.

[50] These four posting-rule principles are outlined earlier in this notice.

[51] Same-day ACH credit transactions have immediate finality consistent with the Reserve Banks' current treatment of ACH credit transfers. See section 11.2 of the Reserve Banks' Operating Circular 4, *Automated Clearing House Items*, available at *www.frbservices.org/files/regulations/pdf/operating_circular_4_07122012.pdf*.

[52] The principle would not apply if a private-sector operator introduced a same-day ACH service where it did not intend the items to be exchanged with the Reserve Banks as another ACH operator.

[53] Currently, the Reserve Banks' NSS is used by EPN to settle intra-EPN transactions (i.e., ACH transactions that do not involve the Reserve Banks' FedACH service).

day ACH service at this time, the principle is not currently applicable. If in the future the Reserve Banks exchanged same-day ACH transactions with a private-sector operator, the Reserve Banks' same-day ACH service would need to conform to the third principle by either modifying the posting rules to meet this requirement or expanding NSS's operating hours to incorporate the posting times for same-day ACH.[54] This principle conforms to the Board's current principle that Reserve Banks should not obtain a competitive advantage from the measurement procedures.

The Board proposes that the principles for future posting rules for the Reserve Banks' same-day ACH service would be effective on final approval.

Questions

In response to the Board's proposals to implement principles for establishing future posting rules for the Reserve Banks' same-day ACH service, the Board requests comment on the proposed principles. In particular,

(1) Are there additional principles that the Board should consider?

(2) Are all the proposed principles necessary?

(3) Should the window between established distribution times and posting be standard for check, ACH debit transactions, and same-day ACH debit transactions? If so, should that standard be 15 minutes, 30 minutes, or some other time?

Language Clarification in Section II.G.3

The Board is requesting comment on a proposed language clarification in part II of the PSR policy regarding operational changes in the administration of the policy as it relates to U.S. branches and agencies of foreign banking organizations (FBOs). The new language clarifies that U.S. branches and agencies of the same foreign bank (also referred to as an FBO family) are expected to manage their accounts so that the daylight overdraft position in each account does not exceed the capacity allocated to this account from the FBO family's net debit cap.[55] An FBO family, unlike most domestic institutions, may have multiple master accounts across Reserve Bank Districts and may request that all or part of its net debit cap be allocated across the Reserve Bank Districts. In the past, the Reserve Banks monitored the master accounts of FBO families on a consolidated basis rather than requiring an FBO family to allocate its net debit cap if it wanted to incur daylight overdrafts in more than one account across Reserve Bank Districts.

The impetus for this administration change stemmed from the 2011 revision to the PSR policy that allowed healthy institutions eligible for intraday credit to eliminate or reduce daylight overdraft fees through the voluntary pledge of collateral.[56] FBO families often only pledged collateral to one Reserve Bank, and state laws governing the resolution of foreign bank branches may limit (or "ring-fence") the assets of a branch located in that state, thereby increasing the risk that a Reserve Bank may not be able to rely on collateral held by another Reserve Bank. In 2012, the Reserve Banks changed their operational practices to address this risk such that an FBO family's master accounts are treated as separate accounts for the purposes of pricing and monitoring net debit cap compliance.[57]

The effective date for the proposed language change intended to clarify the Reserve Banks' administration of the policy for U.S. branches and agencies of FBOs would be effective on final approval.

IV. Competitive Impact Analysis

The Board conducts a competitive impact analysis when it considers a rule or policy change that may have a substantial effect on payment system participants, such as that being proposed for the posting of ACH debit and commercial check transactions. Specifically, the Board determines whether there would be a direct or material adverse effect on the ability of other service providers to compete with the Federal Reserve due to differing legal powers or due to the Federal Reserve's dominant market position deriving such legal differences.[58] The Board believes that there are no adverse effects resulting from the proposed changes due to legal differences.

Shifting the posting of ACH debit transactions to 8:30 a.m. would serve to bring the settlement of ACH debit transactions processed by the Reserve Banks' FedACH service in line with the private-sector operator and reduce any potential competitive disadvantage to the Reserve Banks. The proposed posting-rule change would benefit not only FedACH participants that originate debit transactions but also EPN customers that originate debit transactions sent to FedACH, which settle according to the Board's posting rules.

Under Regulation J, the Reserve Banks have the legal and operational ability to debit paying banks for paper presentments of checks earlier in the day than private-sector collecting banks and, in turn, can pass credits for deposited checks earlier in the day without incurring significant intraday float. To obtain settlement from paying banks for paper checks presented, Regulation J permits the Reserve Banks to debit directly the account of the paying bank or its designated correspondent.[59] In contrast, a paying bank settles for checks presented by a private-sector bank for same-day settlement by sending a Fedwire Funds transaction to the presenting bank or by another agreed upon method.[60] In addition, the Reserve Banks have the right to debit the account of the paying bank for settlement of checks on the next clock hour that is at least one hour after presentment, whereas a private-sector collecting bank may not receive settlement until the close of Fedwire on the day of presentment.[61]

In March 1998, the Board requested comment on whether these legal differences between the Reserve Banks and the private sector provided the Reserve Banks with a competitive advantage. Most commenters acknowledged that the regulation governing the timing and settlement favor Reserve Banks over private-sector collecting banks. None of the commenters, however, suggested an alternative that eliminated the disparity while maintaining a balance between the needs of both the paying bank and collecting banks to control some part of the settlement process.[62]

Additionally, under Regulation J, Reserve Banks can obtain same-day settlement for checks presented to a paying bank before the paying bank's

[54] The Reserve Banks currently settle same-day ACH return transactions at 5:30 p.m., which is a half-hour after the close of NSS's operating hours of 8:30 a.m. to 5:00 p.m.

[55] The previous language in the PSR policy that related to the administration of multiple master accounts was somewhat ambiguous and could have been interpreted to allow the Federal Reserve to administer these accounts as is the current practice (separate administration for the multiple master accounts) or the previous practice (consolidated administration).

[56] The fee for collateralized daylight overdrafts is zero because the collateral mitigates the Reserve Banks' exposure.

[57] As announced by the Reserve Banks in a February 2012 letter, effective April 19, 2012, the Reserve Banks would no longer consolidate the accounts of FBO families across Reserve Bank Districts for the purposes of pricing and ex-post monitoring of cap compliance.

[58] Federal Reserve Regulatory Service, 7–145.2.

[59] 12 CFR 210.9(b)(5).

[60] 12 CFR 229.36(f)(2).

[61] 12 CFR 210.9(b)(2); 12 CFR 229.36(f)(2).

[62] The request for comment and the subsequent notice of the Board's decision can be found, respectively, at 63 FR 12700 (March 16, 1998) and 63 FR 68701 (December 14, 1998).

cutoff hour, generally 2:00 p.m. local time or later.[63] The same-day settlement rule for private-sector banks, however, requires that they make their presentments by 8:00 a.m. local time to ensure that they receive same-day settlement by Fedwire Funds without being assessed presentment fees. In March 1998, the Board also requested comment on the effect of the difference in presentment deadlines for Reserve Banks and private-sector banks. Most commenters did not believe that the six-hour difference in presentment deadlines was a significant impediment to the ability of private-sector banks to compete with the Reserve Banks.

Based on the analysis of the comments received, the Board concluded then and continues to believe that these legal disparities do not materially affect the efficiency of or competition in the check collection system. The costs to paying banks and their customers associated with reducing any remaining legal disparities would outweigh any payment system efficiency gains.

In addition, the Check 21 Act, by authorizing the creation of substitute checks, enabled banks to send checks electronically, rather than in paper form, to banks with which they have agreements to do so, and the vast majority of check activity is cleared electronically today. As a result, banks may determine, as part of the agreement between a depositary and paying bank, the time at which settlement for checks is required to be funded as well as the presentment deadlines. Furthermore, for depositary and paying banks that opt to use a check clearinghouse rather than directly exchange paper or electronic checks, private-sector clearinghouses have the option to use NSS to effect settlement of checks or may settle by directing their members to initiate funds transfers over the Reserve Banks' Fedwire Funds Service. NSS's operating hours extend from 8:30 a.m. to 5:00 p.m., while Fedwire Funds operating hours begin at 9:00 p.m. the previous calendar day and end at 6:30 p.m. The Reserve Banks today settle commercial check transactions (including corrections and adjustments) from 11:00 a.m. to 6:30 p.m. From a payment system risk perspective, the Board has traditionally encouraged the use of NSS for multilateral settlement arrangements and is seeking comment on whether the Reserve Banks should consider extending NSS hours to accommodate a specific later settlement time by private-sector clearinghouses.

[63] 12 CFR 210.9(b)(1).

Under the proposed posting rules, the bulk of the Reserve Banks' postings of credits to depositing banks and debits to paying banks for commercial check transactions may shift to earlier in the day. Depending on the number of checks a bank sends to the Reserve Banks and that it receives from the Reserve Banks, the bank may receive either a "net credit" or a "net debit" earlier in the day. As a result, the earlier posting of commercial check transactions may be viewed as more or less attractive, depending on changes to balances. Further, private-sector banks can achieve improvements similar to those provided by the proposed changes through private agreements among participants, as well as the use of the NSS.

Given the factors discussed above, the Board does not believe that the proposed changes to the posting rules would have any direct adverse effect on other service providers to compete effectively with Reserve Banks in providing similar services.

V. Paperwork Reduction Act

In accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. 3506; 5 CFR part 1320 appendix A.1), the Board reviewed the PSR policy changes it is considering under the authority delegated to the Board by the Office of Management and Budget. No collection of information pursuant to the Paperwork Reduction Act are contained in the policy statement.

VI. Federal Reserve Policy on Payment System Risk

Changes to the Posting Rules

If the Board adopts the proposed posting changes for ACH debit and commercial check transactions, it would amend the "Federal Reserve Policy on Payment System Risk" section II.A. under the subheading "Procedures for Measuring Daylight Overdrafts" as follows in italics.[64]

Procedures for measuring daylight overdrafts[65]

Post at 8:30 a.m. Eastern time:

+/− Term deposit maturities and accrued interest

+/− Government and commercial ACH transactions[66]

+/− Commercial check transactions, including returned checks[67]

+ Treasury checks, postal money orders, local Federal Reserve Bank checks, and savings bond redemptions in separately sorted deposits; these items must be deposited by 12:01 a.m. local time or the local deposit deadline, whichever is later

+ Advance-notice Treasury investments

− Penalty assessments for tax payments from the Treasury Investment Program (TIP).[68]

Post at 8:30 a.m. Eastern time and hourly, on the half-hour, thereafter:

+/− Main account administrative investment or withdrawal from TIP

+/− Special Direct Investment (SDI) administrative investment or withdrawal from TIP

+ 31 CFR part 202 account deposits from TIP

+ Credit corrections amounting to $1 million or more[69]

+ Credit adjustments amounting to $1 million or more[70]

− Uninvested paper tax (PATAX) deposits from TIP

− Main account balance limit withdrawals from TIP

− Collateral deficiency withdrawals from TIP

− 31 CFR part 202 deficiency withdrawals from TIP

[64] In addition to the italicized changes to the "Post After the Close of Fedwire Funds Service" posting rule, the list of transactions posted at that time has been reordered.

[65] This schedule of posting rules does not affect the overdraft restrictions and overdraft-measurement provisions for nonbank banks established by the Competitive Equality Banking Act of 1987 and the Board's Regulation Y (12 CFR 225.52).

[66] Institutions that are monitored in real time must fund the total amount of their commercial ACH credit originations in order for the transactions to be processed. If the Federal Reserve receives commercial ACH credit transactions from institutions monitored in real time after the scheduled close of the Fedwire Funds Service, these transactions will be processed at 12:30 a.m. the next business day, or by the ACH deposit deadline, whichever is earlier. The Account Balance Monitoring System provides intraday account information to the Reserve Banks and institutions and is used primarily to give authorized Reserve Bank personnel a mechanism to control and monitor account activity for selected institutions. For more information on ACH transaction processing, refer to the ACH Settlement Day Finality Guide available through the Federal Reserve Financial Services Web site at *http://www.frbservices.org.*

[67] For the three commercial check transaction posting times, the Reserve Banks will post credits and debits to institutions' accounts for checks deposited and presented, respectively, at least 30 minutes before the posting time.

[68] The Reserve Banks will identify and notify institutions with Treasury-authorized penalties on Thursdays. In the event that Thursday is a holiday, the Reserve Banks will identify and notify institutions with Treasury-authorized penalties on the following business day. Penalties will then be posted on the business day following notification.

[69] Corrections are account entries made to correct discrepancies detected by a Reserve Bank during the initial processing of checks.

[70] Adjustments are account entries made to correct discrepancies detected by an institution after entries have posted to its account and are made at the request of the institution.

Post by 1:00 p.m. Eastern time:
+/− Commercial check transactions, including returned checks
+ Same-day Treasury investments.
Post at 5:30 p.m. Eastern time:
+/− FedACH SameDay Service return transactions.
+/− Commercial check transactions, including returned checks

Post After the Close of Fedwire Funds Service:
+/− All other transactions. These transactions include the following: *currency and coin shipments; noncash collection; term-deposit settlements;* Federal Reserve Bank checks presented after 3:00 p.m. Eastern time but before 3:00 p.m. local time; *foreign check transactions;* small-dollar credit adjustments; and all debit adjustments *and corrections.* Discount-window loans and repayments are normally posted after the close of Fedwire as well; however, in unusual circumstances a discount window loan may be posted earlier in the day with repayment 24 hours later, or a loan may be repaid before it would otherwise become due.

Revisions to Section II.G.3 of the PSR Policy

The Board proposes to revise section II.G.3 of the Federal Reserve Policy on Payment System Risk as follows:

3. Multi-District Institutions

An institution maintaining merger-transition accounts or an Edge or agreement corporation that accesses Fedwire through master accounts in more than one Federal Reserve District is expected to manage its accounts so that the total daylight overdraft position across all accounts does not exceed the institution's net debit cap. One Reserve Bank will act as the administrative Reserve Bank and will have overall risk-management responsibilities for an institution maintaining master accounts in more than one Federal Reserve District. For domestic institutions that have branches in multiple Federal Reserve Districts, the administrative Reserve Bank generally will be the Reserve Bank where the head office of the bank is located.

U.S. branches and agencies of the same foreign bank (also referred to as an FBO family) are assigned one net debit cap per FBO family. FBO families that access Fedwire through master accounts in more than one Federal Reserve District are expected to manage their accounts so that the daylight overdraft position in each account does not exceed the capacity allocated to this account from the FBO family's net debit cap. The administrative Reserve Bank generally is the Reserve Bank that exercises the Federal Reserve's oversight responsibilities under the International Banking Act.[71] The administrative Reserve Bank, in consultation with the management of the foreign bank's U.S. operations and with Reserve Banks in whose territory other U.S. agencies or branches of the same foreign bank are located, may recommend that these agencies and branches not be permitted to incur overdrafts in Federal Reserve accounts. Alternatively, the administrative Reserve Bank, after similar consultation, may recommend that all or part of the foreign family's net debit cap be allocated to the Federal Reserve accounts of agencies or branches that are located outside of the administrative Reserve Bank's District; in this case, the Reserve Bank in whose Districts those agencies or branches are located will be responsible for administering all or part of this policy.[72]

* * * * *

By order of the Board of Governors of the Federal Reserve System, November 25, 2013.

Robert deV. Frierson,

Secretary of the Board.

[FR Doc. 2013–28745 Filed 12–9–13; 8:45 am]

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[71] 12 U.S.C. 3101–3108.

[72] As in the case of Edge and agreement corporations and their branches, with the approval of the designated administrative Reserve Bank, a second Reserve Bank may assume the responsibility for administering this policy regarding particular foreign branch and agency families. This would often be the case when the payments activity and national administrative office of the foreign branch and agency family is located in one District, while the oversight responsibility under the International Banking Act is in another District. If a second Reserve Bank assumes management responsibility, monitoring data will be forwarded to the designated administrator for use in the supervisory process.

FEDERAL RETIREMENT THRIFT INVESTMENT BOARD

Sunshine Act; Notice of Meeting

TIME AND DATE: 9:00 a.m. December 16, 2013.

PLACE: 10th Floor Board Meeting Room, 77 K Street NE., Washington, DC 20002.

STATUS: Parts will be open to the public and parts closed to the public.

MATTERS TO BE CONSIDERED:

Parts Open to the Public

1. Approval of the Minutes of the November 25, 2013 Board Member Meeting
2. Thrift Savings Plan Activity Reports by the Executive Director
   a. Monthly Participant Activity Report
   b. Monthly Investment Policy Report
   c. Legislative Report
3. L Fund Default
4. OPOP Report
5. Financial Auditor Contract
6. OGC Report
7. 2014 Board Calendar

Parts Closed to the Public

1. Litigation Update
2. Personnel

CONTACT PERSON FOR MORE INFORMATION: Kimberly Weaver, Director, Office of External Affairs, (202) 942–1640.

Dated: December 6, 2013.

James B. Petrick,

Secretary, Federal Retirement Thrift Investment Board.

[FR Doc. 2013–29552 Filed 12–6–13; 4:15 pm]

BILLING CODE 6760–01–P

FEDERAL TRADE COMMISSION

Agency Information Collection Activities; Proposed Collection; Comment Request

AGENCY: Federal Trade Commission (FTC or Commission).

ACTION: Notice.

SUMMARY: The information collection requirements described below will be submitted to the Office of Management and Budget (OMB) for review, as required by the Paperwork Reduction Act (PRA). The FTC seeks public comments on its proposal to extend through March 31, 2017, the current PRA clearance for information collection requirements contained in its Informal Dispute Settlement Procedures Rule. That clearance expires on March 31, 2014.

DATES: Comments must be received on or before February 10, 2014.

ADDRESSES: Interested parties may file a comment online or on paper by following the instructions in the Request for Comments part of the **SUPPLEMENTARY INFORMATION** section below.

FOR FURTHER INFORMATION CONTACT: Requests for copies of the collection of information and supporting documentation should be addressed to Svetlana Gans, Attorney, Division of Marketing Practices, Bureau of Consumer Protection, Federal Trade Commission, Room H–286, 600 Pennsylvania Ave. NW., Washington, DC 20580, (202) 326–3708.

SUPPLEMENTARY INFORMATION:

Proposed Information Collection Activities

Under the Paperwork Reduction Act (PRA), 44 U.S.C. 3501–3520, federal agencies must get OMB approval for each collection of information they conduct, sponsor, or require. "Collection of information" means agency requests or requirements to submit reports, keep records, or provide information to a third party. 44 U.S.C. 3502(3); 5 CFR 1320.3(c). As required by section 3506(c)(2)(A) of the PRA, the FTC is providing this opportunity for

public comment before requesting that OMB extend the existing PRA clearance for the information collection requirements associated with the Commission's Informal Dispute Settlement Procedures Rule (the Dispute Settlement Rule or the Rule), 16 CFR 703 (OMB Control Number 3084–0113).

The FTC invites comments on: (1) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility; (2) the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) ways to minimize the burden of the collection of information on those who are to respond. All comments must be received on or before February 10, 2014.

The Dispute Settlement Rule is one of three rules [1] that the FTC implemented pursuant to requirements of the Magnuson-Moss Warranty Act, 15 U.S.C. 2301 et seq. (Warranty Act or Act).[2] The Dispute Settlement Rule, 16 CFR Part 703, specifies the minimum standards which must be met by any informal dispute settlement mechanism (IDSM) that is incorporated into a written consumer product warranty and which the consumer must use before pursuing legal remedies under the Act in court. In enacting the Warranty Act, Congress recognized the potential benefits of consumer dispute mechanisms as an alternative to the judicial process. Section 110(a) of the Act sets out the Congressional policy to "encourage warrantors to establish procedures whereby consumer disputes are fairly and expeditiously settled through informal dispute settlement mechanisms" and erected a framework for their establishment.[3] As an incentive to warrantors to establish IDSMs, Congress provided in Section 110(a)(3) that warrantors may incorporate into their written consumer product warranties a requirement that a consumer must resort to an IDSM before pursuing a legal remedy under the Act for breach of warranty.[4] To ensure fairness to consumers, however, Congress also directed that, if a warrantor were to incorporate such a "prior resort requirement" into its written warranty, the warrantor must comply with the minimum standards set by the Commission for such IDSMs.[5] Section 110(a)(2) of the Act directed the Commission to establish those minimum standards.[6]

The Dispute Settlement Rule contains standards for IDSMs, including requirements concerning the mechanism's structure (e.g., funding, staffing, and neutrality), the qualifications of staff or decision makers, the mechanism's procedures for resolving disputes (e.g., notification, investigation, time limits for decisions, and follow-up), recordkeeping, and annual audits. The Rule requires that IDSMs establish written operating procedures and provide copies of those procedures upon request.

The Dispute Settlement Rule applies only to those firms that choose to require consumers to use an IDSM. Neither the Rule nor the Act requires warrantors to set up IDSMs. A warrantor is free to set up an IDSM that does not comply with the Rule as long as the warranty does not contain a prior resort requirement.

Dispute Settlement Rule Burden Statement

Total annual hours burden: 8,318 hours (derived from 5,757 hours for recordkeeping + 1,919 hours for reporting + 642 hours for disclosures).

The primary burden from the Dispute Settlement Rule comes from the recordkeeping requirements that apply to IDSMs that are incorporated into a consumer product warranty through a prior resort clause. In its 2010 submission to OMB, staff estimated a total annual hours burden of approximately 13,266 hours (derived from 9,114 hours for recordkeeping + 3,038 hours for reporting + 1,114 hours for disclosure requirements). Although the Rule's information collection requirements have not changed since 2010, staff has adjusted its previous estimates downward for 2013 calculations because the annual audits filed by the two IDSMs currently operating under the Rule indicate that, on average, fewer disputes have been handled since the previous submission to OMB in 2010 (18,227 disputes/year in 2010; 11,514 disputes/year in 2013). This factor results in a decreased annual hours burden estimate for the IDSMs. The calculations underlying staff's new estimates follow.

Recordkeeping: The Rule requires IDSMs to maintain records of each consumer warranty dispute that is referred to it. These case files must include information such as the consumer's contact information, the make and model of the product at issue, all letters or other correspondence submitted by the consumer or warrantor, and all evidence collected to resolve the dispute. Because maintaining individual case records is a necessary function for any IDSM, much of the burden would be incurred in the ordinary course of the IDSM's business. Nonetheless, staff retains its previous estimate that maintaining individual case files imposes an additional burden of 30 minutes per case.

- The amount of work required will depend on the number of dispute resolution proceedings undertaken in each IDSM. A review of the annual audits completed since the prior submission to OMB in 2010 (audits for calendar years 2010 through 2012) indicates that there are two IDSMs operating under the Rule: the BBB AUTO LINE and the National Center for Dispute Settlement (NCDS). The BBB AUTO LINE audits from calendar years 2010 through 2012 indicate that it handled an average of 9,358 disputes each year.[7] Audit reports submitted on behalf of NCDS, which most recently handled disputes on behalf of five automobile manufacturers, indicate that an average of 2,156 disputes were closed each year for calendar years 2010 through 2012.[8]

Based on the above figures, staff estimates that the average number of disputes handled annually by IDSMs covered by the Rule is approximately 11,514 (an average of 9,358 disputes handled by BBB AUTO LINE + an average of 2,156 disputes handled by NCDS).[9] Accordingly, staff estimates the total annual recordkeeping burden attributable to the Rule to be approximately 5,757 hours (11,514 disputes × 30 minutes of burden) ÷ 60 minutes).

Reporting: The Rule requires IDSMs to update indexes, complete semiannual statistical summaries, and submit an annual audit report to the FTC. Staff retains its previous estimate that

[1] The other two rules relate to the information that must appear in any written warranty offered on a consumer product costing more than $15 and the pre-sale availability of warranty terms.

[2] 40 FR 60168 (Dec. 31, 1975).

[3] 15 U.S.C. 2310(a).

[4] 15 U.S.C. 2310(a)(3).

[5] *Id.*

[6] 15 U.S.C. 2310(a)(2).

[7] According to its annual audits, the number of disputes filed each year with the BBB AUTO LINE are 8,821 (2012), 9,177 (2011), and 10,075 (2010). As of its most recent audit in 2012, the BBB AUTO LINE handled disputes on a national basis for ten automobile manufacturers.

[8] According to its annual audits, the number of disputes closed each year with NCDS are 1,505 (2012), 1,359 (2011), and 3,603 (2010).

[9] Because the number of annual disputes filed has fluctuated, staff believes that using the average number of disputes filed for years 2010 through 2012 (the most recent available data) is the best way to project what will happen over the next three years of the OMB clearance for the Rule.

covered entities spend approximately 10 minutes per case for these activities, resulting in a total annual burden of approximately 1,919 hours (11,514 disputes × 10 minutes of burden ÷ 60 minutes).

Disclosure

(a) Warrantors' Disclosure Burden

The Rule requires warrantors that incorporate the use of an IDSM into their warranties to disclose in their warranties a statement about the availability of the IDSM, the contact information for the IDSM, and any "prior resort requirement." [10] Similar to 2010, staff has determined that it would be appropriate to account for the disclosure burden as it relates to warrantors based on two types of additional information that warrantors are required to disclose under the Rule: (1) Information concerning IDSM and its procedures; and (2) information that makes consumers aware of the existence of the IDSM.

First, the Rule requires that warrantors include, either in the warranty or in a separate document accompanying the warranted product, more detailed information concerning the IDSM. Among other things, this information may include: A form addressed to the IDSM, filled out by the consumer, that provides the IDSM with information needed to resolve consumer disputes, a brief description of IDSM procedures, the time limits adhered to by the IDSM, and the types of information the IDSM might require for prompt resolution of the consumer dispute.[11] Because warrantors have the option of providing this additional information in materials separate from the warranty, warrantors likely will bear an additional burden that is separate and apart from whatever burden already imposed on warrantors from drafting warranty terms that comply with Rule 701 (the rule on the disclosure of warranty terms).

Second, the Rule requires that warrantors take steps reasonably calculated to make consumers aware of the IDSM's existence at the time consumers experience warranty disputes.[12] The annual audits—which are required to assess how well warrantors comply with this requirement—demonstrate the different steps warrantors take to inform consumers of the existence of the IDSM procedures. For example, some warrantors create separate pamphlets that deal specifically with the IDSM process. Other warrantors publish entire warranty manuals or booklets, within which several pages are dedicated to the IDSM. Still other warrantors have created posters to alert consumers to the existence of the informal dispute settlement process. Based on this information, it is clear that warrantors bear more than a negligible disclosure burden under the Rule. Accordingly, staff now includes an assessment of the disclosure burden for warrantors in its estimates.

A review of the annual audits of the BBB AUTO LINE and the NCDS indicates that there are approximately fifteen automobile manufacturers covered by the Rule. Staff assumes that each manufacturer spends an average of thirty hours a year creating, revising, and distributing the informational materials necessary to comply with the Rule, resulting in an annual disclosure burden of 450 hours (15 manufacturers × 30 hours).

(b) IDSMs' Disclosure Burden

Under the Rule, a portion of the disclosure burden would be borne by the IDSM itself, which is required to provide to interested consumers, upon request, copies of the various types of information the IDSM possesses, including its annual audits. In addition, consumers who have filed disputes with the IDSM also have a right to copies of their records. IDSMs are permitted to charge for providing both types of information.

Based on discussions with representatives of the IDSMs over the years, staff estimates that the burden imposed by the disclosure requirements is approximately 192 hours per year for the existing IDSMs to provide copies of this information. This estimate draws from the average number of consumers who file claims each year with the IDSMs (11,514) and the assumption that twenty percent of consumers individually request copies of the records pertaining to their disputes, or approximately 2,303 consumers. Staff estimates that copying such records would require approximately 5 minutes per consumer, including a negligible number of requests for copies of the annual audit.[13] Thus, the IDSMs currently operating under the Rule have an estimated total disclosure burden of 192 hours (2,303 consumers × 5 minutes of burden ÷ 60 minutes).

Accordingly, the total PRA-related annual hours burden attributed to the Rule is approximately 8,318 hours (5,757 hours for recordkeeping + 1,919 hours for reporting + 642 hours for disclosures).

Total annual labor cost: $161,000, rounded to the nearest thousand.

Recordkeeping: Staff assumes that IDSMs use clerical staff to comply with the recordkeeping requirements contained in the Rule at an hourly rate of $14.07. Thus, the labor cost associated with the 5,757 annual burden hours for recordkeeping is approximately $86,355 (5,757 burden hours × $15 per hour).

Reporting: Staff assumes that IDSMs also use clerical support staff at an hourly rate of $15 to comply with the reporting requirements. Thus, the labor cost associated with the 1,919 annual burden hours for reporting is approximately $28,785 (1,919 burden hours × $15 per hour).

Disclosure: Staff assumes that the work required to comply with the warrantors' disclosure requirements entails an equal mix of legal, clerical, and graphic design work. The legal work entails ensuring that the warranty information and other materials contain the information required to be disclosed by the Rule, as well as reviewing the annual audits for any recommendations for improving the warrantors' materials, and implementing those recommended changes as appropriate. The graphic design work entails creating pamphlets, brochures, posters, or other materials aimed at making consumers aware of the existence of the IDSM and its procedures. The clerical work entails copying and distributing those informational materials. Staff assumes that one third of the total disclosure hours for warrantors (150 hours) require legal work at a rate of $250 per hour, one third requires graphic design at a rate of $23 per hour, and one third requires clerical work at a rate of $15 per hour. This results in a disclosure labor burden of $43,200 for warrantors ((150 × $250) + (150 × $23) + (150 × $15)).

In addition, staff assumes that IDSMs use clerical support at an hourly rate of $15 to reproduce records and, therefore, the labor cost associated with the 192 annual hours of disclosure burden for IDSMs is approximately $2,880 (192 burden hours × $15 per hour).

Accordingly, the combined total annual labor cost for PRA-related burden under the Rule is approximately $161,220 ($86,355 for recordkeeping +

[10] 16 CFR 703.2(b).

[11] 16 CFR 703.2(c).

[12] 16 CFR 703.2(d).

[13] This estimate includes the additional amount of time required to copy the annual audit upon a consumer's request. However, because staff has determined that a very small minority of consumers request a copy of the annual audit, this estimate is likely an overstatement. In addition, some case files are provided to consumers electronically, which further reduces the paperwork burden borne by the IDSMs.

$28,785 for reporting + $46,080 for disclosures).

Total annual capital or other non-labor costs: $314,000, rounded to the nearest thousand.

Total capital and start-up costs: The Rule imposes no appreciable current capital or start-up costs. The vast majority of warrantors have already developed systems to retain the records and provide the disclosures required by the Rule. Rule compliance does not require the use of any capital goods, other than ordinary office equipment, to which providers already have access.

The Rule imposes only one additional cost on IDSMs operating under the Rule that would not apply to other IDSMs: The annual audit requirement. According to representatives of the IDSMs, the vast majority of costs associated with this requirement consist of the fees paid to the auditors and their staffs to perform the annual audit. Representatives of the IDSMs previously estimated a combined cost of $300,000 for both IDSMs currently operating under the Rule. Staff retains that estimate.

Other non-labor costs: $13,707 in copying costs, based on estimated copying costs of 7 cents per page and several conservative assumptions. Staff estimates that the average dispute-related file contains 35 pages and a typical annual audit file contains approximately 200 pages. As discussed above, staff assumes that twenty percent of consumers using an IDSM currently operating under the Rule (approximately 2,303 consumers) request copies of the records relating to their disputes.

Staff also estimates that a very small minority of consumers request a copy of the annual audit. Staff bases this assumption on (1) the number of consumer requests received by the IDSMs in the past; and (2) the fact that the IDSMs' annual audits are available online. For example, annual audits are available on the FTC's Web site, where consumers may view and or print pages as needed, at no cost to the IDSM. In addition, the Better Business Bureau makes available on its Web site the annual audit of the BBB AUTO LINE. Therefore, staff conservatively estimates that only five percent of consumers using an IDSM covered by the Rule (approximately 576 consumers) will request a copy of the IDSM's audit report.

Thus, the total annual copying cost for dispute-related files is approximately $5,643 (35 pages per file × $.07 per page × 2,303 consumer requests) and the total annual copying cost for annual audit reports is approximately $8,064 (200 pages per audit report × $.07 per page × 576 consumer requests). Accordingly, the total cost attributed to copying under the Rule is approximately $13,707. Thus, the total non-labor cost under the Rule is approximately $314,000 ($300,000 for auditor fees + $13,707 for copying costs).

Request for Comments

You can file a comment online or on paper. Write "Warranty Rules: Paperwork Comment, FTC File No. P044403" on your comment. Your comment—including your name and your state—will be placed on the public record of this proceeding, including, to the extent practicable, on the public Commission Web site, at *http://www.ftc.gov/os/publiccomments.shtm.* As a matter of discretion, the Commission tries to remove individuals' home contact information from comments before placing them on the Commission Web site.

Because your comment will be made public, you are solely responsible for making sure that your comment does not include any sensitive personal information, like anyone's Social Security number, date of birth, driver's license number or other state identification number or foreign country equivalent, passport number, financial account number, or credit or debit card number. You are also solely responsible for making sure that your comment does not include any sensitive health information, like medical records or other individually identifiable health information. In addition, do not include any "[t]rade secret or any commercial or financial information which is * * * privileged or confidential," as discussed in Section 6(f) of the FTC Act, 15 U.S.C. 46(f), and FTC Rule 4.10(a)(2), 16 CFR 4.10(a)(2). In particular, do not include competitively sensitive information such as costs, sales statistics, inventories, formulas, patterns, devices, manufacturing processes, or customer names.

If you want the Commission to give your comment confidential treatment, you must file it in paper form, with a request for confidential treatment, and you must follow the procedure explained in FTC Rule 4.9(c), 16 CFR 4.9(c).[14] Your comment will be kept confidential only if the FTC General Counsel, in his or her sole discretion, grants your request in accordance with the law and the public interest.

Postal mail addressed to the Commission is subject to delay due to heightened security screening. As a result, the Commission encourages you to submit your comments online. To make sure that the Commission considers your online comment, you must file it at *https://ftcpublic.commentworks.com/ftc/idsrpra* by following the instructions on the web-based form. If this Notice appears at *http://www.regulations.gov*, you also may file a comment through that Web site.

If you file your comment on paper, write "Warranty Rules: Paperwork Comment, FTC File No. P044403" on your comment and on the envelope, and mail or deliver it to the following address: Federal Trade Commission, Office of the Secretary, Room H–113 (Annex J), 600 Pennsylvania Avenue NW., Washington, DC 20580. If possible, submit your paper comment to the Commission by courier or overnight service.

Visit the Commission Web site at *http://www.ftc.gov* to read this Notice. The FTC Act and other laws that the Commission administers permit the collection of public comments to consider and use in this proceeding as appropriate. The Commission will consider all timely and responsive public comments that it receives on or before February 10, 2014. You can find more information, including routine uses permitted by the Privacy Act, in the Commission's privacy policy, at *http://www.ftc.gov/ftc/privacy.htm.*

David C. Shonka,

Principal Deputy General Counsel.

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[14] In particular, the written request for confidential treatment that accompanies the comment must include the factual and legal basis for the request, and must identify the specific portions of the comment to be withheld from the public record. See FTC Rule 4.9(c), 16 CFR 4.9(c).

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Community Living

Agency Information Collection Activities; Proposed Collection; Comment Request; National Survey of Older Americans Act Participants

AGENCY: Administration for Community Living, HHS.

ACTION: Notice.

SUMMARY: The Administration for Community Living (ACL) is announcing an opportunity for public comment on the proposed collection of certain information by the agency. Under the Paperwork Reduction Act of 1995 (the PRA), Federal agencies are required to

publish notice in the **Federal Register** concerning each proposed collection of information, including each proposed extension of an existing collection of information, and to allow 60 days for public comment in response to the notice. This notice solicits comments on the information collection requirements relating to the information collection requirements contained in consumer assessment surveys that are used by ACL to measure program performance for programs funded under Title III of the Older Americans Act.

DATES: Submit written or electronic comments on the collection of information by February 10, 2014.

ADDRESSES: Submit electronic comments on the collection of information to: *elena.fazio@acl.hhs.gov.*

Submit written comments on the collection of information to Elena Fazio, Administration for Community Living, Office of Performance and Evaluation, Washington, DC 20201.

FOR FURTHER INFORMATION CONTACT: Elena Fazio, 202–357–3583.

SUPPLEMENTARY INFORMATION: Under the PRA (44 U.S.C. 3501–3520), Federal agencies must obtain approval from the Office of Management and Budget (OMB) for each collection of information they conduct or sponsor. "Collection of information" is defined in 44 U.S.C. 3502(3) and 5 CFR 1320.3(c) and includes agency request or requirements that members of the public submit reports, keep records, or provide information to a third party. Section 3506(c)(2)(A) of the PRA (44 U.S.C. 3506(c)(2)(A)) requires Federal agencies to provide a 60-day notice in the **Federal Register** concerning each proposed collection of information, including each proposed extension of an existing collection of information, before submitting the collection to OMB for approval. To comply with this requirement, ACL is publishing notice of the proposed collection of information set forth in this document. With respect to the following collection of information, ACL invites comments on: (1) Whether the proposed collection of information is necessary for the proper performance of ACL's functions, including whether the information will have practical utility; (2) the accuracy of ACL's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques when appropriate, and other forms of information technology.

The National Survey of Older Americans Act (OAA) Participants information collection, which builds on earlier national pilot studies and surveys, as well as performance measurement tools developed by ACL grantees in the Performance Outcomes Measures Project (POMP), will include consumer assessment surveys for the Congregate and Home-delivered meal nutrition programs; Case Management, Homemaker, and Transportation Services; and the National Family Caregiver Support Program. This information will be used by ACL to track performance outcome measures; support budget requests; comply with GPRA Modernization Act of 2010 (GPRAMA) reporting requirements; provide national benchmark information; and inform program development and management initiatives. Descriptions of previous National Surveys of OAA Participants can be found under the section on OAA Performance Information on ACL's Web site at: *http://www.aoa.gov/AoARoot/Program_Results/OAA_Performance.aspx.* Copies of the survey instruments and data from previous National Surveys of OAA Participants can be found and queried using the AGing Integrated Database (AGID) at *http://www.agid.acl.gov/.* The proposed Ninth National Survey entitled National Survey of OAA Participants draft 2013 may be found on the ACL Web site at *http://www.aoa.gov/AoARoot/Program_Results/OAA_Performance.aspx.* ACL estimates the burden of this collection of information as follows: *Respondents:* Individuals; *Number of Respondents:* 6,250; *Number of Responses per Respondent:* one; *Average Burden per Response:* 6000 at 40 minutes, 250 at 4 hours; *Total Burden:* 5,000.

Dated: December 5, 2013.

Kathy Greenlee,

Administrator and Assistant Secretary for Aging.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. FDA–2013–N–0853]

Agency Information Collection Activities; Submission for Office of Management and Budget Review; Comment Request; Medical Devices Current Good Manufacturing Practice Quality System Regulation

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing that a proposed collection of information has been submitted to the Office of Management and Budget (OMB) for review and clearance under the Paperwork Reduction Act of 1995 (the PRA).

DATES: Fax written comments on the collection of information by January 9, 2014.

ADDRESSES: To ensure that comments on the information collection are received, OMB recommends that written comments be faxed to the Office of Information and Regulatory Affairs, OMB, Attn: FDA Desk Officer, FAX: 202–395–7285, or emailed to *oira_submission@omb.eop.gov.* All comments should be identified with the OMB control number 0910–0073. Also include the FDA docket number found in brackets in the heading of this document.

FOR FURTHER INFORMATION CONTACT: FDA PRA Staff, Office of Operations, Food and Drug Administration, 1350 Piccard Dr., PI50–400B, Rockville, MD 20850, *PRAStaff@fda.hhs.gov.*

SUPPLEMENTARY INFORMATION: In compliance with 44 U.S.C. 3507, FDA has submitted the following proposed collection of information to OMB for review and clearance.

Medical Devices Current Good Manufacturing Practice Quality System Regulation—21 CFR Part 820 (OMB Control Number 0910–0073)—Extension

Under section 520(f) of the Federal Food, Drug, and Cosmetic Act (the FD&C Act) (21 U.S.C. 360j(f)), the Secretary of the Department of Health and Human Services has the authority to prescribe regulations requiring that the methods used in, and the facilities and controls used for, the manufacture, preproduction design validation (including a process to assess the performance of a device but not including an evaluation of the safety

and effectiveness of a device), packing, storage, and installation of a device conform to current good manufacturing practice (CGMP), as described in such regulations, to assure that the device will be safe and effective and otherwise in compliance with the FD&C Act.

The CGMP/quality system (QS) regulation implementing authority provided by this statutory provision is found under part 820 (21 CFR part 820) and sets forth basic CGMP requirements governing the design, manufacture, packing, labeling, storage, installation, and servicing of all finished medical devices intended for human use. The authority for this regulation is covered under sections 501, 502, 510, 513, 514, 515, 518, 519, 520, 522, 701, 704, 801, and 803 of the FD&C Act (21 U.S.C. 351, 352, 360, 360c, 360d, 360e, 360h, 360i, 360j, 360l, 371, 374, 381, and 383). The CGMP/QS regulation includes requirements for purchasing and service controls, clarifies recordkeeping requirements for device failure and complaint investigations, clarifies requirements for verifying/validating production processes and process or product changes, and clarifies requirements for product acceptance activities quality data evaluations and corrections of nonconforming product/quality problems.

Requirements are compatible with specifications in the international standards "ISO 9001: Quality Systems Model for Quality Assurance in Design/Development, Production, Installation, and Servicing." The CGMP/QS information collections will assist FDA inspections of manufacturers for compliance with QS requirements encompassing design, production, installation, and servicing processes.

Section 820.20(a) through (e) requires management with executive responsibility to establish, maintain, and/or review the following topics: (1) The quality policy, (2) the organizational structure, (3) the quality plan, and (4) the quality system procedures of the organization.

Section 820.22 requires the conduct and documentation of QS audits and re-audits. Section 820.25(b) requires the establishment of procedures to identify training needs and documentation of such training.

Section 820.30(a)(1) and (b) through (j) requires, in respective order, the establishment, maintenance, and/or documentation of the following topics: (1) Procedures to control design of class III and class II devices and certain class I devices as listed therein; (2) plans for design and development activities and updates; (3) procedures identifying, documenting, and approving design input requirements; (4) procedures defining design output, including acceptance criteria, and documentation of approved records; (5) procedures for formal review of design results and documentation of results in the design history file (DHF); (6) procedures for verifying device design and documentation of results and approvals in the DHF; (7) procedures for validating device design, including documentation of results in the DHF; (8) procedures for translating device design into production specifications; (9) procedures for documenting, verifying, and validating approved design changes before implementation of changes; and (10) the records and references constituting the DHF for each type of device.

Section 820.40 requires manufacturers to establish and maintain procedures controlling approval and distribution of required documents and document changes.

Section 820.40(a) and (b) requires the establishment and maintenance of procedures for the review, approval, issuance, and documentation of required records (documents) and changes to those records.

Section 820.50(a) and (b) requires the establishment and maintenance of procedures and requirements to ensure service and product quality, records of acceptable suppliers, and purchasing data describing specified requirements for products and services.

Sections 820.60 and 820.65 require, respectively, the establishment and maintenance of procedures for identifying all products from receipt to distribution and for using control numbers to track surgical implants and life-sustaining or supporting devices and their components.

Section 820.70(a) through (e), (g)(1) through (g)(3), (h), and (i) requires the establishment, maintenance, and/or documentation of the following topics: (1) Process control procedures; (2) procedures for verifying or validating changes to specification, method, process, or procedure; (3) procedures to control environmental conditions and inspection result records; (4) requirements for personnel hygiene; (5) procedures for preventing contamination of equipment and products; (6) equipment adjustment, cleaning, and maintenance schedules; (7) equipment inspection records; (8) equipment tolerance postings, procedures for utilizing manufacturing materials expected to have an adverse effect on product quality; and (9) validation protocols and validation records for computer software and software changes.

Sections 820.72(a), (b)(1), and (b)(2) and 820.75(a) through (c) require, respectively, the establishment, maintenance, and/or documentation of the following topics: (1) Equipment calibration and inspection procedures; (2) national, international, or in-house calibration standards; (3) records that identify calibrated equipment and next calibration dates; (4) validation procedures and validation results for processes not verifiable by inspections and tests; (5) procedures for keeping validated processes within specified limits; (6) records for monitoring and controlling validated processes; and (7) records of the results of revalidation where necessitated by process changes or deviations.

Sections 820.80(a) through (e) and 820.86, respectively, require the establishment, maintenance, and/or documentation of the following topics: (1) Procedures for incoming acceptance by inspection, test, or other verification; (2) procedures for ensuring that in process products meet specified requirements and the control of product until inspection and tests are completed; (3) procedures for, and records that show, incoming acceptance or rejection is conducted by inspections, tests or other verifications; (4) procedures for, and records that show, finished devices meet acceptance criteria and are not distributed until device master record (DMR) activities are completed; (5) records in the device history record (DHR) showing acceptance dates, results, and equipment used; and (6) the acceptance/rejection identification of products from receipt to installation and servicing.

Sections 820.90(a), (b)(1), and (b)(2) and 820.100 require, respectively, the establishment, maintenance and/or documentation of the following topics: (1) Procedures for identifying, recording, evaluating, and disposing of nonconforming product; (2) procedures for reviewing and recording concessions made for, and disposition of, nonconforming product; (3) procedures for reworking products, evaluating possible adverse rework effect and recording results in the DHR; (4) procedures and requirements for corrective and preventive actions, including analysis, investigation, identification and review of data, records, causes, and results; and (5) records for all corrective and preventive action activities.

Section 820.100(a)(1) through (a)(7) states that procedures and requirements shall be established and maintained for corrective/preventive actions, including the following: (1) Analysis of data from process, work, quality, servicing

records, investigation of nonconformance causes; (2) identification of corrections and their effectiveness; (3) recording of changes made; and (4) appropriate distribution and managerial review of corrective and preventive action information. Section 820.120 states that manufacturers shall establish/maintain procedures to control labeling storage/application; and examination/release for storage and use, and document those procedures.

Sections 820.120(b) and (d), 820.130, 820.140, 820.150(a) and (b), 820.160(a) and (b), and 820.170(a) and (b), respectively, require the establishment, maintenance, and/or documentation of the following topics: (1) Procedures for controlling and recording the storage, examination, release, and use of labeling; (2) the filing of labels/labeling used in the DHR; (3) procedures for controlling product storage areas and receipt/dispatch authorizations; (4) procedures controlling the release of products for distribution; (5) distribution records that identify consignee, product, date, and control numbers; and (6) instructions, inspection and test procedures that are made available, and the recording of results for devices requiring installation.

Sections 820.180(b) and (c), 820.181(a) through (e), 820.184(a) through (f), and 820.186 require, respectively, the maintenance of records that are: (1) Retained at prescribed site(s), made readily available and accessible to FDA and retained for the device's life expectancy or for 2 years; (2) contained or referenced in a DMR consisting of device, process, quality assurance, packaging and labeling, and installation, maintenance, and servicing specifications and procedures; (3) contained in a DHR and demonstrate the manufacture of each unit, lot, or batch of product in conformance with DMR and regulatory requirements, include manufacturing and distribution dates, quantities, acceptance documents, labels and labeling, control numbers; and (4) contained in a quality system record, consisting of references, documents, procedures, and activities not specific to particular devices.

Sections 820.198(a) through (c) and 820.200(a) through (d), respectively, require the establishment, maintenance, and/or documentation of the following topics: (1) Complaint files and procedures for receiving, reviewing, and evaluating complaints; (2) complaint investigation records identifying the device, complainant, and relationship of the device to the incident; (3) complaint records that are reasonably accessible to the manufacturing site or at prescribed sites; (4) procedures for performing and verifying that device servicing requirements are met and that service reports involving complaints are processed as complaints; and (5) service reports that record the device, service activity, and test and inspection data.

Section 820.250 requires the establishment and maintenance of procedures to identify valid statistical techniques necessary to verify process and product acceptability; and sampling plans, when used, which are written and based on valid statistical rationale; and procedures for ensuring adequate sampling methods.

The CGMP/QS regulation added design and purchasing controls, modified previous critical device requirements, revised previous validation and other requirements, and harmonized device CGMP requirements with QS specifications in the international standard "ISO 9001: Quality Systems Model for Quality Assurance in Design/Development, Production, Installation, and Servicing." The rule does not apply to manufacturers of components or parts of finished devices, or to manufacturers of human blood and blood components subject to 21 CFR part 606. With respect to devices classified in class I, design control requirements apply only to class I devices listed in § 820.30(a)(2) of the regulation. The rule imposes burden upon: (1) Finished device manufacturer firms, which are subject to all recordkeeping requirements; (2) finished device contract manufacturers, specification developers; and (3) re-packer, re-labelers, and contract sterilizer firms, which are subject only to requirements applicable to their activities. In addition, remanufacturers of hospital single-use devices (SUDs) are now to be considered to have the same requirements as manufacturers in regard to the regulation. The establishment, maintenance, and/or documentation of procedures, records, and data required by the regulation assists FDA in determining whether firms are in compliance with CGMP requirements, which are intended to ensure that devices meet their design, production, labeling, installation, and servicing specifications and, thus are safe, effective, and suitable for their intended purpose. In particular, compliance with CGMP design control requirements should decrease the number of design-related device failures that have resulted in deaths and serious injuries.

The CGMP/QS regulation applies to approximately 25,986 respondents. A query of the Agency's registration and listing database shows that approximately 15,113 domestic and 10,873 foreign establishments are respondents to this information collection.[1] These recordkeepers consist of manufacturers, subject to all requirements and contract manufacturers, specification developers, re-packers, re-labelers, and contract sterilizers, subject only to requirements applicable to their activities. Hospital remanufacturers of SUDs are now defined to be manufacturers under guidance issued by FDA's Center for Devices and Radiological Health, Office of Surveillance and Biometrics. Respondents to this collection have no reporting activities, but must make required records available for review or copying during FDA inspection. Except for manufacturers, not every type of firm is subject to every CGMP/QS requirement. For example, all are subject to Quality Policy (§ 820.20(a)), Document Control (§ 820.40), and other requirements, whereas only manufacturers and specification developers are subject to subpart C, Design Controls. The PRA burden placed on the 25,986 establishments is an average burden.

In the **Federal Register** of July 31, 2013 (78 FR 46347), FDA published a 60-day notice requesting public comment on the proposed collection of information to which one comment was received.

The comment agreed that the information has practical utility but requested clarification regarding whether records gathered in electronic format will be made available outside of FDA.

Disclosure of QS records is governed by the Freedom of Information Act (5 U.S.C. 552) and FDA's Public Information regulation at part 20 (21 CFR part 20). Section 820.180(a) of the CGMP/QS regulation provides that records deemed confidential by manufacturers may be marked to aid FDA in determining what information may be disclosed under part 20. This applies to both paper and electronic QS records.

Another part of the comment expressed a belief that "the burden on industry of complying with FDA requests for information during an inspection is based on data FDA maintains on actual inspections; the estimates are averages" and that "it is unclear how FDA arrived at these estimates since they seem high when spread out across all registered device manufacturers."

The comment assumes that the burden estimate includes only the burden of responding to information requests during an inspection. However,

[1] Based on fiscal year 2012 data.

the estimates also include the burden of collecting, maintaining, and retaining the records. The comment's suggestion of 3.5 hours per year for "responding to information requests during an inspection" does not appear to include the burden of collecting, maintaining, and retaining the records and is based on the experience of only one segment of industry. Except for manufacturers, not every type of firm is subject to every CGMP/QS requirement. For example, all are subject to Quality Policy (§ 820.20(a)), Document Control (§ 820.40), and other requirements, whereas only manufacturers and specification developers are subject to subpart C, Design Controls. The estimated burden is, therefore, an average burden.

As a basis for its burden estimates, the Agency relied in part on certain information found in a study originally developed under FDA contract by Eastern Research Group, Inc., when the CGMP/QS regulation became final. The study was submitted to OMB as part of the original PRA approval and is part of the Federal docket. The Agency performs ongoing reviews of the information collection burden as required under the PRA for purposes of evaluating burden associated with its information collection requests and has done so for the purpose of extending the recordkeeping requirements associated with the CGMP/QS regulations. The commenter believes that the estimates the Agency provides are too high. However, the commenter does not offer an alternative methodology for estimating that the Agency may review. For these reasons we have not changed the hourly burden estimate.

The comment also suggests that FDA did not make clear what was meant by the "quality, utility, and clarity of the collected information" in the 60-day notice requesting public comment on the information collection. "Quality, utility, and clarity" have the same meaning as in OMB's regulations at 5 CFR 1320.8(d)(1)(iii).

Another part of the comment addressed concerns about the use of electronic means to fulfill the information collection requirements. The comment seems to assume that it would take additional time to provide electronic records at the request of an inspector because records that are not kept in electronic format would need to be scanned in order to fulfill the inspector's request. The comment also requests that FDA "publish procedures for the use of any electronic submissions which may be contemplated" to help the commenter allay concerns about misuse of photographs and electronic submissions.

At this time, fulfillment of the information collection via electronic means is optional. We estimate that approximately 75 percent of respondents currently use some form of electronic recordkeeping to fulfill the information collection. Firms may use appropriate technology in accordance with FDA's "Electronic Records; Electronic Signatures" final rule (62 FR 13430; March 20, 1997) to comply with the CGMP/QS recordkeeping requirements. However, respondents may make the records available in paper format. There is no additional requirement that respondents convert existing paper records to an electronic format.

The comment also requests an explanation regarding the citation of the standard "ISO 9001" in the 60-day notice for public comment, rather than "ISO 13485."

In the notice, we included background information regarding the Quality System Regulation (part 820). We referenced "ISO 9001: Quality Systems Model for Quality Assurance in Design/Development, Production, Installation, and Servicing" because at the time the Quality System Regulation was issued and the preamble was written, ISO 9001 was the current standard.

Additionally, the comment requests clarification regarding the Agency's contemplation of new submissions of information and includes suggestions related to such new submissions.

At this time, there is no new requirement for submission of information under the QS regulations. Any future new requirements for information collection will be made available for public comment as required by 5 CFR part 1320.

The Center for Devices and Radiological Health is proactive in ensuring that the medical device industry and other affected individuals are made aware of ongoing issues relating to the CGMP/QS regulations. FDA's Medical Device GMP/QS experts have participated in numerous conferences and seminars relating to the CGMP/QS regulatory requirements. During these sessions, our GMP/QS experts share information through speeches and panel discussions that provide a forum for open discussion. During these discussions guidance and direction is often given to the audience to help them understand their regulatory responsibilities under the GMP/QS regulation. In addition, issues are sometimes identified by the audience that provides the Agency areas that we may need to clarify to affected individuals.

FDA estimates the burden of this collection of information as follows:

TABLE 1—ESTIMATED ANNUAL RECORDKEEPING BURDEN [1]

Activity/21 CFR Section	Number of recordkeepers	Number of records per recordkeeper	Total annual records	Average burden per recordkeeping	Total hours
Quality policy—820.20(a)	25,986	1	25,986	7	181,902
Organization—820.20(b)	25,986	1	25,986	4	103,944
Management review—820.20(c)	25,986	1	25,986	6	155,916
Quality planning—820.20(d)	25,986	1	25,986	10	259,860
Quality system procedures—820.20(e)	25,986	1	25,986	10	259,860
Quality audit—820.22	25,986	1	25,986	33	857,538
Training—820.25(b)	25,986	1	25,986	13	337,818
Design procedures—820.30(a)(1)	25,986	1	25,986	2	51,972
Design and development planning—820.30(b)	25,986	1	25,986	6	155,916
Design input—820.30(c)	25,986	1	25,986	2	51,972
Design output—820.30(d)	25,986	1	25,986	2	51,972
Design review—820.30(e)	25,986	1	25,986	23	597,678
Design verification—820.30(f)	25,986	1	25,986	37	961,482
Design validation—820.30(g)	25,986	1	25,986	37	961,482
Design transfer—820.30(h)	25,986	1	25,986	3	77,958
Design changes—820.30(i)	25,986	1	25,986	17	441,762

TABLE 1—ESTIMATED ANNUAL RECORDKEEPING BURDEN [1]—Continued

Activity/21 CFR Section	Number of recordkeepers	Number of records per recordkeeper	Total annual records	Average burden per recordkeeping	Total hours
Design history file—820.30(j)	25,986	1	25,986	3	77,958
Document controls—820.40	25,986	1	25,986	9	233,874
Documentation approval and distribution and document changes—820.40(a) and (b)	25,986	1	25,986	2	51,972
Purchasing controls—820.50(a)	25,986	1	25,986	22	571,692
Purchasing data—820.50(b)	25,986	1	25,986	6	155,916
Identification—820.60	25,986	1	25,986	1	25,986
Traceability—820.65	25,986	1	25,986	1	25,986
Production and process controls—820.70(a)	25,986	1	25,986	2	51,972
Production and process changes and environmental control—820.70(b) and (c)	25,986	1	25,986	2	51,972
Personnel—820.70(d)	25,986	1	25,986	3	77,958
Contamination control—820.70(e)	25,986	1	25,986	2	51,972
Equipment maintenance schedule, inspection, and adjustment—820.70(g)(1) to (g)(3)	25,986	1	25,986	1	25,986
Manufacturing material—820.70(h)	25,986	1	25,986	2	51,972
Automated processes—820.70(i)	25,986	1	25,986	8	207,888
Control of inspection, measuring, and test equipment—820.72(a)	25,986	1	25,986	.5	129,930
Calibration procedures, standards, and records—820.72(b)(1) to (b)(2)	25,986	1	25,986	1	25,986
Process validation—820.75(a)	25,986	1	25,986	3	77,958
Validated process parameters, monitoring, control methods, and data—820.75(b)	25,986	1	25,986	1	25,986
Revalidation—820.75(c)	25,986	1	25,986	1	25,986
Acceptance activities—820.80(a) to (e)	25,986	1	25,986	5	129,930
Acceptance status—820.86	25,986	1	25,986	1	25,986
Control of nonconforming product—820.90(a)	25,986	1	25,986	5	129,930
Nonconforming product review/disposition procedures and rework procedures—820.90(b)(1) to (b)(2)	25,986	1	25,986	5	129,930
Procedures for corrective/preventive actions—820.100(a)(1) to (a)(7)	25,986	1	25,986	12	311,832
Corrective/preventive activities—820.100(b)	25,986	1	25,986	1	25,986
Labeling procedures—820.120(b)	25,986	1	25,986	1	25,986
Labeling documentation—820.120(d)	25,986	1	25,986	1	25,986
Device packaging—820.130	25,986	1	25,986	1	25,986
Handling—820.140	25,986	1	25,986	6	155,916
Storage—820.150(a) and (b)	25,986	1	25,986	6	155,916
Distribution procedures and records—820.160(a) and (b)	25,986	1	25,986	1	25,986
Installation—820.170	25,986	1	25,986	2	51,972
Record retention period—820.180(b) and (c)	25,986	1	25,986	2	51,972
Device master record—820.181	25,986	1	25,986	1	25,986
Device history record—820.184	25,986	1	25,986	1	25,986
Quality system record—820.186	25,986	1	25,986	1	25,986
Complaint files—820.198(a), (c), and (g)	25,986	1	25,986	5	129,930
Servicing procedures and reports—820.200(a) and (d)	25,986	1	25,986	3	77,958
Statistical techniques procedures and sampling plans—820.250	25,986	1	25,986	1	25,986
Total					9,043,128

[1] There are no capital costs or operating and maintenance costs associated with this collection of information.

Dated: December 3, 2013.

Leslie Kux,

Assistant Commissioner for Policy.

[FR Doc. 2013–29394 Filed 12–9–13; 8:45 am]

BILLING CODE 4160–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. FDA–2013–D–1478]

Agency Information Collection Activities; Proposed Collection; Comment Request; Providing Waiver-Related Materials in Accordance With Draft Guidance for Industry on Providing Postmarket Periodic Safety Reports in the International Conference on Harmonisation E2C(R2) Format

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing an opportunity for public comment on the proposed collection of certain information by the Agency. Under the Paperwork Reduction Act of 1995 (the PRA), Federal Agencies are required to publish notice in the **Federal Register** concerning each proposed collection of information and to allow 60 days for public comment in response to the notice. This notice solicits comments on the information collection associated with the submission of periodic safety reports as described in the guidance entitled "Periodic Benefit-Risk Evaluation Report (PBRER) (E2C(R2))." The guidance was prepared under the auspices of the International Conference on Harmonisation (ICH) of Technical Requirements for Registration of Pharmaceuticals for Human Use, and describes the format, content, and timing of a PBRER for an approved drug or biologic. This notice also solicits comments on the information collection associated with the submission of waiver-related materials as described in the draft guidance entitled "Providing Postmarket Periodic Safety Reports in the ICH E2C(R2) Format." The draft guidance is intended to inform applicants of the conditions under which FDA will exercise its waiver authority to permit applicants to submit an ICH E2C(R2) PBRER in place of the ICH E2C(R1) Periodic Safety Update Report (PSUR), U.S. periodic adverse drug experience report (PADER), or U.S. periodic adverse experience report (PAER), to satisfy the periodic safety reporting requirements in FDA regulations.

DATES: Submit either electronic or written comments on the collection of information by February 10, 2014.

ADDRESSES: Submit electronic comments on the collection of information to *http://www.regulations.gov.* Submit written comments on the collection of information to the Division of Dockets Management (HFA–305), Food and Drug Administration, 5630 Fishers Lane., Rm. 1061, Rockville, MD 20852. All comments should be identified with the docket number found in brackets in the heading of this document.

FOR FURTHER INFORMATION CONTACT: FDA PRA Staff, Office of Operations, Food and Drug Administration,1350 Piccard Dr.,PI50–400B, Rockville, MD 20850, *PRAStaff@fda.hhs.gov.*

SUPPLEMENTARY INFORMATION: Under the PRA (44 U.S.C. 3501–3520), Federal Agencies must obtain approval from the Office of Management and Budget (OMB) for each collection of information they conduct or sponsor. "Collection of information" is defined in 44 U.S.C. 3502(3) and 5 CFR 1320.3(c) and includes Agency requests or requirements that members of the public submit reports, keep records, or provide information to a third party. Section 3506(c)(2)(A) of the PRA (44 U.S.C. 3506(c)(2)(A)) requires Federal Agencies to provide a 60-day notice in the **Federal Register** concerning each proposed collection of information before submitting the collection to OMB for approval. To comply with this requirement, FDA is publishing notice of the proposed collection of information set forth in this document.

With respect to the following collection of information, FDA invites comments on these topics: (1) Whether the proposed collection of information is necessary for the proper performance of FDA's functions, including whether the information will have practical utility; (2) the accuracy of FDA's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques, when appropriate, and other forms of information technology.

Providing Waiver-Related Materials in Accordance With International Conference on Harmonisation—Periodic Benefit-Risk Evaluation Report (E2C(R2)) Guidance

I. Background

ICH was organized to provide an opportunity for tripartite harmonization initiatives to be developed with input from both regulatory and industry representatives. ICH is concerned with harmonization of technical requirements for the registration of pharmaceutical products among three regions: The European Union, Japan, and the United States. In January 2012, the ICH Steering Committee agreed that the "E2C(R2) Periodic Benefit-Risk Evaluation Report" draft guidance (the draft PBRER guidance) should be made available for public comment. The PBRER is intended to provide a common standard for periodic reporting on approved drugs or biologics among the ICH regions. The harmonized PBRER is intended to promote a consistent approach to periodic postmarket safety reporting among the ICH regions and to enhance efficiency by reducing the number of reports generated for submission to the regulatory authorities.

The draft PBRER guidance revises an earlier version of this guidance issued in 1997 with an addendum issued in 2004. In the **Federal Register** of April 11, 2012 (77 FR 21782), FDA announced the availability of the draft PBRER guidance for public comment. FDA presented the comments received as part of the considerations by the E2C(R2) Expert Working Group for revisions of the guidance. A final version of the guidance was subsequently endorsed by the ICH on November 15, 2012, and published as the ICH harmonized tripartite guideline "Periodic Benefit-Risk Evaluation Report (PBRER) E2C(R2)" (the PBRER guidance), available at *http://www.ich.org/products/guidelines/efficacy/article/efficacy-guidelines.html.* FDA anticipates issuing final guidance on this topic that is consistent with the final ICH document, published November 2012, and thus is seeking PRA approval for information collections consistent with that document.

The April 11, 2012, **Federal Register** notice stated that the draft PBRER guidance includes information collection provisions that are subject to review by OMB under the PRA, and that before publication of the final guidance document, FDA intends to solicit public comment and obtain OMB approval for any information collections recommended in the guidance that are

new or that would represent material modifications to previously approved collections of information found in FDA regulations. This **Federal Register** notice begins the process of requesting public comment and obtaining OMB approval for collections of information associated with reporting in accordance with the PBRER guidance.

II. Voluntary Preparation of Periodic Safety Reports in Conformance With the ICH E2C(R2) PBRER Guidance, in Lieu of PADERs/PAERs Required Under 21 CFR 314.80(c)(2) and 600.80(c)(2)

FDA currently has OMB approval for the required submission of PADERs for drugs subject to a new drug application (NDA) or an abbreviated new drug application (ANDA) (§ 314.80(c)(2) (21 CFR 314.80(c)(2)); OMB control number 0910–0230), and for the required submission of PAERs for drugs subject to a biologics license application (BLA) (§ 600.80(c)(2) (21 CFR 600.80(c)(2)); OMB control number 0910–0308). Such reports include, for the reporting interval, reports of serious, expected adverse experiences and all non-serious adverse experiences and an index of these reports, a narrative summary and analysis of adverse experiences, an analysis of the 15-day Alert reports submitted during the reporting interval, and a history of actions taken because of adverse experiences. Applicants must submit each PADER/PAER to FDA quarterly for the first 3 years after the product is approved by FDA and annually thereafter. As described in the supporting documentation under OMB control numbers 0910–0230 and 0910–0308, FDA currently has OMB approval for approximately 60 hours for the preparation and submission of each PADER under § 314.80(c)(2) and 28 hours for the preparation and submission of each PAER under § 600.80(c)(2).

There is considerable overlap in the information required under §§ 314.80(c)(2) and 600.80(c)(2) and the information requested in a periodic safety report using the ICH E2C(R2) PBRER format. As a result, and as discussed further in this document, FDA, in the **Federal Register** of April 8, 2013 (78 FR 20926), announced the availability of a draft guidance to indicate its willingness to accept postmarket periodic safety reports using the ICH PBRER format in lieu of the specific reports described in FDA regulations. (As described further in this document, the April 2013 draft guidance also addresses waiver-related information that should be submitted to FDA by companies who wish to exercise this alternative reporting.)

Companies who submit periodic reports on the same drug to multiple regulators, including not only the United States, but, also the European Union, Japan, and regulators in other countries who have elected to adopt the ICH standards, may find it in their interest to prepare a single PBRER, rather than preparing multiple types of reports for multiple regulators. Companies who choose to submit a PBRER to FDA would include some information beyond that required by FDA regulations, including worldwide marketing approval status; estimated exposure and use patterns; information from clinical trials, non-interventional studies, non-clinical data, and literature; benefit evaluation, and benefit-risk analysis for approved indications, and should use a particular format described in that guidance.

FDA is not proposing to require submission of the PBRER; applicants subject to periodic safety reporting requirements under FDA regulations could choose to continue to submit the reports as specified in those regulations, and would be permitted to alternate between submission of reports in the PBRER format and submission of reports as specified in FDA regulations with an approved waiver. Based on FDA's experience with submission of periodic safety reports under previous ICH periodic reporting guidance, FDA believes that applicants would elect to submit the PBRER to FDA only in cases where they are also submitting that report to other regulatory authorities, some of which have underlying legal requirements that closely parallel the elements of the PBRER. For this reason, FDA believes that the additional burden associated with preparation of a PBRER in lieu of existing PADERs/PAERs is not attributable to the proposed collection of information by FDA, but rather is a "usual and customary" expenditure of time, effort, and financial resources that would be "incurred by persons in the normal course of their activities," and thus is excluded from the calculation of burden under the PRA (5 CFR 1320.5(b)(2).) Cf. 5 CFR 1320.5(b)(3) (permitting exclusion from Federal burden of burden incurred in complying with an information collection that is also conducted by a State or local government if the State or local requirement would be imposed even in the absence of a Federal requirement).

We therefore believe that the existing estimate of burden for submission of periodic safety reports, approved under OMB control numbers 0910–0230 and 0910–0308, would be unchanged by this proposed collection, which would permit, but not require, the substitution of a PBRER for the periodic safety report otherwise required. We request comment on the assumption that all PBRERs submitted to FDA would be prepared in any event to submit to other jurisdictions, or alternatively, on the number of PBRERs that applicants will choose to prepare solely for submission to FDA, and the estimated burden for submitting such a report.

III. Materials Related to Waivers Permitting Submission of a PBRER To Satisfy the Periodic Safety Reporting Requirements in §§ 314.80(c)(2) and 600.80(c)(2)

Because FDA regulations in §§ 314.80(c)(2) and 600.80(c)(2) include specific requirements for periodic safety reports, in order for an applicant to submit an alternative report, such as the PBRER, for a given product, FDA must grant a waiver. Existing regulations permit applicants to request waivers of any postmarketing safety reporting requirement, and the information collections associated with such waiver requests generally are approved under existing control numbers. (See § 314.90(a), waivers for drugs subject to NDAs and ANDAs (approved under OMB control number 0910–0001); and § 600.90(a), waivers for products subject to BLAs (approved under OMB control number 0910–0308).)

In the **Federal Register** of April 8, 2013, FDA announced the availability of a draft guidance entitled "Providing Postmarket Periodic Safety Reports in the ICH E2C(R2) Format," which indicates that FDA will be prepared to grant waivers to enable submission of the PBRER in the United States in place of a PADER required under § 314.80(c)(2) or in place of a PAER required under § 600.80(c)(2). The draft guidance both explains conditions under which applicants that have previously received waivers to submit reporting information in the format of the previous ICH guidance would be permitted to apply those existing waivers to the submission of PBRERs, and also advises how applicants that have not previously obtained a waiver may submit waiver requests that would be granted for the submission of PBRERs. This **Federal Register** notice solicits comment on certain information collections proposed in the April 8, 2013, draft guidance that are related to waivers specifically to enable the submission of PBRERs, and that are not already addressed under approved control numbers covering waiver submissions and periodic safety reports generally.

FDA has previously granted waiver requests, submitted under §§ 314.90(a)

and 600.90(a), that allow applicants to prepare and submit reports using the PSUR format described in the 1997 and 2004 ICH E2C guidance. In accordance with the recommendations of the April 8, 2013, draft guidance, if an applicant already has a PSUR waiver in place for a given approved application, FDA will consider the existing PSUR waiver to allow the applicant to submit a PBRER instead of a PSUR because the PBRER replaces the PSUR for postmarketing periodic safety reporting for that application. The applicant would not need to submit a new waiver request unless the applicant wishes to use a different data lock point or change the frequency of reporting.

If an applicant submits a PBRER in place of the PSUR and uses a different data lock point, the applicant should submit overlapping reports or submit a one-time PADER/PAER in order to cover the gap in reporting intervals. The applicant should request a waiver to change the data lock point and this waiver request should include a description of the measures taken to ensure that there are no resulting gaps in reporting with the change.

If an applicant submits a PBRER in place of the PSUR and uses a different reporting frequency for the PBRER than was used for the PSUR, the applicant must request a waiver. This waiver request should describe the measures taken to ensure that the periodicity requirements under §§ 314.80(c)(2)(i) and 600.80(c)(2)(i) are being met. If an applicant requests to submit a PBRER less frequently than is permitted under the applicant's PSUR waiver, the continued validity of the waiver will be conditioned on the submission of a PADER/PAER as needed to fulfill the reporting frequency requirement under FDA regulations. The draft guidance also states that if an applicant is on a quarterly reporting schedule but wishes to submit a PBRER every 6 months without submitting a quarterly PADER/PAER in the intervening quarters, the applicant may request a waiver of the quarterly reporting requirement.

FDA expects approximately 189 waiver requests to include the additional information and notifications described previously in this document for using a different data lock point and/or for using a different reporting frequency when submitting a PBRER. FDA expects approximately 55 applicants to make these submissions, and we estimate that the time for submitting the additional information and notifications described previously would be on average approximately 1 hour for each waiver request.

If an applicant does not have a PSUR waiver in place for an approved application, the applicant may submit a waiver request under § 314.90(a) or § 600.90(a) to submit a PBRER instead of the PADER/PAER. The applicant should submit a request to FDA for each approved application for which a waiver is requested, and a single waiver request letter can include multiple applications. Waiver requests should be submitted to each of the application(s) in the request, and may be submitted electronically or by mail as described in the April 8, 2013, draft guidance. Each PBRER waiver request should include the following information:

(1) The product name(s) and application number(s);

(2) A brief description of the justification for the request:

(3) The U.S. approval date for the product(s) and current reporting interval used;

(4) The reporting interval of the last PADER/PAER submitted for the product(s);

(5) The data lock point that will be used for each PBRER. If a data lock point other than one aligned to the U.S. approval date is proposed, the applicant should describe how he/she will ensure that there are no gaps in reporting intervals (e.g., by submitting overlapping reports; submitting a one-time PADER/PAER to cover the gap period; or, if the gap is less than 2 months, extending the reporting interval of the final PADER/PAER to close the gap).

(6) The frequency for submitting the PBRER. as described in section IV.C of the April 8, 2013, draft guidance.

(7) The email address and telephone number for the individual who can provide additional information regarding the waiver request.

As explained earlier, existing regulations at §§ 314.90(a) or 600.90(a) permit applicants to request waivers of any postmarketing safety reporting requirement, and the information collections associated with such waiver requests generally are approved under OMB control numbers 0910–0001and 0910–0308. FDA believes that the information submitted under numbers 1–4 and number 7 in the list in the previous paragraph is information that is typical of any waiver request regarding postmarketing safety reporting and is accounted for in the existing approved collections of information for waiver requests and reports. Concerning numbers 5 and 6, FDA expects approximately 67 waiver requests to include the additional information for using a different data lock point and/or for using a different reporting frequency when submitting a PBRER. FDA expects approximately 29 applicants to make these submissions, and we estimate that the time for submitting the additional information described in the previous paragraph would be on average approximately 2 hours for each waiver request.

FDA estimates the additional burden of this collection of information as follows:

TABLE 1—ESTIMATED REPORTING BURDEN [1]

Additional information and/or notifications for using a different data lock point and/or a different reporting frequency	Number of respondents	Number of responses per respondent	Total annual responses	Average burden per response	Total hours
Applicants that have a PSUR waiver for an approved application	55	3.4	187	1	187
Applicants that do not have a PSUR waiver for an approved application	29	2.3	67	2	134
Total					321

[1] There are no capital costs or operating and maintenance costs associated with this collection of information.

Dated: December 3, 2013.

Leslie Kux,

Assistant Commissioner for Policy.

[FR Doc. 2013–29393 Filed 12–9–13; 8:45 am]

BILLING CODE 4160–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. FDA–2013–N–1434]

Draft Guidance for Industry on Size, Shape, and Other Physical Attributes of Generic Tablets and Capsules; Availability

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing the availability of a draft guidance for industry entitled "Size, Shape, and Other Physical Attributes of Generic Tablets and Capsules." This guidance discusses FDA recommendations for the size, shape, and other physical attributes of generic tablets intended to be swallowed intact. FDA is concerned that these characteristics of generic drugs are too varied compared to the originator drug and could affect patient outcomes.

DATES: Although you can comment on any guidance at any time (see 21 CFR 10.115(g)(5)), to ensure that the Agency considers your comment on this draft guidance before it begins work on the final version of the guidance, submit either electronic or written comments on the draft guidance by March 10, 2014.

ADDRESSES: Submit written requests for single copies of the draft guidance to the Division of Drug Information, Center for Drug Evaluation and Research, Food and Drug Administration, 10903 New Hampshire Ave., Bldg. 51, Rm. 2201, Silver Spring, MD 20993–0002. Send one self-addressed adhesive label to assist that office in processing your requests. See the **SUPPLEMENTARY INFORMATION** section for electronic access to the draft guidance document.

Submit electronic comments on the draft guidance to *http://www.regulations.gov*. Submit written comments to the Division of Dockets Management (HFA–305), Food and Drug Administration, 5630 Fishers Lane, Rm. 1061, Rockville, MD 20852.

FOR FURTHER INFORMATION CONTACT: Debra Catterson, Center for Drug Evaluation and Research (HFD–600), Food and Drug Administration, 11919 Rockville Pike, Rockville, MD 20852, 240–402–3861; or Vilayat Sayeed, Center for Drug Evaluation and Research (HFD–630), Food and Drug Administration, 7520 Standish Pl., Rockville, MD 20855, 240–276–8486.

SUPPLEMENTARY INFORMATION:

I. Background

FDA is announcing the availability of a draft guidance for industry entitled "Size, Shape, and Other Physical Attributes of Generic Tablets and Capsules." FDA is concerned that the differences in size, shape, and other physical characteristics between the generic and the originator could adversely affect patient outcomes. For example, studies show that tablet size can affect ease of swallowing, and generic tablets that are significantly larger than their corresponding reference drug product may be more difficult to swallow, leading to potential adverse events as well as noncompliance with treatment regimens. FDA is recommending generic manufacturers consider the size, shape, and other physical characteristics of the originator drug when developing a generic version.

This draft guidance is being issued consistent with FDA's good guidance practices regulation (21 CFR 10.115). The draft guidance, when finalized, will represent the Agency's current thinking on tablet size, shape, and other physical attributes of generic solid oral dosage forms. It does not create or confer any rights for or on any person and does not operate to bind FDA or the public. An alternative approach may be used if such approach satisfies the requirements of the applicable statutes and regulations.

II. Paperwork Reduction Act of 1995

This draft guidance contains information collection provisions that are subject to review by the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995 (the PRA) (44 U.S.C. 3501–3520). The collection of information requested in the draft guidance is covered under FDA regulations at 21 CFR 314 and approved under OMB control number 0910–0001. In accordance with the PRA, prior to publication of any final guidance document, FDA intends to solicit public comment and obtain OMB approval for any information collections recommended in this guidance that are new or that would represent material modifications to those previously approved collections of information found in FDA regulations or guidances.

III. Comments

Interested persons may submit either electronic comments regarding this document to *http://www.regulations.gov* or written comments to the Division of Dockets Management (see **ADDRESSES**). It is only necessary to send one set of comments. Identify comments with the docket number found in brackets in the heading of this document. Received comments may be seen in the Division of Dockets Management between 9 a.m. and 4 p.m., Monday through Friday, and will be posted to the docket at *http://www.regulations.gov*.

IV. Electronic Access

Persons with access to the Internet may obtain the document at either *http://www.fda.gov/Drugs/GuidanceComplianceRegulatoryInformation/Guidances/default.htm* or *http://www.regulations.gov*.

Dated: December 2, 2013.

Leslie Kux,

Assistant Commissioner for Policy.

[FR Doc. 2013–29395 Filed 12–9–13; 8:45 am]

BILLING CODE 4160–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. FDA–2013–D–0928]

Draft Guidance for Industry on Recommendations for Preparation and Submission of Animal Food Additive Petitions; Reopening of the Comment Period

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice; reopening of the comment period.

SUMMARY: The Food and Drug Administration (FDA) is reopening the comment period for the notice published in the **Federal Register** of Wednesday, September 11, 2013 (78 FR 55727), announcing the availability of the draft guidance for industry (GFI #221) entitled "Recommendations for Preparation and Submission of Animal Food Additive Petitions."

DATES: Submit either electronic or written comments by January 9, 2014.

ADDRESSES: Submit electronic comments to *http://www.regulations.gov*. Submit written comments to the Division of Dockets Management (HFA–305), Food and Drug Administration, 5630 Fishers Lane, Rm. 1061, Rockville, MD 20852.

FOR FURTHER INFORMATION CONTACT: Sharon Benz, Center for Veterinary

Medicine (HFV–220), Food and Drug Administration, 7519 Standish Pl., Rockville, MD 20855, 240–453–6864, *sharon.benz@fda.hhs.gov.*

SUPPLEMENTARY INFORMATION:

I. Background

In the **Federal Register** of Wednesday, September 11, 2013 (78 FR 55727), FDA announced the availability of a draft guidance for industry (GFI #221). entitled "Recommendations for Preparation and Submission of Animal Food Additive Petitions."

Interested persons were originally given until November 12, 2013, to comment on the draft guidance.

II. Request for Comments

FDA is reopening the comment period due to the inability of some commenters to submit comments through the *http://www.regulations.gov* Web site from November 4, 2013, through November 13, 2013, because of technical difficulties at that Web site.

III. How To Submit Comments

Interested persons may submit either electronic comments regarding this document to *http://www.regulations.gov* or written comments to the Division of Dockets Management (see **ADDRESSES**). It is only necessary to send one set of comments. Identify comments with the docket number found in brackets in the heading of this document. Received comments may be seen in the Division of Dockets Management between 9 a.m. and 4 p.m., Monday through Friday, and will be posted to the docket at *http://www.regulations.gov.*

Dated: December 4, 2013.

Leslie Kux,

Assistant Commissioner for Policy.

[FR Doc. 2013–29392 Filed 12–9–13; 8:45 am]

BILLING CODE 4160–01–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

[USCG–2013–0950]

Information Collection Request to Office of Management and Budget

AGENCY: Coast Guard, DHS.

ACTION: Sixty-day notice requesting comments.

SUMMARY: In compliance with the Paperwork Reduction Act of 1995, the U.S. Coast Guard intends to submit an Information Collection Request (ICRs) to the Office of Management and Budget (OMB), Office of Information and Regulatory Affairs (OIRA), requesting approval of a revision to the following collection of information: 1625–0019, Alternative Compliance for International and Inland Navigation Rules—33 CFR Parts 81 through 89. Our ICR describes the information we seek to collect from the public. Before submitting this ICR to OIRA, the Coast Guard is inviting comments as described below.

DATES: Comments must reach the Coast Guard on or before February 10, 2014.

ADDRESSES: You may submit comments identified by Coast Guard docket number [USCG–2013–0950] to the Docket Management Facility (DMF) at the U.S. Department of Transportation (DOT). To avoid duplicate submissions, please use only one of the following means:

(1) *Online: http://www.regulations.gov.*

(2) *Mail:* DMF (M–30), DOT, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE., Washington, DC 20590–0001.

(3) *Hand delivery:* Same as mail address above, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The telephone number is 202–366–9329.

(4) *Fax:* 202–493–2251. To ensure your comments are received in a timely manner, mark the fax, to attention Desk Officer for the Coast Guard.

The DMF maintains the public docket for this Notice. Comments and material received from the public, as well as documents mentioned in this Notice as being available in the docket, will become part of the docket and will be available for inspection or copying at room W12–140 on the West Building Ground Floor, 1200 New Jersey Avenue SE., Washington, DC, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. You may also find the docket on the Internet at *http://www.regulations.gov.*

Copies of the ICR(s) are available through the docket on the Internet at *http://www.regulations.gov.* Additionally, copies are available from: Commandant (CG–612), Attn Paperwork Reduction Act Manager, U.S. Coast Guard, 2703 Martin Luther King Jr. Ave. SE., Stop 7710, Washington, DC 20593–7710.

FOR FURTHER INFORMATION CONTACT: Contact Mr. Anthony Smith, Office of Information Management, telephone 202–475–3532, or fax 202–372–8405, for questions on these documents. Contact Ms. Barbara Hairston, Program Manager, Docket Operations, 202–366–9826, for questions on the docket.

SUPPLEMENTARY INFORMATION:

Public Participation and Request for Comments

This Notice relies on the authority of the Paperwork Reduction Act of 1995; 44 U.S.C. Chapter 35, as amended. An ICR is an application to OIRA seeking the approval, extension, or renewal of a Coast Guard collection of information (Collection). The ICR contains information describing the Collection's purpose, the Collection's likely burden on the affected public, an explanation of the necessity of the Collection, and other important information describing the Collection. There is one ICR for each Collection.

The Coast Guard invites comments on whether these ICRs should be granted based on the Collections being necessary for the proper performance of Departmental functions. In particular, the Coast Guard would appreciate comments addressing: (1) The practical utility of the Collections; (2) the accuracy of the estimated burden of the Collections; (3) ways to enhance the quality, utility, and clarity of information subject to the Collections; and (4) ways to minimize the burden of the Collections on respondents, including the use of automated collection techniques or other forms of information technology. In response to your comments, we may revise these ICRs or decide not to seek approval of revisions of the Collections. We will consider all comments and material received during the comment period.

We encourage you to respond to this request by submitting comments and related materials. Comments must contain the OMB Control Number of the ICR and the docket number of this request, [USCG–2013–0950], and must be received by February 10, 2014. We will post all comments received, without change, to *http://www.regulations.gov.* They will include any personal information you provide. We have an agreement with DOT to use their DMF. Please see the "Privacy Act" paragraph below.

Submitting Comments

If you submit a comment, please include the docket number [USCG–2013–0950], indicate the specific section of the document to which each comment applies, providing a reason for each comment. You may submit your comments and material online (*via http://www.regulations.gov*), by fax, mail, or hand delivery, but please use only one of these means. If you submit a comment online via *www.regulations.gov,* it will be considered received by the Coast Guard when you successfully transmit the

comment. If you fax, hand deliver, or mail your comment, it will be considered as having been received by the Coast Guard when it is received at the DMF. We recommend you include your name, mailing address, an email address, or other contact information in the body of your document so that we can contact you if we have questions regarding your submission.

You may submit your comments and material by electronic means, mail, fax, or delivery to the DMF at the address under **ADDRESSES**; but please submit them by only one means. To submit your comment online, go to *http://www.regulations.gov*, and type "USCG–2013–0950" in the "Keyword" box. If you submit your comments by mail or hand delivery, submit them in an unbound format, no larger than 8½ by 11 inches, suitable for copying and electronic filing. If you submit comments by mail and would like to know that they reached the Facility, please enclose a stamped, self-addressed postcard or envelope. We will consider all comments and material received during the comment period and will address them accordingly.

Viewing comments and documents: To view comments, as well as documents mentioned in this Notice as being available in the docket, go to *http://www.regulations.gov*, click on the "read comments" box, which will then become highlighted in blue. In the "Keyword" box insert "USCG–2013–0950" and click "Search." Click the "Open Docket Folder" in the "Actions" column. You may also visit the DMF in Room W12–140 on the ground floor of the DOT West Building, 1200 New Jersey Avenue SE., Washington, DC 20590, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

Privacy Act

Anyone can search the electronic form of comments received in dockets by the name of the individual submitting the comment (or signing the comment, if submitted on behalf of an association, business, labor union, etc.). You may review a Privacy Act statement regarding Coast Guard public dockets in the January 17, 2008, issue of the **Federal Register** (73 FR 3316).

Information Collection Request

1. *Title:* Alternative Compliance for International and Inland Navigation Rules—33 CFR Parts 81 through 89.

OMB Control Number: 1625–0019.

Summary: The information collected provides an opportunity for an owner, operator, builder, or agent of a unique vessel to present their reasons why the vessel cannot comply with existing International/Inland Navigation Rules and how alternative compliance can be achieved. If appropriate, a Certificate of Alternative Compliance is issued.

Need: Certain vessels cannot comply with the International Navigation Rules (see 33 U.S.C. 1601 through 1608; 28 U.S.T. 3459, and T.I.A.S. 8587) and Inland Navigation Rules (33 U.S.C. 2001 through 2073). The Coast Guard thus provides an opportunity for alternative compliance. However, it is not possible to determine whether alternative compliance is appropriate, or what kind of alternative procedures might be necessary, without this collection.

Forms: N/A.

Respondents: Vessel owners, operators, builders and agents.

Frequency: One-time application.

Burden Estimate: The estimated burden has increased from 50 hours to 230 hours a year due to an increase in the estimated annual number of responses.

Authority: The Paperwork Reduction Act of 1995; 44 U.S.C. Chapter 35, as amended.

Dated: November 25, 2013.

R.E. Day,

Rear Admiral, U.S. Coast Guard Assistant Commandant for Command, Control, Communications, Computers and Information Technology.

[FR Doc. 2013–29365 Filed 12–9–13; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

[USCG–2013–0782]

Collection of Information Under Review by Office of Management and Budget

AGENCY: Coast Guard, DHS.

ACTION: Thirty-day notice requesting comments.

SUMMARY: In compliance with the Paperwork Reduction Act of 1995 the U.S. Coast Guard is forwarding Information Collection Request (ICR), abstracted below, to the Office of Management and Budget (OMB), Office of Information and Regulatory Affairs (OIRA), requesting approval of a revision to the following collection of information: 1625–0102, National Response Resource Inventory. Our ICR describes the information we seek to collect from the public. Review and comments by OIRA ensure we only impose paperwork burdens commensurate with our performance of duties.

DATES: Comments must reach the Coast Guard and OIRA on or before January 9, 2014.

ADDRESSES: You may submit comments identified by Coast Guard docket number [USCG–2013–0782] to the Docket Management Facility (DMF) at the U.S. Department of Transportation (DOT) and/or to OIRA. To avoid duplicate submissions, please use only one of the following means:

(1) *Online:* (a) To Coast Guard docket at *http://www.regulations.gov*. (b) To OIRA by email via: *OIRA-submission@omb.eop.gov*.

(2) *Mail:* (a) DMF (M–30), DOT, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE., Washington, DC 20590–0001. (b) To OIRA, 725 17th Street NW., Washington, DC 20503, attention Desk Officer for the Coast Guard.

(3) *Hand Delivery:* To DMF address above, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The telephone number is 202–366–9329.

(4) *Fax:* (a) To DMF, 202–493–2251. (b) To OIRA at 202–395–6566. To ensure your comments are received in a timely manner, mark the fax, attention Desk Officer for the Coast Guard.

The DMF maintains the public docket for this Notice. Comments and material received from the public, as well as documents mentioned in this Notice as being available in the docket, will become part of the docket and will be available for inspection or copying at room W12–140 on the West Building Ground Floor, 1200 New Jersey Avenue SE., Washington, DC, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. You may also find the docket on the Internet at *http://www.regulations.gov*.

Copies of the ICRs are available through the docket on the Internet at *http://www.regulations.gov*. Additionally, copies are available from: COMMANDANT (CG–612), ATTN: PAPERWORK REDUCTION ACT MANAGER, US COAST GUARD, 2703 MARTIN LUTHER KING JR AVE SE., STOP 7710, WASHINGTON DC 20593–7710.

FOR FURTHER INFORMATION CONTACT: Contact Anthony Smith, Office of Information Management, telephone 202–475–3532 or fax 202–372–8405, for questions on these documents. Contact Ms. Barbara Hairston, Program Manager, Docket Operations, 202–366–9826, for questions on the docket.

SUPPLEMENTARY INFORMATION:

Public Participation and Request for Comments

This Notice relies on the authority of the Paperwork Reduction Act of 1995; 44 U.S.C. Chapter 35, as amended. An ICR is an application to OIRA seeking the approval, extension, or renewal of a Coast Guard collection of information (Collection). The ICR contains information describing the Collection's purpose, the Collection's likely burden on the affected public, an explanation of the necessity of the Collection, and other important information describing the Collection. There is one ICR for each Collection.

The Coast Guard invites comments on whether these ICRs should be granted based on the Collections being necessary for the proper performance of Departmental functions. In particular, the Coast Guard would appreciate comments addressing: (1) The practical utility of the Collections; (2) the accuracy of the estimated burden of the Collections; (3) ways to enhance the quality, utility, and clarity of information subject to the Collections; and (4) ways to minimize the burden of the Collections on respondents, including the use of automated collection techniques or other forms of information technology. These comments will help OIRA determine whether to approve the ICR(s) referred to in this Notice.

We encourage you to respond to this request by submitting comments and related materials. Comments to Coast Guard or OIRA must contain the OMB Control Number of the ICR. They must also contain the docket number of this request, [USCG 2013–0782], and must be received by January 9, 2014. We will post all comments received, without change, to *http://www.regulations.gov*. They will include any personal information you provide. We have an agreement with DOT to use their DMF. Please see the "Privacy Act" paragraph below.

Submitting Comments

If you submit a comment, please include the docket number [USCG–2013–0782]; indicate the specific section of the document to which each comment applies, providing a reason for each comment. You may submit your comments and material online (via *http://www.regulations.gov*), by fax, mail, or hand delivery, but please use only one of these means. If you submit a comment online via *www.regulations.gov*, it will be considered received by the Coast Guard when you successfully transmit the comment. If you fax, hand deliver, or mail your comment, it will be considered as having been received by the Coast Guard when it is received at the DMF. We recommend you include your name, mailing address, an email address, or other contact information in the body of your document so that we can contact you if we have questions regarding your submission.

You may submit comments and material by electronic means, mail, fax, or delivery to the DMF at the address under **ADDRESSES**, but please submit them by only one means. To submit your comment online, go to *http://www.regulations.gov*, and type "USCG–2013–0782" in the "Keyword" box. If you submit your comments by mail or hand delivery, submit them in an unbound format, no larger than 8½ by 11 inches, suitable for copying and electronic filing. If you submit comments by mail and would like to know that they reached the Facility, please enclose a stamped, self-addressed postcard or envelope. We will consider all comments and material received during the comment period and will address them accordingly.

Viewing Comments and Documents

To view comments, as well as documents mentioned in this Notice as being available in the docket, go to *http://www.regulations.gov*, click on the "read comments" box, which will then become highlighted in blue. In the "Keyword" box insert "USCG–2013–0782" and click "Search." Click the "Open Docket Folder" in the "Actions" column. You may also visit the DMF in Room W12–140 on the ground floor of the DOT West Building, 1200 New Jersey Avenue SE., Washington, DC 20590, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

OIRA posts its decisions on ICRs online at *http://www.reginfo.gov/public/do/PRAMain* after the comment period for each ICR. An OMB Notice of Action on each ICR will become available via a hyperlink in the OMB Control Number: 1625–0102.

Privacy Act

Anyone can search the electronic form of comments received in dockets by the name of the individual submitting the comment (or signing the comment, if submitted on behalf of an association, business, labor union, etc.). You may review a Privacy Act statement regarding Coast Guard public dockets in the January 17, 2008, issue of the **Federal Register** (73 FR 3316).

Previous Request for Comments

This request provides a 30-day comment period required by OIRA. The Coast Guard published the 60-day notice (78 FR 54666, September 5, 2013) required by 44 U.S.C. 3506(c)(2). That Notice elicited no comments.

Information Collection Request

1. *Title:* National Response Resource Inventory.

OMB Control Number: 1625–0102.

Type Of Request: Revision of a currently approved collection.

Respondents: Oil spill removal organizations.

Abstract: The information is needed to improve the effectiveness of deploying response equipment in the event of an oil spill. It may also be used in the development of contingency plans. Respondents are oil spill removal organizations.

Forms: None.

Burden Estimate: The estimated burden has increased from 1,296 hours to 1,752 hours a year due to an increase in the estimated annual number of respondents.

Authority: The Paperwork Reduction Act of 1995; 44 U.S.C. Chapter 35, as amended.

Dated: November 25, 2013.

R.E. Day,

Rear Admiral, U.S. Coast Guard, Assistant Commandant for Command, Control, Communications, Computers and Information Technology.

[FR Doc. 2013–29368 Filed 12–9–13; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

[Docket No. FR–5748–N–01]

Notice of HUD-Held Multifamily Loan Sale (MLS 2014–1)

AGENCY: Office of the Assistant Secretary for Housing—Federal Housing Commissioner, HUD.

ACTION: Notice of sale of an individual mortgage loan.

SUMMARY: This notice announces HUD's intention to sell an unsubsidized multifamily mortgage loan, without Federal Housing Administration (FHA) insurance, in a competitive auction limited to participation by Units of Local Governments (ULGs) and Non-profit Corporations on December 12, 2013 (MLS 2014–1). This notice also describes generally the bidding process for the sale and certain persons who are ineligible to bid.

DATES: A Bidder's Information Package (BIP) was made available on or about

November 18, 2013. Bids for the loan must be submitted on the bid date of December 12, 2013, during the specified timeframe. HUD anticipates that the award will be made on or shortly after bid day, December 12, 2013. Closing is expected to take place between December 18, 2013, and December 20, 2013.

ADDRESSES: To become a qualified bidder and receive the BIP, prospective bidders must complete, execute, and submit a Confidentiality Agreement and a Qualification Statement acceptable to HUD. Both documents are available on the HUD Web site at *www.hud.gov/fhaloansales*. Please mail and fax executed documents to JS Watkins Realty Partners, LLC: J.S. Watkins Realty Partners, LLC, c/o The Debt Exchange, 133 Federal Street, 10th Floor, Boston, MA 02111, Attention: MLS 2014–1 Sale Coordinator, Fax: 1–978–967–8607.

FOR FURTHER INFORMATION CONTACT: John Lucey, Deputy Director, Asset Sales Office, Room 3136, U.S. Department of Housing and Urban Development, 451 Seventh Street SW., Washington, DC 20410–8000; telephone 202–708–2625, extension 3927. Hearing- or speech-impaired individuals may call 202–708–4594 (TTY). These are not toll-free numbers.

SUPPLEMENTARY INFORMATION: HUD announces its intention to sell, in MLS 2014–1, an individual unsubsidized multifamily mortgage loan (Mortgage Loan) secured by one (1) multifamily property located in St. Louis, Missouri. The Mortgage Loan is a non-performing mortgage loan. A listing of this Mortgage Loan is included in the BIP. The Mortgage Loan will be sold without FHA insurance and with servicing released. HUD will offer qualified bidders an opportunity to bid competitively on the Mortgage Loan.

Qualified bidders may submit bids on this Mortgage Loan. A mortgagor who is a qualified bidder may submit an individual bid on its own Mortgage Loan. Interested Mortgagors should review the Qualification Statement to determine whether they may also be eligible to qualify to submit a bid.

The Bidding Process

The BIP describes in detail the procedure for bidding MLS 2014–1. The BIP also includes a standardized non-negotiable loan sale agreement (Loan Sale Agreement).

As part of its bid, each bidder must submit a minimum deposit of the greater of 10 percent or $100,000. HUD will evaluate the bids submitted and determine the successful bids in its sole and absolute discretion. If a bidder is successful, the bidder's deposit will be non-refundable and will be applied toward the purchase price. Deposits will be returned to unsuccessful bidders. The Closing is expected to take place between December 18, 2013 and December 20, 2013.

These are the essential terms of sale. The BIP and the Loan Sale Agreement, which is included in the BIP, contains additional terms and details. To ensure a competitive bidding process, the terms of the bidding process and the Loan Sale Agreement are not subject to negotiation.

Due Diligence Review

The BIP describes the due diligence process for reviewing the loan file in MLS 2014–1. Qualified bidders can access loan information remotely via a high-speed Internet connection. Further information on performing due diligence review of the Mortgage Loan is provided in the BIP.

Mortgage Loan Sale Policy

HUD reserves the right to add Mortgage Loans to or delete the Mortgage Loan from MLS 2014–1 at any time prior to the Award Date. HUD also reserves the right to reject any and all bids, in whole or in part, without prejudice to HUD's right to include the Mortgage Loan in a later sale. The Mortgage Loan will not be withdrawn after the Award Date except as is specifically provided in the Loan Sale Agreement.

This is a sale of an unsubsidized mortgage loan, pursuant to Section 204(a) of the Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act of 1997, (12 U.S.C. 1715z–11a(a)).

Mortgage Loan Sale Procedure

HUD selected a competitive sale as the method to sell the Mortgage Loan. This method of sale optimizes HUD's return on the sale of this Mortgage Loan, affords the greatest opportunity for all qualified bidders to bid on the Mortgage Loan, and provides the quickest and most efficient vehicle for HUD to dispose of the Mortgage Loan.

Bidder Eligibility

In order to bid in the sale, a prospective bidder must complete, execute and submit both a Confidentiality Agreement and a Qualification Statement acceptable to HUD. The following individuals and entities are ineligible to bid on the Mortgage Loan included in the MLS 2014–1:

1. Any employee of HUD, a member of such employee's household, or an entity owned or controlled by any such employee or member of such an employee's household;
2. Any individual or entity that is debarred, suspended, or excluded from doing business with HUD pursuant to Title 24 of the Code of Federal Regulations, Part 24, and Title 2 of the Code of Federal Regulations, Part 24;
3. Any contractor, subcontractor and/or consultant or advisor (including any agent, employee, partner, director, principal or affiliate of any of the foregoing) who performed services for, or on behalf of, HUD in connection with MLS 2014–1;
4. Any individual who was a principal, partner, director, agent or employee of any entity or individual described in subparagraph 3 above, at any time during which the entity or individual performed services for or on behalf of HUD in connection with MLS 2014–1;
5. Any individual or entity that uses the services, directly or indirectly, of any person or entity ineligible under subparagraphs 1 through 4 above to assist in preparing any of its bids on the Mortgage Loan;
6. Any individual or entity which employs or uses the services of an employee of HUD (other than in such employee's official capacity) who is involved in MLS 2014–1;
7. Any affiliate, principal or employee of any person or entity that, within the two-year period prior to December 1, 2013, serviced the Mortgage Loan or performed other services for or on behalf of HUD;
8. Any contractor or subcontractor to HUD that otherwise had access to information concerning the Mortgage Loan on behalf of HUD or provided services to any person or entity which, within the two-year period prior to December 1, 2013 had access to information with respect to the Mortgage Loan on behalf of HUD;
9. Any employee, officer, director or any other person that provides or will provide services to the potential bidder with respect to such Mortgage Loan during any warranty period established for the Loan Sale, that serviced the Mortgage Loan or performed other services for or on behalf of HUD or within the two-year period prior to December 1, 2013 or that provided services to any person or entity which serviced, performed services or otherwise had access to information with respect to the Mortgage Loan for or on behalf of HUD;
10. Any mortgagor or operator that failed to submit to HUD on or before

March 31, 2013 audited financial statements for fiscal years 2010 through 2012 (for such time as the project has been in operation or the prospective bidder served as operator, if less than three (3) years) for a project securing a Mortgage Loan;

11. Any individual or entity, and any Related Party (as such term is defined in the Qualification Statement) of such individual or entity, that is a mortgagor in any of HUD's multifamily housing programs or a mortgagor or operator in a healthcare facility (regardless of whether such mortgage loan is included in the Loan Sale) and that is in default under such mortgage loan or is in violation of any regulatory or business agreements with HUD and fails to cure such default or violation by no later than November 30, 2013.

12. Any individual or entity that is not/cannot be classified as a Unit of Local Government (ULG) or Non-profit Corporation.

The Qualification Statement provides further details pertaining to eligibility requirements. Prospective bidders should carefully review the Qualification Statement to determine whether they are eligible to submit bids on the Mortgage Loans in this offering of MLS 2014–1.

Freedom of Information Act Requests

HUD reserves the right, in its sole and absolute discretion, to disclose information regarding MLS 2014–1, including, but not limited to, the identity of any successful bidder and its bid price or bid percentage for any individual loan, upon the closing of the sale of the Mortgage Loan. Even if HUD elects not to publicly disclose any information relating to MLS 2014–1, HUD will have the right to disclose any information that HUD is obligated to disclose pursuant to the Freedom of Information Act and all regulations promulgated thereunder.

Scope of Notice

This notice applies to MLS 2014–1 and does not establish HUD's policy for the sale of other mortgage loans.

Dated: December 5, 2013.

Carol J. Galante,

Assistant Secretary for Housing—Federal Housing Commissioner.

[FR Doc. 2013–29440 Filed 12–9–13; 8:45 am]

BILLING CODE 4210–67–P

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

[FWS–R6–ES–2013–N197; FXES11110600000 FUND 145]

Programmatic Candidate Conservation Agreement With Assurances for Least Chub Receipt of Application for Enhancement of Survival Permit

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Notice of availability; receipt of application.

SUMMARY: We, the U.S. Fish and Wildlife Service (Service), have received an application from the Utah Division of Wildlife Resources (UDWR) for an enhancement of survival permit (permit) under the Endangered Species Act of 1973, as amended (Act). The permit application includes a proposed programmatic Candidate Conservation Agreement with Assurances (CCAA) for the least chub, a fish endemic to the Bonneville Basin of Utah. We have made a preliminary determination that the proposed CCAA and permit issuance are eligible for categorical exclusion under the National Environmental Policy Act of 1969 (NEPA). The basis for our preliminary determination is contained in an Environmental Action Statement. We are accepting comments on the permit application, the proposed CCAA, and the Environmental Action Statement.

DATES: We must receive comments no later than January 9, 2014.

ADDRESSES: Address all written comments to Larry Crist, by U.S. mail at the Utah Field Office, U.S. Fish and Wildlife Service, 2369 West Orton Circle, Suite 50, West Valley City, UT 84119; by facsimile at 801–975–3331; or by email to *larry_crist@fws.gov*.

FOR FURTHER INFORMATION CONTACT: Larry Crist, Utah Field Office Supervisor, at 801–975–3330. If you use a telecommunications device for the deaf, you may call the Federal Information Relay Service at 800–877–8339.

SUPPLEMENTARY INFORMATION: We, the U.S. Fish and Wildlife Service (Service), have received an application from the Utah Division of Wildlife Resources (UDWR) for an enhancement of survival permit (permit) under the Endangered Species Act of 1973, as amended (Act; 16 U.S.C. 1531 et seq.).

The permit application includes a proposed programmatic Candidate Conservation Agreement with Assurances (CCAA) for the least chub (*Iotichthys phlegethontis*). We have made a preliminary determination that the proposed CCAA and permit application are eligible for categorical exclusion under the National Environmental Policy Act of 1969 (NEPA; 42 U.S.C. 4321 et seq.). The basis for our preliminary determination is contained in an Environmental Action Statement. We are accepting comments on the permit application, the proposed CCAA, and the Environmental Action Statement.

Candidate Conservation Agreements With Assurances (CCAA)

Under a Candidate Conservation Agreement with Assurances (CCAA), participating landowners voluntarily undertake management activities on their property to enhance, restore, or maintain habitat benefiting species that are proposed for listing or candidates for listing under the Endangered Species Act of 1973, as amended (the Act; 16 U.S.C. 1531 et seq.), or those species that may become candidates. Candidate Conservation Agreements with Assurances, and the subsequent permits that are issued pursuant to section 10(a)(1)(A) of the Act, encourage private and other non-Federal property owners to implement conservation efforts for species by assuring property owners that they will not be subjected to increased land use restrictions as a result of efforts to attract or increase the numbers or distribution of a listed species on their property, if that species becomes listed under the Act in the future. Candidate Conservation Agreement with Assurances permit application requirements and issuance criteria are found in 50 CFR 17.22(d) and 17.32(d).

About This Proposed CCAA

The purpose of this CCAA is for the Service to partner with the UDWR and participating non-Federal property owners (Participants) to implement conservation measures for least chub in a manner that is consistent with our Policy on CCAAs (June 17, 1999; 64 FR 32726) and applicable regulations. The conservation goal of this CCAA is to reduce the threats to least chub and its habitat and increase the number of viable, stable, and secure least chub populations within the species' historic range. The CCAA project area includes all non-Federal lands in the Bonneville Basin of Utah encompassed by the current and historic distribution of least chub, including potentially suitable habitats within the following Utah counties: Beaver, Box Elder, Cache, Davis, Garfield, Iron, Juab, Kane, Millard, Morgan, Piute, Rich, Salt Lake, Sanpete, Sevier, Summit, Tooele, Utah,

Weber, Wasatch, and Washington. However, the CCAA is programmatic, and, as such, we cannot identify site-specific project locations at this time.

This proposed CCAA represents a significant milestone in the cooperative conservation efforts for least chub and is consistent with section 2(a)(5) of the Act, which encourages creative partnerships among public, private, and government entities to conserve imperiled species and their habitats. As identified in our CCAA Final Policy (64 FR 32726), and regulations at 50 CFR 17.22, to enter into a CCAA and issue a permit and assurances, we must determine that the conservation measures and expected benefits, when combined with those benefits that would be achieved if it is assumed that similar conservation measures were also implemented on other necessary properties, would preclude or remove the need to list least chub. Consistent with the CCAA policy, meeting the CCAA standard does not depend on the number of acres enrolled, and adoption of the CCAA and enrollment of property owners does not guarantee that listing will be unnecessary. Through a separate finding, we will determine whether this CCAA meets the standard specified in the CCAA policy and regulations.

Non-Federal land makes up a large proportion of the land within the historic range of least chub. While we currently have willing voluntary non-Federal landowners interested in least chub conservation, there is not a federally recognized document providing regulatory assurances for these landowners in the case that least chub becomes federally listed under ESA. The proposed CCAA will provide protection and incentive to these property owners and will likely encourage additional property owners to consider conservation actions for least chub on their properties. The greater the number we have of willing participants in least chub conservation, the greater the likelihood that we are able to achieve our conservation goals for least chub.

Least chub conservation will be enhanced by providing ESA regulatory assurances for participating property owners. Participating property owners will have assurances that, if the species is listed under the ESA in the future, we would not impose additional commitments or land use restrictions as long as the CCAA is properly implemented. Enrollment of property owners under this CCAA will provide an additional pathway to achieve the conservation goal of establishing two or more refuge populations representing each wild population.

Determining Whether To Issue the Permit

When determining whether to issue the permit, we will consider a number of factors and information sources, including the project's administrative record, any public comments received, and the application requirements and issuance criteria for CCAAs contained in 50 CFR 17.22(d) and 17.32(d). We will also evaluate whether the issuance of the permit complies with section 7 of the Act by conducting an intra-Service consultation. The results of this consultation, in combination with the above findings, regulations, and public comments, will determine whether or not to issue the permit. The proposed CCAA also provides Participants with regulatory assurances that, in the event of unforeseen circumstances, we would not require additional conservation measures or the commitment of additional land, water, or resource use restrictions beyond the level obligated in the proposed CCAA, without the consent of the Participant and the UDWR.

We have made a preliminary determination that the proposed CCAA and permit issuance are eligible for categorical exclusion under NEPA. The basis for this determination is the Environmental Action Statement, which is available for public review (see **ADDRESSES**).

Public Availability of Comments

If you wish to comment on the proposed CCAA and associated documents, you may submit your comments to the Service (see **ADDRESSES**). Before including your address, phone number, email address, or other personal identifying information in your comment, you should be aware that your entire comment—including your personal identifying information—may be made publicly available at any time. While you can ask us in your comment to withhold your personal identifying information from public review, we cannot guarantee that we will be able to do so.

Next Steps

We will evaluate this permit application, associated documents, and comments submitted thereon to determine whether the permit application meets the requirements of section 10(a) of the Act and NEPA (40 CFR 1506.6). When we determine that the requirements are met, we will sign the proposed Agreement and issue a permit under section 10(a)(1)(A) of the Act to the Applicants for take of the covered species in accordance with the terms of the Agreement. We will not make our final decision until after the end of the 30-day comment period; we will fully consider all comments received during the comment period.

Authority: The Service provides this notice under section 10(c) of the Act and implementing regulations for NEPA (40 CFR 1506.6).

Dated: November 18, 2013.

Larry Crist,

Field Supervisor, Salt Lake City, Utah.

[FR Doc. 2013–29463 Filed 12–9–13; 8:45 am]

BILLING CODE 4310–55–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[LLCO956000 L14200000.BJ0000]

Notice of Filing of Plats of Survey; Colorado

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice of filing of plats of survey; Colorado.

SUMMARY: The Bureau of Land Management (BLM) Colorado State Office is publishing this notice to inform the public of the intent to officially file the survey plats listed below and afford a proper period of time to protest this action prior to the plat filing. During this time, the plats will be available for review in the BLM Colorado State Office.

DATES: Unless there are protests of this action, the filing of the plats described in this notice will happen on January 9, 2014.

ADDRESSES: BLM Colorado State Office, Cadastral Survey, 2850 Youngfield Street, Lakewood, CO 80215–7093.

FOR FURTHER INFORMATION CONTACT: Randy Bloom, Chief Cadastral Surveyor for Colorado, (303) 239–3856.

Persons who use a telecommunications device for the deaf (TDD) may call the Federal Information Relay Service (FIRS) at 1–800–877–8339 to contact the above individual during normal business hours. The FIRS is available 24 hours a day, seven days a week, to leave a message or question with the above individual. You will receive a reply during normal business hours.

SUPPLEMENTARY INFORMATION: The plat and field notes of the dependent resurvey and survey in Township 7 South, Range 74 West, Sixth Principal Meridian, Colorado, were accepted October 18, 2013.

The plat and field notes of the dependent resurvey and survey in Township 8 South, Range 69 West, Sixth Principal Meridian, Colorado, were accepted on October 29, 2013.

The plat incorporating the field notes of the dependent resurvey in Township 49 North, Range 5½ West, New Mexico Principal Meridian, Colorado, was accepted on November 1, 2013.

The plat and field notes of the dependent resurvey in Township 9 South, Range 70 West, Sixth Principal Meridian, Colorado, were accepted on November 4, 2013.

Randy Bloom,

Chief Cadastral Surveyor for Colorado.

[FR Doc. 2013–29431 Filed 12–9–13; 8:45 am]

BILLING CODE 4310–JB–P

INTERNATIONAL TRADE COMMISSION

[Investigation Nos. 701–TA–449 and 731–TA–1118–1121 (Review)]

Light-Walled Rectangular Pipe and Tube From China, Korea, Mexico, and Turkey; Scheduling of Full Five-Year Reviews Concerning the Countervailing Duty Order on Light-Walled Rectangular Pipe and Tube From China and the Antidumping Duty Orders on Light-Walled Rectangular Pipe and Tube From China, Korea, Mexico, and Turkey

AGENCY: United States International Trade Commission.

ACTION: Notice.

SUMMARY: The Commission hereby gives notice of the scheduling of full reviews pursuant to section 751(c)(5) of the Tariff Act of 1930 (19 U.S.C. 1675(c)(5)) (the Act) to determine whether revocation of the countervailing duty order on light-walled rectangular pipe and tube from China and/or revocation of the antidumping duty orders on light-walled rectangular pipe and tube from China, Korea, Mexico, and Turkey would be likely to lead to continuation or recurrence of material injury within a reasonably foreseeable time. The Commission has determined to exercise its authority to extend the review period by up to 90 days pursuant to 19 U.S.C. 1675(c)(5)(B). For further information concerning the conduct of these reviews and rules of general application, consult the Commission's Rules of Practice and Procedure, part 201, subparts A through E (19 CFR part 201), and part 207, subparts A, D, E, and F (19 CFR part 207).

DATES: *Effective Date:* December 3, 2013.

FOR FURTHER INFORMATION CONTACT: Edward Petronzio (202–205–3176), Office of Investigations, U.S. International Trade Commission, 500 E Street SW., Washington, DC 20436. Hearing-impaired persons can obtain information on this matter by contacting the Commission's TDD terminal on 202–205–1810. Persons with mobility impairments who will need special assistance in gaining access to the Commission should contact the Office of the Secretary at 202–205–2000. General information concerning the Commission may also be obtained by accessing its internet server (*http://www.usitc.gov*). The public record for these reviews may be viewed on the Commission's electronic docket (EDIS) at *http://edis.usitc.gov*.

SUPPLEMENTARY INFORMATION:

Background. On July 5, 2013, the Commission determined that responses to its notice of institution of the subject five-year reviews were such that full reviews pursuant to section 751(c)(5) of the Act should proceed (78 F.R. 42546, July 16, 2013). A record of the Commissioners' votes, the Commission's statement on adequacy, and any individual Commissioner's statements are available from the Office of the Secretary and at the Commission's Web site.

Participation in the reviews and public service list. Persons, including industrial users of the subject merchandise and, if the merchandise is sold at the retail level, representative consumer organizations, wishing to participate in these reviews as parties must file an entry of appearance with the Secretary to the Commission, as provided in section 201.11 of the Commission's rules, by 45 days after publication of this notice. A party that filed a notice of appearance following publication of the Commission's notice of institution of the reviews need not file an additional notice of appearance. The Secretary will maintain a public service list containing the names and addresses of all persons, or their representatives, who are parties to the reviews.

Limited disclosure of business proprietary information (BPI) under an administrative protective order (APO) and BPI service list. Pursuant to section 207.7(a) of the Commission's rules, the Secretary will make BPI gathered in these reviews available to authorized applicants under the APO issued in the reviews, provided that the application is made by 45 days after publication of this notice. Authorized applicants must represent interested parties, as defined by 19 U.S.C. 1677(9), who are parties to the reviews. A party granted access to BPI following publication of the Commission's notice of institution of the reviews need not reapply for such access. A separate service list will be maintained by the Secretary for those parties authorized to receive BPI under the APO.

Staff report. The prehearing staff report in the reviews will be placed in the nonpublic record on March 17, 2014, and a public version will be issued thereafter, pursuant to section 207.64 of the Commission's rules.

Hearing. The Commission will hold a hearing in connection with the reviews beginning at 9:30 a.m. on April 3, 2014, at the U.S. International Trade Commission Building. Requests to appear at the hearing should be filed in writing with the Secretary to the Commission on or before March 27, 2014. A nonparty who has testimony that may aid the Commission's deliberations may request permission to present a short statement at the hearing. All parties and nonparties desiring to appear at the hearing and make oral presentations should attend a prehearing conference to be held at 9:30 a.m. on March 31, 2014, at the U.S. International Trade Commission Building. Oral testimony and written materials to be submitted at the public hearing are governed by sections 201.6(b)(2), 201.13(f), 207.24, and 207.66 of the Commission's rules. Parties must submit any request to present a portion of their hearing testimony *in camera* no later than 7 business days prior to the date of the hearing.

Written submissions. Each party to the reviews may submit a prehearing brief to the Commission. Prehearing briefs must conform with the provisions of section 207.65 of the Commission's rules; the deadline for filing is March 26, 2014. Parties may also file written testimony in connection with their presentation at the hearing, as provided in section 207.24 of the Commission's rules, and posthearing briefs, which must conform with the provisions of section 207.67 of the Commission's rules. The deadline for filing posthearing briefs is April 11, 2014. In addition, any person who has not entered an appearance as a party to the reviews may submit a written statement of information pertinent to the subject of the reviews on or before April 11, 2014. On May 14, 2014, the Commission will make available to parties all information on which they have not had an opportunity to comment. Parties may submit final comments on this information on or before May 16, 2014, but such final comments must not

contain new factual information and must otherwise comply with section 207.68 of the Commission's rules. All written submissions must conform with the provisions of section 201.8 of the Commission's rules; any submissions that contain BPI must also conform with the requirements of sections 201.6, 207.3, and 207.7 of the Commission's rules. The Commission's *Handbook on E-Filing*, available on the Commission's Web site at *http://edis.usitc.gov*, elaborates upon the Commission's rules with respect to electronic filing.

Additional written submissions to the Commission, including requests pursuant to section 201.12 of the Commission's rules, shall not be accepted unless good cause is shown for accepting such submissions, or unless the submission is pursuant to a specific request by a Commissioner or Commission staff.

In accordance with sections 201.16(c) and 207.3 of the Commission's rules, each document filed by a party to the reviews must be served on all other parties to the reviews (as identified by either the public or BPI service list), and a certificate of service must be timely filed. The Secretary will not accept a document for filing without a certificate of service.

Authority: These reviews are being conducted under authority of title VII of the Tariff Act of 1930; this notice is published pursuant to section 207.62 of the Commission's rules.

Issued: December 4, 2013.

By order of the Commission.

Lisa R. Barton,

Acting Secretary to the Commission.

[FR Doc. 2013–29379 Filed 12–9–13; 8:45 am]

BILLING CODE 7020–02–P

INTERNATIONAL TRADE COMMISSION

[USITC SE–13–034]

Sunshine Act Meeting Notice

AGENCY HOLDING THE MEETING: United States International Trade Commission

TIME AND DATE: December 12, 2013 at 11:00 a.m.

PLACE: Room 101, 500 E Street SW., Washington, DC 20436, Telephone: (202) 205–2000.

STATUS: Open to the public

MATTERS TO BE CONSIDERED:

1. Agendas for future meetings: none.
2. Minutes.
3. Ratification List.
4. Vote in Inv. No. 731–TA–1205 (Final)(Silica Bricks from China). The Commission is currently scheduled to complete and file its determinations and views on or before December 23, 2013.
5. Outstanding action jackets: none.

In accordance with Commission policy, subject matter listed above, not disposed of at the scheduled meeting, may be carried over to the agenda of the following meeting.

Issued: December 5, 2013.

By order of the Commission.

Lisa R. Barton,

Acting Secretary to the Commission.

[FR Doc. 2013–29479 Filed 12–6–13; 11:15 am]

BILLING CODE 7020–02–P

DEPARTMENT OF JUSTICE

Office of Justice Programs

[OJP (NIJ) Docket No. 1641]

Draft Criminal Justice Offender Tracking System Standard and Companion Documents

AGENCY: National Institute of Justice, Department of Justice.

ACTION: Notice and request for comments.

SUMMARY: In an effort to obtain comments from interested parties, the U.S. Department of Justice, Office of Justice Programs, National Institute of Justice will make available to the general public four draft documents: (1) A draft standard entitled, "Criminal Justice Offender Tracking System Standard"; (2) a draft companion document entitled, "Criminal Justice Offender Tracking System Certification Program Requirements"; (3) a draft companion Selection and Application Guide, and (4) a new draft companion document entitled, "Criminal Justice Offender Tracking System Refurbishment Service Program Requirements". The opportunity to provide comments on these four documents is open to industry technical representatives, criminal justice agencies and organizations, research, development and scientific communities, and all other stakeholders and interested parties. Those individuals wishing to obtain, and provide comments on, the draft documents under consideration are directed to the following Web site: *https://www.justnet.org/standards/Offender_Tracking_Standards.html.*

DATES: Responses to this request will be accepted through 11:59 p.m. Eastern Time on January 9, 2014.

FOR FURTHER INFORMATION CONTACT: Jack Harne, by telephone at 202–616–2911 [**Note:** this is not a toll-free telephone number], or by email at *Jack.Harne@usdoj.gov*. Those individuals wishing to obtain, and provide comments on, the draft documents under consideration are directed to the following Web site: *https://www.justnet.org/standards/Offender_Tracking_Standards.html.*

Gregory K. Ridgeway,

Acting Director, National Institute of Justice.

[FR Doc. 2013–29398 Filed 12–9–13; 8:45 am]

BILLING CODE 4410–18–P

DEPARTMENT OF LABOR

Employment and Training Administration

[TA–W–83,058]

Sysco Denver LLC, a Subsidiary of Sysco Corporation, IT Department, Denver, Colorado; Notice of Affirmative Determination Regarding Application for Reconsideration

By application dated October 1, 2013, a worker requested administrative reconsideration of the negative determination regarding workers' eligibility to apply for Trade Adjustment Assistance (TAA) applicable to workers and former workers of Sysco Denver LLC., a subsidiary of Sysco Corporation, IT Department, Denver, Colorado (subject firm). The negative determination was issued on September 17, 2013 and the Department's Notice of determination was published in the **Federal Register** on October 24, 2013 (78 FR 63498). Workers at the subject firm were engaged in activities related to the supply of information technology (IT) services.

The negative determination was based on the Department's findings that, with respect to Section 222(a) and Section 222(b) of the Act, Criterion (1) has not been met because a significant number or proportion of the workers in such workers' firm, have not become totally or partially separated, or threatened with such separation.

In addition, the group eligibility requirements under Section 222(e) of the Act have not been satisfied because the workers' firm has not been publicly identified by name by the International Trade Commission as a member of a domestic industry in an investigation resulting in an affirmative finding of serious injury, market disruption, or material injury, or threat thereof.

The request for reconsideration alleges that the two workers at the subject firm location were part of a larger worker group (those supplying IT services at various Sysco Corporation facilities) and that IT functions are being outsourced to India.

The Department has carefully reviewed the request for reconsideration and the existing record, and will conduct further investigation to determine if the workers meet the eligibility requirements of the Trade Act of 1974, as amended.

Conclusion

After careful review of the application, I conclude that the claim is of sufficient weight to justify reconsideration of the U.S. Department of Labor's prior decision. The application is, therefore, granted.

Signed at Washington, DC, this 27th day of November, 2013.

Del Min Amy Chen,

Certifying Officer, Office of Trade Adjustment Assistance.

[FR Doc. 2013–29357 Filed 12–9–13; 8:45 am]

BILLING CODE 4510–FN–P

DEPARTMENT OF LABOR

Employment and Training Administration

[TA–W–83,085; TA–W–83,085A]

Keywell LLC, Frewsburg, New York and Keywell LLC, Falconer, New York; Amended Certification Regarding Eligibility To Apply for Worker Adjustment Assistance

In accordance with Section 223 of the Trade Act of 1974, as amended ("Act"), 19 U.S.C. 2273, the Department of Labor issued a Certification of Eligibility to Apply for Worker Adjustment Assistance on November 6, 2013, applicable to workers of Keywell LLC, Frewsburg, New York. The workers are engaged in activities related to the production of scrap stainless, titanium and high temperature alloys. The subject worker group includes workers engaged in employment related to the processing of the metals from scrap for use in other products for customers. The notice will be published soon in the **Federal Register**.

At the request of New York State agency, the Department reviewed the certification for workers of the subject firm. Information shows that the correct city location for 1873 Lyndon Boulevard is Falconer, New York not Frewsburg, New York as indicated on the petition. The original intent of the Chautauqua Workforce Office and the subject firm was to include the Frewsburg, New York and Falconer, New York locations of Keywell LLC in the certification determination.

The intent of the Department's certification is to include all workers of the subject firm who were adversely affected by increased company imports of scrap stainless steel, titanium and high temperature alloys.

Accordingly, the Department is amending the certification to include workers of the Frewsburg, New York and Falconer, New York locations of Keywell LLC.

The amended notice applicable to TA–W–83,085 and TA–W–83,085A are hereby issued as follows:

All workers of Keywell LLC, Frewsburg, New York (TA–W–83,085) and Keywell LLC, Falconer, New York (TA–W–83,085A), who became totally or partially separated from employment on or after September 10, 2012 through November 6, 2015, and all workers in the group threatened with total or partial separation from employment on the date of certification through two years from the date of certification, are eligible to apply for adjustment assistance under Chapter 2 of Title II of the Trade Act of 1974, as amended.

Signed in Washington, DC, this 27th day of November 2013.

Del Min Amy Chen,

Certifying Officer, Office of Trade Adjustment Assistance.

[FR Doc. 2013–29358 Filed 12–9–13; 8:45 am]

BILLING CODE 4510–FN–P

DEPARTMENT OF LABOR

Employment and Training Administration

[TA–W–82,671]

Johnstown Specialty Castings Inc., a Subsidiary of WHEMCO, Including On-Site Leased Workers From Berkebile Excavating Company, Inc., Johnstown, Pennsylvania; Amended Certification Regarding Eligibility To Apply for Worker Adjustment Assistance

In accordance with Section 223 of the Trade Act of 1974, as amended ("Act"), 19 U.S.C. 2273, the Department of Labor issued a Certification of Eligibility To Apply for Worker Adjustment Assistance on June 25, 2013, applicable to workers of Johnstown Specialty Castings, Inc., a subsidiary of WHEMCO, Johnstown, Pennsylvania. The Department's notice of determination was published in the **Federal Register** on July 12, 2013 (Volume 78 FR page 41956).

At the request of three workers, the Department reviewed the certification for workers of the subject firm. The workers were engaged in production of rolling mill rolls.

New information from the company revealed that workers leased from Berkebile Excavating Company, Inc. were employed on-site at the Johnstown, Pennsylvania location of Johnstown Specialty Castings, Inc., a subsidiary of WHEMCO. The Department has determined that these workers were sufficiently under the control of the subject firm to be considered leased workers.

The intent of the Department's certification is to include all workers of the firm who were adversely affected by increased imports of articles like or directly competitive with rolling mill rolls. Based on these findings, the Department is amending this certification to include workers leased from Berkebile Excavating Company, Inc. working on-site at the Johnstown, Pennsylvania location of Johnstown Specialty Castings, Inc.

The amended notice applicable to TA–W–82,671 is hereby issued as follows:

All workers of Berkebile Excavating Company, Inc., reporting to Johnstown Specialty Castings, Inc., a subsidiary of WHEMCO, Johnstown, Pennsylvania, who became totally or partially separated from employment on or after April 17, 2012, through June 25, 2015, and all workers in the group threatened with total or partial separation from employment on the date of certification through two years from the date of certification, are eligible to apply for adjustment assistance under Chapter 2 of Title II of the Trade Act of 1974, as amended.

Signed in Washington, DC, this 27th day of November, 2013.

Michael W. Jaffe,

Certifying Officer, Office of Trade Adjustment Assistance.

[FR Doc. 2013–29359 Filed 12–9–13; 8:45 am]

BILLING CODE 4510–FN–P

DEPARTMENT OF LABOR

Employment and Training Administration

[TA–W–83,070]

Harrison Medical Center, a Subsidiary of Franciscan Health System Bremerton, Washington; Notice of Negative Determination Regarding Application for Reconsideration

By application dated November 14, 2013, the Washington State Labor Council requested administrative reconsideration of the Department of Labor's negative determination regarding eligibility to apply for Trade Adjustment Assistance (TAA), applicable to workers and former workers of Harrison Medical Center, a subsidiary of Franciscan Health System, Bremerton, Washington (subject firm). On November 12, 2013 the Department issued a negative determination applicable to workers and former

workers of the subject firm. The Department's Notice of determination will soon be published in the **Federal Register**. The subject firm supplies acute care hospital physician office services.

Pursuant to 29 CFR 90.18(c) reconsideration may be granted under the following circumstances:

(1) If it appears on the basis of facts not previously considered that the determination complained of was erroneous;

(2) If it appears that the determination complained of was based on a mistake in the determination of facts not previously considered; or

(3) If in the opinion of the Certifying Officer, a misinterpretation of facts or of the law justified reconsideration of the decision.

The negative determination applicable to workers and former workers of the subject firm was based on the Department's findings that the subject firm did not import services like or directly competitive with the services supplied by the workers, and a shift in the supply of such services to a foreign country by the workers' firm or an acquisition of such services from a foreign country by the workers' firm did not occur in the relevant time period. The investigation revealed that the petitioning worker group did not meet the criteria set forth in Section 222(a) and Section 222(e) of the Trade Act of 1974, as amended.

In the request for reconsideration, the petitioner did not supply facts not previously considered and did not provide additional documentation indicating that there was either (1) a mistake in the determination of facts not previously considered or (2) a misinterpretation of facts or of the law justifying reconsideration of the initial determination.

The request for reconsideration alleges that the subject firm entered into a contract with M Modal that may have allowed the outsourcing of services, and requested that the Department confirm that no such outsourcing occurred.

Based on these findings, the Department determines that 29 CFR 90.18(c) has not been met.

In addition, a careful review of the administrative record reveals that the Department did confirm with both the subject firm and M Modal that no such shift had occurred.

Conclusion

After careful review of the application and investigative findings, I conclude that there has been no error or misinterpretation of the law or of the facts which would justify reconsideration of the Department of Labor's prior decision. Accordingly, the application is denied.

Signed in Washington, DC, this 27th day of November, 2013.

Del Min Amy Chen,

Certifying Officer, Office of Trade Adjustment Assistance.

[FR Doc. 2013–29360 Filed 12–9–13; 8:45 am]

BILLING CODE 4510–FN–P

DEPARTMENT OF LABOR

Employment and Training Administration

Notice of Determinations Regarding Eligibility To Apply for Worker Adjustment Assistance

In accordance with Section 223 of the Trade Act of 1974, as amended (19 U.S.C. 2273) the Department of Labor herein presents summaries of determinations regarding eligibility to apply for trade adjustment assistance for workers by (TA–W) number issued during the period of November 18, 2013 through November 22, 2013.

In order for an affirmative determination to be made for workers of a primary firm and a certification issued regarding eligibility to apply for worker adjustment assistance, each of the group eligibility requirements of Section 222(a) of the Act must be met.

I. Under Section 222(a)(2)(A), the following must be satisfied:

(1) A significant number or proportion of the workers in such workers' firm have become totally or partially separated, or are threatened to become totally or partially separated;

(2) the sales or production, or both, of such firm have decreased absolutely; and

(3) One of the following must be satisfied:

(A) imports of articles or services like or directly competitive with articles produced or services supplied by such firm have increased;

(B) imports of articles like or directly competitive with articles into which one or more component parts produced by such firm are directly incorporated, have increased;

(C) imports of articles directly incorporating one or more component parts produced outside the United States that are like or directly competitive with imports of articles incorporating one or more component parts produced by such firm have increased;

(D) imports of articles like or directly competitive with articles which are produced directly using services supplied by such firm, have increased; and

(4) the increase in imports contributed importantly to such workers' separation or threat of separation and to the decline in the sales or production of such firm; or

II. Section 222(a)(2)(B) all of the following must be satisfied:

(1) a significant number or proportion of the workers in such workers' firm have become totally or partially separated, or are threatened to become totally or partially separated;

(2) One of the following must be satisfied:

(A) there has been a shift by the workers' firm to a foreign country in the production of articles or supply of services like or directly competitive with those produced/supplied by the workers' firm;

(B) there has been an acquisition from a foreign country by the workers' firm of articles/services that are like or directly competitive with those produced/supplied by the workers' firm; and

(3) the shift/acquisition contributed importantly to the workers' separation or threat of separation.

In order for an affirmative determination to be made for adversely affected workers in public agencies and a certification issued regarding eligibility to apply for worker adjustment assistance, each of the group eligibility requirements of Section 222(b) of the Act must be met.

(1) a significant number or proportion of the workers in the public agency have become totally or partially separated, or are threatened to become totally or partially separated;

(2) the public agency has acquired from a foreign country services like or directly competitive with services which are supplied by such agency; and

(3) the acquisition of services contributed importantly to such workers' separation or threat of separation.

In order for an affirmative determination to be made for adversely affected secondary workers of a firm and a certification issued regarding eligibility to apply for worker adjustment assistance, each of the group eligibility requirements of Section 222(c) of the Act must be met.

(1) a significant number or proportion of the workers in the workers' firm have become totally or partially separated, or are threatened to become totally or partially separated;

(2) the workers' firm is a Supplier or Downstream Producer to a firm that employed a group of workers who received a certification of eligibility

under Section 222(a) of the Act, and such supply or production is related to the article or service that was the basis for such certification; and

(3) either—

(A) the workers' firm is a supplier and the component parts it supplied to the firm described in paragraph (2) accounted for at least 20 percent of the production or sales of the workers' firm; or

(B) a loss of business by the workers' firm with the firm described in paragraph (2) contributed importantly to the workers' separation or threat of separation.

In order for an affirmative determination to be made for adversely affected workers in firms identified by the International Trade Commission and a certification issued regarding eligibility to apply for worker adjustment assistance, each of the group eligibility requirements of Section 222(f) of the Act must be met.

(1) the workers' firm is publicly identified by name by the International Trade Commission as a member of a domestic industry in an investigation resulting in—

(A) an affirmative determination of serious injury or threat thereof under section 202(b)(1);

(B) an affirmative determination of market disruption or threat thereof under section 421(b)(1); or

(C) an affirmative final determination of material injury or threat thereof under section 705(b)(1)(A) or 735(b)(1)(A) of the Tariff Act of 1930 (19 U.S.C. 1671d(b)(1)(A) and 1673d(b)(1)(A));

(2) the petition is filed during the 1-year period beginning on the date on which—

(A) a summary of the report submitted to the President by the International Trade Commission under section 202(f)(1) with respect to the affirmative determination described in paragraph (1)(A) is published in the **Federal Register** under section 202(f)(3); or

(B) notice of an affirmative determination described in subparagraph (1) is published in the **Federal Register**; and

(3) the workers have become totally or partially separated from the workers' firm within—

(A) the 1-year period described in paragraph (2); or

(B) notwithstanding section 223(b)(1), the 1-year period preceding the 1-year period described in paragraph (2).

Affirmative Determinations for Worker Adjustment Assistance

The following certifications have been issued. The date following the company name and location of each determination references the impact date for all workers of such determination.

The following certifications have been issued. The requirements of Section 222(a)(2)(A) (increased imports) of the Trade Act have been met.

TA–W number	Subject firm	Location	Impact date
82,897	Alorica, Inc.	Cedar Rapids, IA	July 10, 2012.
83,041	American Customer Care, Inc., Haier Tier One Group, Aerotek	Montoursville, PA	August 28, 2012.

The following certifications have been issued. The requirements of Section 222(a)(2)(B) (shift in production or services) of the Trade Act have been met.

TA–W number	Subject firm	Location	Impact date
83,133	Alkco, Philips Lighting, Beco Group, and Adecco	Franklin Park, IL	October 11, 2012.
83,145	Westinghouse Fuel Company, LLC, Windsor Fuel Components	Windsor, CT	October 17, 2012.
83,149	Navistar Truck Development & Technology Center, Populus Group, Technical Training, Inc., PPP, OTEK, Staffmark, Mid-States.	Fort Wayne, IN	October 21, 2013.
83,176	Spence Engineering Company, Inc., Circor International, Inc., Knapp Consultants.	Walden, NY	October 22, 2012.
83,182	MetLife Group, Inc., MetLife, Inc., Service Delivery Center, CLR Operations Unit.	Johnstown, PA	October 29, 2012.
83,187	Clyde Union, Inc., SPX Power and Energy, Manpower, Aerotek, Impact Solutions.	Battle Creek, MI	October 22, 2012.
83,196	Standard Microsystems Corporation, Microchip Technology, Test Division, Stivers Staffing.	Hauppauge, NY	November 4, 2012.
83,211	Creavey Seal Company, Sanders Industries, Express Employment and ERG Staffing.	Scott Township, PA	November 7, 2012.

The following certifications have been issued. The requirements of Section 222(c) (supplier to a firm whose workers are certified eligible to apply for TAA) of the Trade Act have been met.

TA–W number	Subject firm	Location	Impact date
83,027	Meritor Heavy Vehicle Systems, LLC, Specialty Group Division, Meritor, Inc., Populus Group and Academy Medical.	Heath, OH	April 30, 2013.

Negative Determinations for Worker Adjustment Assistance

In the following cases, the investigation revealed that the eligibility criteria for worker adjustment assistance have not been met for the reasons specified.

The investigation revealed that the criteria under paragraphs (a)(2)(A) (increased imports) and (a)(2)(B) (shift in production or services to a foreign country) of section 222 have not been met.

TA–W number	Subject firm	Location	Impact date
83,113	JP Morgan Chase and Company, Mortgage Banking Division, Production Operations.	Westerville, OH	

Determinations Terminating Investigations of Petitions for Worker Adjustment Assistance

After notice of the petitions was published in the **Federal Register** and on the Department's Web site, as required by Section 221 of the Act (19 U.S.C. 2271), the Department initiated investigations of these petitions.

The following determinations terminating investigations were issued because the petitioning groups of workers are covered by active certifications. Consequently, further investigation in these cases would serve no purpose since the petitioning group of workers cannot be covered by more than one certification at a time.

TA–W number	Subject firm	Location	Impact date
82,932	Atmel Corporation	Colorado Springs, CO.	
83,174	Atmel Corporation	Colorado Springs, CO.	

I hereby certify that the aforementioned determinations were issued during the period of November 18, 2013 through November 22, 2013. These determinations are available on the Department's Web site *tradeact/taa/taa_search_form.cfm* under the searchable listing of determinations or by calling the Office of Trade Adjustment Assistance toll free at 888–365–6822.

Signed at Washington, DC, this 27th day of November 2013.

Michael W. Jaffe,

Certifying Officer, Office of Trade Adjustment Assistance.

[FR Doc. 2013–29362 Filed 12–9–13; 8:45 am]

BILLING CODE 4510–FN–P

DEPARTMENT OF LABOR

Employment and Training Administration

Investigations Regarding Eligibility To Apply for Worker Adjustment Assistance

Petitions have been filed with the Secretary of Labor under Section 221(a) of the Trade Act of 1974 ("the Act") and are identified in the Appendix to this notice. Upon receipt of these petitions, the Director of the Office of Trade Adjustment Assistance, Employment and Training Administration, has instituted investigations pursuant to Section 221(a) of the Act.

The purpose of each of the investigations is to determine whether the workers are eligible to apply for adjustment assistance under Title II, Chapter 2, of the Act. The investigations will further relate, as appropriate, to the determination of the date on which total or partial separations began or threatened to begin and the subdivision of the firm involved.

The petitioners or any other persons showing a substantial interest in the subject matter of the investigations may request a public hearing, provided such request is filed in writing with the Director, Office of Trade Adjustment Assistance, at the address shown below, not later than December 20, 2013.

Interested persons are invited to submit written comments regarding the subject matter of the investigations to the Director, Office of Trade Adjustment Assistance, at the address shown below, not later than December 20, 2013.

The petitions filed in this case are available for inspection at the Office of the Director, Office of Trade Adjustment Assistance, Employment and Training Administration, U.S. Department of Labor, Room N–5428, 200 Constitution Avenue NW., Washington, DC 20210.

Signed at Washington, DC, this 27th day of November 2013.

Michael W. Jaffe,

Certifying Officer, Office of Trade Adjustment Assistance.

APPENDIX

[18 TAA petitions instituted between 11/18/13 and 11/22/13]

TA–W	Subject firm (petitioners)	Location	Date of institution	Date of petition
83221	State Industries (State/One-Stop)	Eugene, OR	11/19/13	11/13/13
83222	Advance Auto Parts (Workers)	Roanoke, VA	11/19/13	11/18/13
83223	CDS Publications/Yamagata (State/One-Stop)	Vista, CA	11/19/13	11/17/13
83224	Blake One, Inc. (State/One-Stop)	New York, NY	11/19/13	11/18/13
83225	Pilkington, NA (Union)	Lathrop, CA	11/19/13	11/18/13
83226	American Express, World Service (State/One-Stop).	Salt Lake City, UT	11/19/13	11/18/13
83227	CCL Industries, frmly Avery North America Supply Chain (Union).	Chicopee, MA	11/20/13	11/19/13

APPENDIX—Continued

[18 TAA petitions instituted between 11/18/13 and 11/22/13]

TA–W	Subject firm (petitioners)	Location	Date of institution	Date of petition
83228	Covidien (Company)	Argyle, NY	11/20/13	11/19/13
83229	Amphenol Aerospace (Union)	Sidney, NY	11/20/13	11/20/13
83230	IBM Corporation (Workers)	Somers, NY	11/20/13	11/19/13
83231	VISA INC. (State/One-Stop)	Highlands Ranch, CO	11/21/13	11/20/13
83232	Glen Oak Lumber & Milling, Inc. (Company)	Montello, WI	11/21/13	11/20/13
83233	Meggitt Aircraft Braking Systems (Union)	Akron, OH	11/21/13	11/20/13
83234	Keywell LLC (Company)	West Mifflin, PA	11/21/13	11/20/13
83235	QBE (Workers)	Sun Praire, WI	11/22/13	11/21/13
83236	Cameron International, Compression Specialties, Inc. (Workers).	Ponca City, OK	11/22/13	11/21/13
83237	REC Advanced Silicon Materials LLC (Company)	Silver Bow, MT	11/22/13	11/21/13
83238	Keywell LLC (Company)	Chicago, IL	11/22/13	11/21/13

[FR Doc. 2013–29361 Filed 12–9–13; 8:45 am]

BILLING CODE 4510–FN–P

DEPARTMENT OF LABOR

Occupational Safety and Health Administration

[Docket No. OSHA–2010–0039]

Portable Fire Extinguishers (Annual Maintenance Certification Record); Extension of the Office of Management and Budget's (OMB) Approval of the Information Collection (Paperwork) Requirements

AGENCY: Occupational Safety and Health Administration (OSHA), Labor.

ACTION: Request for public comments.

SUMMARY: OSHA solicits public comments concerning its proposal to extend the Office of Management and Budget's (OMB) approval of the information collection requirements contained in the Portable Fire Extinguishers Standard (Annual Maintenance Certification Record) (29 CFR 1910.157(e)(3)).

DATES: Comments must be submitted (postmarked, sent or received) by February 10, 2014.

ADDRESSES:

Electronically: You may submit comments and attachments electronically at *http://www.regulations.gov*, which is the Federal eRulemaking Portal. Follow the instructions online for submitting comments.

Facsimile: If your comments, including attachments, are not longer than 10 pages you may fax them to the OSHA Docket Office at (202) 693–1648.

Mail, hand delivery, express mail, messenger, or courier service: When using this method, you must submit a copy of your comments and attachments to the OSHA Docket Office, Docket No. OSHA–2010–0039, U.S. Department of Labor, Occupational Safety and Health Administration, Room N–2625, 200 Constitution Avenue NW., Washington, DC 20210. Deliveries (hand, express mail, messenger, and courier service) are accepted during the Department of Labor's and Docket Office's normal business hours, 8:15 a.m. to 4:45 p.m., e.t.

Instructions: All submissions must include the Agency name and the OSHA docket number for the Information Collection Request (ICR) (OSHA–2010–0039). All comments, including any personal information you provide, are placed in the public docket without change, and may be made available online at *http://www.regulations.gov*. For further information on submitting comments see the "Public Participation" heading in the section of this notice titled **SUPPLEMENTARY INFORMATION.**

Docket: To read or download comments or other materials in the docket, go to *http://regulations.gov* or the OSHA Docket Office at the address above. All documents in the docket (including this **Federal Register** notice) are listed in the *http://www.regulations.gov* index; however, some information (e.g., copyrighted material) is not publically available to read or download from the Web site. All submissions, including copyrighted material, are available for inspection and copying at the OSHA Docket Office. You may contact Theda Kenney at the address below to obtain a copy of the ICR.

FOR FURTHER INFORMATION CONTACT: Todd Owen or Theda Kenney, Directorate of Standards and Guidance, OSHA, U.S. Department of Labor, Room N–3909, 200 Constitution Avenue NW., Washington, DC 20210; telephone (202) 693–2222.

SUPPLEMENTARY INFORMATION:

I. Background

The Department of Labor, as part of its continuing effort to reduce paperwork and respondent (i.e., employer) burden, conducts a preclearance consultation program to provide the public with an opportunity to comment on proposed and continuing information collection requirements in accord with the paperwork Reduction Act of 1995 (PRA–95) (44 U.S.C. 3506(c)(2)(A)). This program ensures that information is in the desired format, reporting burden (time and costs) is minimal, collection instruments are clearly understood, and OSHA's estimate of the information collection burden is accurate. The Occupational Safety and Health Act of 1970 (the OSH Act) (29 U.S.C. 651 *et. seq.*) authorizes information collection by employers as necessary or appropriate for enforcement of the OSH Act or for developing information regarding the causes and prevention of occupational injuries, illnesses, and accidents (29 U.S.C. 657). The OSH Act also requires that OSHA obtain such information with minimum burden upon employers, especially those operating small businesses, and to reduce to the maximum extent feasible unnecessary duplication of efforts in obtaining information (29 U.S.C. 657).

Paragraph (e)(3) of the Standard specifies that employers must subject each portable fire extinguisher to an annual maintenance inspection and

record the date of the inspection. In addition, this provision requires employers to retain the inspection record for one year after the last entry or for the life of the shell, whichever is less, and to make the record available to OSHA on request. This recordkeeping requirement assures employees and Agency compliance officers that portable fire extinguishers located in the workplace will operate normally in case of fire; in addition, this requirement provides evidence to OSHA compliance officers during an inspection that the employer performed the required maintenance checks on the portable fire extinguishers.

II. Special Issues for Comment

OSHA has a particular interest in comments on the following issues:

- Whether the proposed information collection requirements are necessary for the proper performance of the Agency's functions, including whether the information is useful;
- The accuracy of OSHA's estimate of the burden (time and costs) of the information collection requirements, including the validity of the methodology and assumptions used;
- The quality, utility, and clarity of the information collected; and
- Ways to minimize the burden on employers who must comply; for example, by using automated or other technological information collection and transmission techniques.

III. Proposed Actions

OSHA is requesting that OMB extend its approval of the information collection requirements contained in the Portable Fire Extinguishers Standard (Annual Maintenance Certification Record) (29 CFR 1910.157(e)(3)). OSHA is proposing to increase the burden hours in the currently approved information collection request from 67,995 to 69,038 (a total increase of 1,043 hours). This increase is due to updated data showing an increase in the number of fire extinguishers affected by the Standard. The Agency will summarize the comments submitted in response to this notice and will include this summary in the request to OMB.

Type of Review: Extension of a currently approved collection.

Title: Portable Fire Extinguishers (Annual Maintenance Certification Record (29 CFR 1910.157(e)(3)).

OMB Control Number: 1218–0238.

Affected Public: Business or other for-profits.

Number of Responses: 1,380,750

Frequency of Responses: On occasion

Average Time per Response: Approximately 30 minutes (.50 hour) to perform and record the required maintenance inspection.

Estimated Total Burden Hours: 69,038

Estimated Cost (Operation and Maintenance): $20,193,469

IV. Public Participation—Submission of Comments on This Notice and Internet Access to Comments and Submissions

You may submit comments in response to this document as follows: (1) Electronically at *http://regulations.gov*, which is the Federal eRulemaking Portal; (2) by facsimile (fax); or (3) by hard copy. All comments, attachments, and other materials must identify the Agency name and the OSHA docket number for the ICR (Docket No. OSHA–2010–0039). You may supplement electronic submissions by uploading document files electronically. If you wish to mail additional materials in reference to an electronic or facsimile submission, you must submit them to the OSHA Docket Office (see the section of this notice titled **ADDRESSES**). The additional materials must clearly identify your electronic comments by your name, date, and the docket number so the Agency can attach them to your comments.

Because of security procedures, the use of regular mail may cause a significant delay in the receipt of comments. For information about security procedures concerning the delivery of materials by hand, express delivery, messenger, or courier service, please contact the OSHA Docket Office at (202) 693–2350, (TTY (877) 889–5627).

Comments and submissions are posted without change at *http://www.regulations.gov*. Therefore, OSHA cautions comments about submitting personal information such as social security numbers and date of birth. Although all submissions are listed in the *http://www.regulations.gov* index, some information (*e.g.*, copyrighted material) is not publically available to read or download through this Web site. All submissions, including copyrighted material, are available for inspection and copying at the OSHA Docket Office. Information on using the *http://www.regulations.gov* Web site to submit comments and access the docket is available at the Web site's "User Tips" link. Contact the OSHA Docket Office for information about materials not available through the Web site, and for assistance in using the Internet to locate docket submissions.

V. Authority and Signature

David Michaels, Ph.D., MPH, Assistant Secretary of Labor for Occupational Safety and Health, directed the preparation of this notice. The authority for this notice is the paperwork Reduction Act of 1995 (44 U.S.C. 3506 *et. seq.*) and Secretary of Labor's Order No. 1–2012 (77 FR 3912).

Signed at Washington, DC, on December 5, 2013.

David Michaels,

Assistant Secretary of Labor for Occupational Safety and Health.

[FR Doc. 2013–29444 Filed 12–9–13; 8:45 am]

BILLING CODE 4510–26–P

MILITARY COMPENSATION AND RETIREMENT MODERNIZATION COMMISSION

Agency Information Collection: Emergency Submission for OMB Review (Survey of Military Retirees); Comment Request

AGENCY: Military Compensation and Retirement Modernization Commission.

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act (PRA) of 1995 (44 U.S.C. §§ 3501–3521) the Military Compensation and Retirement Modernization Commission (MCRMC) will submit to the Office of Management and Budget (OMB) the following emergency proposal for the collection of information under Section 3507(j)(1) of the PRA. An emergency clearance is being requested for the collection of information from military retirees. Comments are being sought on the proposed survey.

DATES: Consideration will be given to all comments received on or before January 15, 2014.

ADDRESSES: Send comments concerning the information collection to MCRMC's OMB desk officer at *oira_submission@OMB.eop.gov*.

FOR FURTHER INFORMATION CONTACT: Christopher Nuneviller, Associate Director, Military Compensation and Retirement Modernization Commission, P.O. Box 13170, Arlington VA 22209, telephone 703–692–2080, fax 703–697–8330, email *response@mcrmc.gov*.

SUPPLEMENTARY INFORMATION: The Military Compensation and Retirement Modernization Commission (MCRMC) was established by the National Defense Authorization Act FY 2013, Public Law 112–239, 126 Stat. 1787 (2013), to conduct a review of the military compensation and retirement systems and to make recommendations to modernize those systems in a report to be transmitted to the President by May 1, 2014. Pursuant to the Act, the

Commission is required to examine all laws, policies and practices of the Federal Government that result in any direct payment of authorized or appropriated funds to current and former members (veteran and retired) of the uniformed services, including the reserve components of those services, as well as the spouses, family members, children, survivors, and other persons authorized to receive such payments as a result of their connection to the members of these uniformed services (§ 671(b)(1)(A)) and to seek written comment from the general public and interested parties, to hold public hearings and to examine such other matters as it considers appropriate (§ 671(b)(1)(C)).

The Commission considers it essential to survey the recipients of the government funding that is the focus of the statute in order to write the report due May 1, 2014. The Commission has designed a survey that measures preferences for alternative levels and types of compensation across a broad cross-section of people either directly or indirectly benefiting from various forms of military compensation. In our review of existing surveys, we have determined that no available sources cover the demographic diversity of participants the Commission would like to cover using a preference-based approach. Because the statute requires the Commission to produce a report by May 1, 2014, the agency cannot comply with normal clearance procedures for authorizing a survey and it is requesting emergency processing.

Respondents: Military Retirees.

Estimated Number of Respondents: 50,000.

Estimated Number of Responses: 5,000.

Frequency of Response: One time.

Average Hours of Response: .5 hours.

Total Estimated Burden: 2,500.

Christopher Nuneviller,

Associate Director, Administration and Operations.

[FR Doc. 2013–29432 Filed 12–9–13; 8:45 am]

BILLING CODE P

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

[Notice: 13–144]

Notice of Information Collection

AGENCY: National Aeronautics and Space Administration (NASA).

ACTION: Notice of information collection.

SUMMARY: The National Aeronautics and Space Administration, as part of its continuing effort to reduce paperwork and respondent burden, invites the general public and other Federal agencies to take this opportunity to comment on proposed and/or continuing information collections, as required by the Paperwork Reduction Act of 1995 (Pub. L. 104–13, 44 U.S.C. 3506(c)(2)(A)).

DATES: All comments should be submitted within 60 calendar days from the date of this publication.

ADDRESSES: All comments should be addressed to Frances Teel, Mail Code JF000, National Aeronautics and Space Administration, Washington, DC 20546–0001.

FOR FURTHER INFORMATION CONTACT: Requests for additional information or copies of the information collection instrument(s) and instructions should be directed to Frances Teel, NASA PRA Clearance Officer, NASA Headquarters, 300 E Street SW., Mail Code JF000, Washington, DC 20546, *Frances.C.Teel@nasa.gov.*

SUPPLEMENTARY INFORMATION:

I. Abstract

NASA's founding legislation, the Space Act of 1958, as amended, directs the Agency to expand human knowledge of Earth and space phenomena and to preserve the role of the United States as a leader in aeronautics, space science, and technology. The NASA Office of Education has three primary goals (1) strengthen NASA and the Nation's future workforce, (2) attract and retain students in science, technology, engineering and mathematics, or STEM, disciplines, and (3) engage Americans in NASA's mission. This regular clearance will enable the NASA Office of Education to fulfill federally mandated reporting on its education activities and investments portfolio as well as selected Agency annual performance indicators.

This information collection will consist of project activity-level data submitted by program managers external to NASA, but who are responsible for reporting to NASA on the programs they manage that are within the NASA investments portfolio. Pertinent examples of this data include number of participants, duration of activity, and institution location of the activity.

II. Method of Collection

Electronic and paper.

III. Data

Title: NASA Office of Education Program-level Data Collection.

OMB Number: 2700–XXXX.

Type of Review: Regular Clearance.

Affected Public: Individuals.

Estimated Number of Respondents: 844.

Estimated Annual Responses: 3,376.

Estimated Time per Response: 60 min.

Estimated Total Annual Burden Hours: 3,376.

Estimated Total Annual Cost: $84,704.

IV. Request for Comments

Comments are invited on: (1) Whether the proposed collection of information is necessary for the proper performance of the functions of NASA, including whether the information collected has practical utility; (2) the accuracy of NASA's estimate of the burden (including hours and cost) of the proposed collection of information; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) ways to minimize the burden of the collection of information on respondents, including automated collection techniques or the use of other forms of information technology.

Frances Teel,

NASA PRA Clearance Officer.

[FR Doc. 2013–29391 Filed 12–9–13; 8:45 am]

BILLING CODE 7510–13–P

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

[Notice: 13–141]

Notice of Information Collection

AGENCY: National Aeronautics and Space Administration (NASA).

ACTION: Notice of information collection.

SUMMARY: The National Aeronautics and Space Administration, as part of its continuing effort to reduce paperwork and respondent burden, invites the general public and other Federal agencies to take this opportunity to comment on proposed and/or continuing information collections, as required by the Paperwork Reduction Act of 1995 (Pub. L. 104–13, 44 U.S.C. 3506(c)(2)(A)).

DATES: All comments should be submitted within 60 calendar days from the date of this publication.

ADDRESSES: All comments should be addressed to Frances Teel, Mail Code JF000, National Aeronautics and Space Administration, Washington, DC 20546–0001.

FOR FURTHER INFORMATION CONTACT: Requests for additional information or copies of the information collection instrument(s) and instructions should be directed to Frances Teel, NASA PRA

Clearance Officer, NASA Headquarters, 300 E Street SW., Mail Code JF000, Washington, DC 20546, *Frances.C.Teel@nasa.gov.*

I. Abstract

NASA's founding legislation, the Space Act of 1958, as amended, directs the agency to expand human knowledge of Earth and space phenomena and to preserve the role of the United States as a leader in aeronautics, space science, and technology. The NASA Office of Education administers the agency's national education activities in support of the Space Act, including the performance measurement and evaluation of educational projects and programs.

This generic clearance will allow the NASA Office of Education to test and pilot with subject matter experts, secondary students, higher education students, educators, and interested parties new and existing information collection forms and assessment instruments for the purposes of improvement and establishing validity and reliability characteristics of the forms and instruments. Forms and instruments to be tested include program application forms, customer satisfaction questionnaires, focus group protocols, and project activity survey instruments. Methodological testing will include focus group discussions, pilot surveys to test new individual question items as well as the complete form and instrument. In addition, test-retest and similar protocols will be used to determine reliability characteristics of the forms and instruments. Methodological testing will assure that forms and instruments accurately and consistently collect and measure what they are intended to measure and that data collection items are interpreted precisely and consistently, all towards the goal of accurate Agency reporting while improving the execution of NASA Education project activities.

II. Method of Collection

Electronic, paper, and focus group interviews.

III. Data

Title: Generic Clearance for the NASA Office of Education/Performance Measurement and Evaluation (Testing).

OMB Number: 2700–XXXX.

Type of review: New Generic Clearance.

Affected Public: Individuals and Households.

Estimated Number of Respondents: 10,756.

Estimated Annual Responses: Variable.

Estimated Time per Response: Variable.

Estimated Total Annual Burden Hours: 4,487.

Estimated Total Annual Cost: $50,913.23.

IV. Request for Comments

Comments are invited on: (1) Whether the proposed collection of information is necessary for the proper performance of the functions of NASA, including whether the information collected has practical utility; (2) the accuracy of NASA's estimate of the burden (including hours and cost) of the proposed collection of information; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) ways to minimize the burden of the collection of information on respondents, including automated collection techniques or the use of other forms of information technology.

Frances Teel,

NASA PRA Clearance Officer.

[FR Doc. 2013–29388 Filed 12–9–13; 8:45 am]

BILLING CODE 7510–13–P

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

[Notice: 13–143]

Notice of Information Collection

AGENCY: National Aeronautics and Space Administration (NASA).

ACTION: Notice of information collection.

SUMMARY: The National Aeronautics and Space Administration, as part of its continuing effort to reduce paperwork and respondent burden, invites the general public and other Federal agencies to take this opportunity to comment on proposed and/or continuing information collections, as required by the Paperwork Reduction Act of 1995 (Pub. L. 104–13, 44 U.S.C. 3506(c)(2)(A)).

DATES: All comments should be submitted within 60 calendar days from the date of this publication.

ADDRESSES: All comments should be addressed to Frances Teel, Mail Code JF000, National Aeronautics and Space Administration, Washington, DC 20546–0001.

FOR FURTHER INFORMATION CONTACT: Requests for additional information or copies of the information collection instrument(s) and instructions should be directed to Frances Teel, NASA PRA Clearance Officer, NASA Headquarters, 300 E Street SW., Mail Code JF000, Washington, DC 20546, *Frances.C.Teel@nasa.gov.*

I. Abstract

NASA's founding legislation, the Space Act of 1958, as amended, directs the agency to expand human knowledge of Earth and space phenomena and to preserve the role of the United States as a leader in aeronautics, space science, and technology. The NASA Office of Education administers the agency's national education activities in support of the Space Act, including the performance measurement and evaluation of educational projects and programs.

This generic clearance will allow the Office of Education to test and pilot with subject matter experts, secondary students, higher education students, educators, and interested parties new and existing information collection forms and assessment instruments for the purposes of improvement and establishing validity and reliability characteristics of the forms and instruments. Forms and instruments to be tested include program application forms, customer satisfaction questionnaires, focus group protocols, and project activity survey instruments. Methodological testing will include focus group discussions, pilot surveys to test new individual question items as well as the complete form and instrument. In addition, test-retest and similar protocols will be used to determine reliability characteristics of the forms and instruments. Methodological testing will assure that forms and instruments accurately and consistently collect and measure what they are intended to measure and that data collection items are interpreted precisely and consistently, all towards the goal of accurate Agency reporting while improving the execution of NASA Education project activities.

II. Method of Collection

Electronic, paper, and focus group interviews.

III. Data

Title: Generic Clearance for the Office of Education Performance Measurement and Evaluation (Testing).

OMB Number: 2700–XXXX.

Type of Review: New Generic Clearance.

Affected Public: Individuals and Households.

Estimated Number of Respondents: 10,756.

Estimated Annual Responses: Variable.

Estimated Time per Response: Variable.

Estimated Total Annual Burden Hours: 4,487.

Estimated Total Annual Cost: $50,913.23.

IV. Request for Comments

Comments are invited on: (1) Whether the proposed collection of information is necessary for the proper performance of the functions of NASA, including whether the information collected has practical utility; (2) the accuracy of NASA's estimate of the burden (including hours and cost) of the proposed collection of information; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) ways to minimize the burden of the collection of information on respondents, including automated collection techniques or the use of other forms of information technology.

Frances Teel,

NASA PRA Clearance Officer.

[FR Doc. 2013–29390 Filed 12–9–13; 8:45 am]

BILLING CODE 7510–13–P

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

[Notice: 13–142]

Notice of Information Collection

AGENCY: National Aeronautics and Space Administration (NASA).

ACTION: Notice of information collection.

SUMMARY: The National Aeronautics and Space Administration, as part of its continuing effort to reduce paperwork and respondent burden, invites the general public and other Federal agencies to take this opportunity to comment on proposed and/or continuing information collections, as required by the Paperwork Reduction Act of 1995 (Pub. L. 104–13, 44 U.S.C. 3506(c)(2)(A)).

DATES: All comments should be submitted within 60 calendar days from the date of this publication.

ADDRESSES: All comments should be addressed to Frances Teel, Mail Code JF000, National Aeronautics and Space Administration, Washington, DC 20546–0001.

FOR FURTHER INFORMATION CONTACT: Requests for additional information or copies of the information collection instrument(s) and instructions should be directed to Frances Teel, NASA PRA Clearance Officer, NASA Headquarters, 300 E Street SW., Mail Code JF000, Washington, DC 20546, *Frances.C.Teel@nasa.gov.*

SUPPLEMENTARY INFORMATION:

I. Abstract

NASA's founding legislation, the Space Act of 1958, as amended, directs the Agency to expand human knowledge of Earth and space phenomena and to preserve the role of the United States as a leader in aeronautics, space science, and technology. The NASA Office of Education has three primary goals (1) strengthen NASA and the Nation's future workforce, (2) attract and retain students in science, technology, engineering and mathematics, or STEM, disciplines, and (3) engage Americans in NASA's mission. This regular clearance will enable the NASA Office of Education to fulfill federally mandated reporting on its education activities and investments portfolio as well as selected Agency annual performance indicators.

This information collection will consist of individual-level data such as user profile and program application demographic information submitted by participants in NASA project activities. Participants include educators, and secondary, undergraduate, graduate, and post-graduate students.

II. Method of Collection

Electronic and paper.

III. Data

Title: NASA Office of Education Individual-level Data Collection.

OMB Number: 2700–XXXX.

Type of Review: Regular Clearance.

Affected Public: Individuals.

Estimated Number of Respondents: 1,403,473.

Estimated Annual Responses: 1,425,908.

Estimated Time per Response: Variable.

Estimated Total Annual Burden Hours: 262,316.

Estimated Total Annual Cost: $2,718,148.

IV. Request for Comments

Comments are invited on: (1) Whether the proposed collection of information is necessary for the proper performance of the functions of NASA, including whether the information collected has practical utility; (2) the accuracy of NASA's estimate of the burden (including hours and cost) of the proposed collection of information; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) ways to minimize the burden of the collection of information on respondents, including automated collection techniques or the use of other forms of information technology.

Frances Teel,

NASA PRA Clearance Officer.

[FR Doc. 2013–29389 Filed 12–9–13; 8:45 am]

BILLING CODE 7510–13–P

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

[Notice 13–145]

Notice of Intent To Grant Partially Exclusive License

AGENCY: National Aeronautics and Space Administration.

ACTION: Notice of Intent to Grant Exclusive License.

SUMMARY: This notice is issued in accordance with 35 U.S.C. 209(e) and 37 CFR 404.7(a)(1)(i). NASA hereby gives notice of its intent to grant an partially exclusive license in the United States to practice the inventions described and claimed in USPN 6,485,963, Production Growth Stimulation Of Biological Cells And Tissue By Electromagnetic Fields (EMF) And Uses Thereof, NASA Case No. MSC–22633–1 and USPN 6,673,597, Growth Stimulation Of Biological Cells And Tissue By Electromagnetic Fields And Uses Thereof, NASA Case No. MSC–22633–3 to Technology Applications International Corporation (TAIC)/Renuèll International Incorporated, having its principal place of business in Aventura, Florida. The fields of use may be limited to research and development, use of EMF rotating wall bioreactor for 3–D expansion of plant and mammalian cell cultures including but not limited to human dermal cells cultures and co-cultures, as well as use of cell culture conditioned media for topical and internal applications. The patent rights in these inventions have been assigned to the United States of America as represented by the Administrator of the National Aeronautics and Space Administration. The prospective partially exclusive license will comply with the terms and conditions of 35 U.S.C. 209 and 37 CFR 404.7.

DATES: The prospective partially exclusive license may be granted unless within fifteen (15) days from the date of this published notice, NASA receives written objections including evidence and argument that establish that the grant of the license would not be consistent with the requirements of 35 U.S.C. 209 and 37 CFR 404.7. Competing applications completed and received by NASA within fifteen (15) days of the date of this published notice

will also be treated as objections to the grant of the contemplated exclusive license.

Objections submitted in response to this notice will not be made available to the public for inspection and, to the extent permitted by law, will not be released under the Freedom of Information Act. 5 U.S.C. 552.

ADDRESSES: Objections relating to the prospective license may be submitted to Patent Counsel, Office of Chief Counsel, NASA Johnson Space Center, 2101 NASA Parkway, Houston, Texas 77058, Mail Code AL; Phone (281) 483–3021; Fax (281) 483–6936.

FOR FURTHER INFORMATION CONTACT: Ted Ro, Intellectual Property Attorney, Office of Chief Counsel, NASA Johnson Space Center, 2101 NASA Parkway, Houston, Texas 77058, Mail Code AL; Phone (281) 244–7148; Fax (281) 483–6936. Information about other NASA inventions available for licensing can be found online at *http://technology.nasa.gov/.*

Sumara M. Thompson-King,

Deputy General Counsel.

[FR Doc. 2013–29409 Filed 12–9–13; 8:45 am]

BILLING CODE 7510–13–P

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

[Notice 13–146]

Notice of Intent To Grant a Partially Exclusive License

AGENCY: National Aeronautics and Space Administration.

ACTION: Notice of intent to grant partially exclusive license.

SUMMARY: This notice is issued in accordance with 35 U.S.C. 209(e) and 37 CFR 404.7(a)(1)(i). NASA hereby gives notice of its intent to grant a partially exclusive license in the United States to practice the inventions described and claimed in U.S. Patent No. 7,075,295 B2, "Magnetic Field Response Sensor for Conductive Media," NASA Case No. LAR–16571–1; U.S. Patent No. 7,589,525 B2, "Magnetic Field Response Sensor for Conductive Media," NASA Case No. LAR–16571–2; U.S. Patent No. 7,255,004 B2, "Wireless Fluid Level Measuring System," NASA Case No. LAR–17155–1; U.S. Patent No. 7,086,593 B2, "Magnetic Field Response Measurement Acquisition System," NASA Case No. LAR–16908–1; U.S. Patent No. 7,159,774 B2, "Magnetic Field Response Measurement Acquisition System," NASA Case No. LAR–17280–1; U.S. Patent No. 8,430,327 B2, "Wireless Sensing System Using Open-Circuit, Electrically-Conductive Spiral-Trace Sensor," NASA Case No. LAR–17294–1; and U.S. Patent No. 7,711,509 B2, "Method of Calibrating a Fluid-Level Measurement System," NASA Case No. LAR–17480–1 to Caplan Taylor Enterprises LLC (DBA Tidewater Sensors LLC) having its principal place of business in Newport News, Virginia. The fields of use may be limited to, but not necessarily limited to, fluid level measurement in automotive (including cars, trucks, recreational vehicles, and motorcycles) and train applications limited to gasoline, diesel fuel, biodiesel fuel, fuel oil, waste water, and liquid waste. The patent rights in these inventions have been assigned to the United States of America as represented by the Administrator of the National Aeronautics and Space Administration. The prospective partially exclusive license will comply with the terms and conditions of 35 U.S.C. 209 and 37 CFR 404.7.

DATES: The prospective partially exclusive license may be granted unless, within fifteen (15) days from the date of this published notice, NASA receives written objections including evidence and argument that establish that the grant of the license would not be consistent with the requirements of 35 U.S.C. 209 and 37 CFR 404.7. Competing applications completed and received by NASA within fifteen (15) days of the date of this published notice will also be treated as objections to the grant of the contemplated partially exclusive license.

Objections submitted in response to this notice will not be made available to the public for inspection and, to the extent permitted by law, will not be released under the Freedom of Information Act, 5 U.S.C. 552.

ADDRESSES: Objections relating to the prospective license may be submitted to Patent Counsel, Office of Chief Counsel, NASA Langley Research Center, MS 30, Hampton, VA 23681; (757) 864–3230 (phone), (757) 864–9190 (fax).

FOR FURTHER INFORMATION CONTACT: Robin W. Edwards, Patent Counsel, Office of Chief Counsel, NASA Langley Research Center, MS 30, Hampton, VA 23681; (757) 864–3230; Fax: (757) 864–9190. Information about other NASA inventions available for licensing can be found online at *http://technology.nasa.gov.*

Sumara M. Thompson-King,

Deputy General Counsel.

[FR Doc. 2013–29408 Filed 12–9–13; 8:45 am]

BILLING CODE 7510–13–P

NATIONAL ARCHIVES AND RECORDS ADMINISTRATION

[NARA–2014–007]

Records Schedules; Availability and Request for Comments

AGENCY: National Archives and Records Administration (NARA).

ACTION: Notice of availability of proposed records schedules; request for comments.

SUMMARY: The National Archives and Records Administration (NARA) publishes notice at least once monthly of certain Federal agency requests for records disposition authority (records schedules). Once approved by NARA, records schedules provide mandatory instructions on what happens to records when no longer needed for current government business. They authorize the preservation of records of continuing value in the National Archives of the United States and the destruction, after a specified period, of records lacking administrative, legal, research, or other value. Notice is published for records schedules in which agencies propose to destroy records not previously authorized for disposal or reduce the retention period of records already authorized for disposal. NARA invites public comments on such records schedules, as required by 44 U.S.C. 3303a(a).

DATES: Requests for copies must be received in writing on or before January 9, 2014. Once the appraisal of the records is completed, NARA will send a copy of the schedule. NARA staff usually prepares appraisal memoranda that contain additional information concerning the records covered by a proposed schedule. These, too, may be requested and will be provided once the appraisal is completed. Requesters will be given 30 days to submit comments.

ADDRESSES: You may request a copy of any records schedule identified in this notice by contacting Records Management Services (ACNR) using one of the following means:

Mail: NARA (ACNR), 8601 Adelphi Road, College Park, MD 20740–6001.

Email: request.schedule@nara.gov.

FAX: 301–837–3698.

Requesters must cite the control number, which appears in parentheses after the name of the agency which submitted the schedule, and must provide a mailing address. Those who desire appraisal reports should so indicate in their request.

FOR FURTHER INFORMATION CONTACT: Margaret Hawkins, Director, Records Management Services (ACNR), National

Archives and Records Administration, 8601 Adelphi Road, College Park, MD 20740–6001. Telephone: 301–837–1799. Email: *request.schedule@nara.gov.*

SUPPLEMENTARY INFORMATION: Each year, Federal agencies create billions of records on paper, film, magnetic tape, and other media. To control this accumulation, agency records managers prepare schedules proposing retention periods for records and submit these schedules for NARA's approval. These schedules provide for the timely transfer into the National Archives of historically valuable records and authorize the disposal of all other records after the agency no longer needs them to conduct its business. Some schedules are comprehensive and cover all the records of an agency or one of its major subdivisions. Most schedules, however, cover records of only one office or program or a few series of records. Many of these update previously approved schedules, and some include records proposed as permanent.

The schedules listed in this notice are media neutral unless specified otherwise. An item in a schedule is media neutral when the disposition instructions may be applied to records regardless of the medium in which the records are created and maintained. Items included in schedules submitted to NARA on or after December 17, 2007, are media neutral unless the item is limited to a specific medium. (See 36 CFR 1225.12(e).)

No Federal records are authorized for destruction without the approval of the Archivist of the United States. This approval is granted only after a thorough consideration of their administrative use by the agency of origin, the rights of the government and of private people directly affected by the government's activities, and whether or not they have historical or other value.

Besides identifying the Federal agencies and any subdivisions requesting disposition authority, this public notice lists the organizational unit(s) accumulating the records or indicates agency-wide applicability in the case of schedules that cover records that may be accumulated throughout an agency. This notice provides the control number assigned to each schedule, the total number of schedule items, and the number of temporary items (the records proposed for destruction). It also includes a brief description of the temporary records. The records schedule itself contains a full description of the records at the file unit level as well as their disposition. If NARA staff has prepared an appraisal memorandum for the schedule, it, too, includes information about the records. Further information about the disposition process is available on request.

Schedules Pending

1. Department of Health and Human Services, Agency-wide (DAA–0468–2013–0009, 4 items, 2 temporary items). Routine and working files of high-level officials. Proposed for permanent retention are official files and briefing books of high-level officials.

2. Department of Health and Human Services, Administration for Children and Families (DAA–0292–2012–0001, 6 items, 6 temporary items). Children's Bureau records including child and family services plans, child and family services reviews, and eligibility review reports.

3. Department of Health and Human Services, Office of the Secretary (DAA–0468–2013–0010, 3 items, 1 temporary item). Final audit reports and audit working papers. Proposed for permanent retention are significant final audit reports.

4. Department of Homeland Security, Transportation Security Administration (N1–560–12–12, 5 items, 5 temporary items). Working papers, reports, and referrals of a passenger security program.

5. Department of the Interior, Bureau of Land Management (DAA–0049–2013–0002, 2 items, 1 temporary item). Production accountability review records for oil and gas leases on public lands. Proposed for permanent retention are production accountability review records for Indian Trust lands.

6. Department of Justice, United States Marshals Service (DAA–0527–2013–0021, 1 item, 1 temporary item). Identity records created for witnesses or potential witnesses for the Federal or state government in criminal proceedings.

7. Department of State, Bureau of Diplomatic Security (DAA–0059–2012–0002, 7 items, 5 temporary items). Records of the Public Affairs Office including subject files, publications, newsletters, and presentations. Proposed for permanent retention are photographs and historical publications.

8. Department of State, Bureau of International Narcotics and Law Enforcement (DAA–0059–2013–0003, 6 items, 2 temporary items). Audit and project files of the Office of Iraq Programs. Proposed for permanent retention are program files and significant project files.

9. Department of the Treasury, Office of the Chief Information Officer (DAA–0056–2012–0002, 4 items, 4 temporary items). Master files and system documentation of an electronic information system used to track information systems within the Department. Records also include program development and reporting records.

Dated: December 4, 2013.

Paul M. Wester, Jr.,

Chief Records Officer for the U.S. Government.

[FR Doc. 2013–29424 Filed 12–9–13; 8:45 am]

BILLING CODE 7515–01–P

NATIONAL FOUNDATION FOR THE ARTS AND THE HUMANITIES

Notice of Proposed Information Collection Requests: Heritage Health Index II on the State of America's Collections (HHI II)

AGENCY: Institute of Museum and Library Services, National Foundation for the Arts and the Humanities.

ACTION: Notice, request for comments, collection of information.

SUMMARY: The Institute of Museum and Library Services (IMLS), as part of its continuing effort to reduce paperwork and respondent burden, conducts a pre-clearance consultation program to provide the general public and federal agencies with an opportunity to comment on proposed and/or continuing collections of information in accordance with the Paperwork Reduction Act (44 U.S.C. Chapter 35). This pre-clearance consultation program helps to ensure that requested data can be provided in the desired format, reporting burden (time and financial resources) is minimized, collection instruments are clearly understood, and the impact of collection requirements on respondents can be properly assessed. By this notice, IMLS is soliciting comments concerning a proposed survey to collect information to monitor the use, expectations of and satisfaction with cultural programs and services, most especially library and museum services.

A copy of the proposed information collection request can be obtained by contacting the individual listed below in the **ADDRESSES** section of this notice.

DATES: Written comments must be submitted to the office listed in the addressee section below on or before February 6, 2014. IMLS is particularly interested in comments that help the agency to:

- Evaluate whether the proposed collection of information is necessary for the proper performance of the

functions of the agency, including whether the information will have practical utility;

- Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information including the validity of the methodology and assumptions used;
- Enhance the quality, utility, and clarity of the information to be collected; and
- Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated electronic, mechanical, or other technological collection techniques, or other forms of information technology, e.g., permitting electronic submissions of responses.

ADDRESSES: Send comments to: Christopher J. Reich, Senior Advisor, Institute of Museum and Library Services, 1800 M St. NW. 9th Floor, Washington, DC 20036. Mr. Reich can be reached by Telephone: 202–653–4685, Fax: 202–653–4608, or by email at *creich@imls.gov,* or by teletype (TTY/TDD) for persons with hearing difficulty at 202–653–4614.

SUPPLEMENTARY INFORMATION:

I. Background

The Institute of Museum and Library Services is the primary source of federal support for the Nation's 123,000 libraries and 17,500 museums. The Institute's mission is to inspire libraries and museums to advance innovation, learning and civic engagement. The Institute works at the national level and in coordination with state and local organizations to sustain heritage, culture, and knowledge; enhance learning and innovation; and support professional development. IMLS is responsible for identifying national needs for and trends in museum, library, and information services; measuring and reporting on the impact and effectiveness of museum, library and information services throughout the United States, including programs conducted with funds made available by IMLS; identifying, and disseminating information on, the best practices of such programs; and developing plans to improve museum, library and information services of the United States and strengthen national, State, local, regional, and international communications and cooperative networks (20 U.S.C. Chapter 72, 20 U.S.C. 9108).

II. Current Actions

The intention of the Heritage Health Index II on the State of America's Collections (HHI II) is to assess the state of preservation across the entire spectrum of collecting institutions, large and small, from internationally renowned art museums and research libraries to local historical societies and specialized archives. Conservation practices on all types of media will be covered, with a small number of questions about each topic included on the survey.

The purpose of this survey is to gather information on the state of collections care across cultural heritage organizations, including tracking trends and assessing the current state of digital conservation. The design of the HHI II will be a repeated cross-sectional web survey of U.S. cultural heritage organizations, which will yield a minimum of 3,000 cases.

The HHI II will include a core set of institutional and administrative questions (e.g., size, number of paid staff, number of visitors, governance, geographic area) as well as a core set of questions grouped by conservation practices and standards (e.g., environmental controls; long-range and emergency planning; funding and expenditures on collections; number of collections items and the state of each item). In addition to these core questions, supplemental questions may also be included.

Agency: Institute of Museum and Library Services.

Title: Heritage Health Index II on the State of America's Collections (HHI II).

OMB Number: To Be Determined.

Frequency: N/A.

Affected Public: The target population for the HHI II Survey is U.S. cultural heritage organizations, including libraries, museums, archives, and archaeological repositories. A national probability sample of institutions generated using available mailing lists will be employed by the survey. Individual survey respondents within selected institutions will be knowledgeable persons about collections care and practices.

Number of Respondents: 3,000.

Estimated Average Burden per Response: The burden per respondent is estimated to be an average of 45 minutes based on the size of the questionnaire.

Estimated Total Annual Burden: 2,250 hours.

Total Annualized capital/startup costs: n/a.

Total Annual costs: To be determined.

Public Comments Invited: Comments submitted in response to this notice will be summarized and/or included in the request for OMB's clearance of this information collection.

FOR FURTHER INFORMATION CONTACT: Christopher J. Reich, Senior Advisor, Institute of Museum and Library Services, 1800 M St., NW., 9th Floor, Washington, DC 20036. Mr. Reich can be reached by Telephone: 202–653–4685, Fax: 202–653–4608, or by email at *creich@imls.gov,* or by teletype (TTY/TDD) for persons with hearing difficulty at 202/653–4614. Office hours are from 8:30 a.m. to 5 p.m., E.T., Monday through Friday, except Federal holidays.

Dated: December 5, 2013.

Kim Miller,

Management Analyst.

[FR Doc. 2013–29455 Filed 12–9–13; 8:45 am]

BILLING CODE 7036–01–P

NATIONAL FOUNDATION ON THE ARTS AND THE HUMANITIES

Humanities Panel Advisory Committee

AGENCY: National Endowment for the Humanities.

ACTION: Notice of Charter Renewal for Humanities Panel Advisory Committee.

SUMMARY: Pursuant to section 9(a)(2) of the Federal Advisory Committee Act (5 U.S.C. App.) and its implementing regulations, 41 CFR 102–3.65, the National Endowment for the Humanities (NEH) gives notice that the Charter for the Humanities Panel advisory committee was renewed for an additional two-year period on November 26, 2013. The Acting Chairman of NEH determined that the renewal of the Humanities Panel is necessary and in the public interest in connection with the performance of duties imposed upon the Chairperson of NEH by the National Foundation on the Arts and the Humanities Act of 1965, 20 U.S.C. 951 et seq., as amended.

FOR FURTHER INFORMATION CONTACT: Lisette Voyatzis, Committee Management Officer, 1100 Pennsylvania Ave. NW., Room 529, Washington, DC 20506. Telephone: (202) 606–8322, facsimile (202) 606–8600, or email at *gencounsel@neh.gov.* Hearing-impaired individuals are advised that information on this matter may be obtained by contacting the National Endowment for the Humanities' TDD terminal at (202) 606–8282.

Dated: December 5, 2013.

Lisette Voyatzis,

Committee Management Officer.

[FR Doc. 2013–29452 Filed 12–9–13; 8:45 am]

BILLING CODE 7536–01–P

NATIONAL FOUNDATION ON THE ARTS AND THE HUMANITIES

Federal Council on the Arts and the Humanities; Arts and Artifacts Indemnity Panel Advisory Committee

AGENCY: National Endowment for the Humanities

ACTION: Notice of Charter Renewal for Arts and Artifacts Indemnity Panel Advisory Committee.

SUMMARY: Pursuant to section 9(a)(2) of the Federal Advisory Committee Act (5 U.S.C. App.) and its implementing regulations, 41 CFR 102–3.65, the Federal Council on the Arts and the Humanities (the Council) gives notice that the Charter for the Arts and Artifacts Indemnity Panel advisory committee was renewed for an additional two-year period on November 26, 2013. The Council determined that renewing the advisory committee is in the public interest in connection with the duties imposed on the Council by the Arts and Artifacts Indemnity Act, 20 U.S.C. 971 et seq., as amended.

FOR FURTHER INFORMATION CONTACT: Lisette Voyatzis, Committee Management Officer, 1100 Pennsylvania Ave., NW., Room 529, Washington, DC 20506. Telephone: (202) 606–8322, facsimile (202) 606–8600, or email at *gencounsel@neh.gov*. Hearing-impaired individuals are advised that information on this matter may be obtained by contacting the National Endowment for the Humanities' TDD terminal at (202) 606–8282.

Dated: December 5, 2013.

Lisette Voyatzis,

Committee Management Officer.

[FR Doc. 2013–29456 Filed 12–9–13; 8:45 am]

BILLING CODE 7536–01–P

NATIONAL FOUNDATION ON THE ARTS AND THE HUMANITIES

Meetings of Humanities Panel

AGENCY: National Endowment for the Humanities.

ACTION: Notice of meetings.

SUMMARY: Pursuant to section 10(a)(2) of the Federal Advisory Committee Act (5 U.S.C. App.), notice is hereby given that three meetings of the Humanities Panel will be held during January 2014 as follows. The purpose of the meetings is for panel review, discussion, evaluation, and recommendation of applications for financial assistance under the National Foundation on the Arts and Humanities Act of 1965 (20 U.S.C. 951–960, as amended).

DATES: See **SUPPLEMENTARY INFORMATION** section for meeting dates.

ADDRESSES: The meetings will be held at The John W. Kluge Center at the Library of Congress, 101 Independence Avenue SE., Washington, DC 20540–4860.

FOR FURTHER INFORMATION CONTACT: Lisette Voyatzis, Committee Management Officer, 1100 Pennsylvania Ave. NW., Room, 529, Washington, DC 20506, or call (202) 606–8322. Hearing-impaired individuals are advised that information on this matter may be obtained by contacting the National Endowment for the Humanities' TDD terminal at (202) 606–8282.

SUPPLEMENTARY INFORMATION:

Meetings

1. *Date:* January 13, 2014

Time: 8:30 a.m. to 5:00 p.m.

This meeting will discuss applications for the Kluge Fellowships grant program, submitted to the division of Research Programs.

2. *Date:* January 14, 2014

Time: 8:30 a.m. to 5:00 p.m.

This meeting will discuss applications for the Klug Fellowships grant program, submitted to the division of Research Programs.

3. *Date:* January 16, 2014

Time: 8:30 a.m. to 5:00 p.m.

This meeting will discuss applications for the Kluge Fellowships grant program, submitted to the division of Research Programs.

Because these meetings will include review of personal and/or proprietary financial and commercial information given in confidence to the agency by grant applicants, the meetings will be closed to the public pursuant to sections 552b(c)(4) and 552b(c)(6) of Title 5, U.S.C., as amended. I have made this determination pursuant to the authority granted me by the Chairman's Delegation of Authority to Close Advisory Committee Meetings dated July 19, 1993.

Dated: December 5, 2013.

Lisette Voyatzis,

Committee Management Officer.

[FR Doc. 2013–29453 Filed 12–9–13; 8:45 am]

BILLING CODE 7536–01–P

NUCLEAR REGULATORY COMMISSION

[Docket No. NRC–2013–0268]

Agency Information Collection Activities: Proposed Collection; Comment Request; Generic Clearance for the Collection of Qualitative Feedback on Agency Service Delivery

AGENCY: Nuclear Regulatory Commission.

ACTION: 30-day notice of submission of information collection approval from the Office of Management and Budget (OMB) and request for comments.

SUMMARY: As part of a Federal Governmentwide effort to streamline the process to seek feedback from the public on service delivery, the U.S. Nuclear Regulatory Commission (NRC) has submitted a Generic Information Collection Request (Generic ICR): "Generic Clearance for the Collection of Qualitative Feedback on Agency Service Delivery" to OMB for approval under the Paperwork Reduction Act (PRA) (44 U.S.C. 3501 et. seq.).

DATES: Comments must be submitted January 9, 2014.

ADDRESSES: Written comments may be submitted directly to the OMB reviewer Chad Whiteman, Desk Officer, Office of Information and Regulatory Affairs, NEOB–10202, Office of Management and Budget, Washington, DC 20503. Comments can also be emailed to *Chad_S_Whiteman@omb.eop.gov* or submitted by telephone at 202–395–4718. The NRC Clearance Officer is Tremaine Donnell, 301–415–6258. Comments received after this date will be considered if it is practical to do so, but assurance of consideration cannot be given to comments received after this date.

FOR FURTHER INFORMATION CONTACT: To request additional information, please contact the NRC Clearance Officer, Tremaine Donnell (T–5 F53), U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001; telephone: 301–415–6258, or by email to *INFOCOLLECTS.Resource@NRC.GOV*.

SUPPLEMENTARY INFORMATION:

Title: Generic Clearance for the Collection of Qualitative Feedback on Agency Service Delivery.

Abstract: The information collection activity will garner qualitative customer and stakeholder feedback in an efficient, timely manner, in accordance with the Administration's commitment to improving service delivery. By qualitative feedback we mean information that provides useful insights on perceptions and opinions,

but are not statistical surveys that yield quantitative results that can be generalized to the population of study. This feedback will provide insights into customer or stakeholder perceptions, experiences and expectations, provide an early warning of issues with service, or focus attention on areas where communication, training or changes in operations might improve delivery of products or services. These collections will allow for ongoing, collaborative and actionable communications between the Agency and its customers and stakeholders. It will also allow feedback to contribute directly to the improvement of program management.

Feedback collected under this generic clearance will provide useful information, but it will not yield data that can be generalized to the overall population. This type of generic clearance for qualitative information will not be used for quantitative information collections that are designed to yield reliably actionable results, such as monitoring trends over time or documenting program performance. Such data uses require more rigorous designs that address: The target population to which generalizations will be made, the sampling frame, the sample design (including stratification and clustering), the precision requirements or power calculations that justify the proposed sample size, the expected response rate, methods for assessing potential non-response bias, the protocols for data collection, and any testing procedures that were or will be undertaken prior fielding the study. Depending on the degree of influence the results are likely to have, such collections may still be eligible for submission for other generic mechanisms that are designed to yield quantitative results.

The NRC received no comments in response to the 60-day notice published in the **Federal Register** of December 22, 2010 (75 FR 80542).

Below we provide NRC's projected average estimates for the next 3 years: [1]

Current Actions: New collection of information.

Type of Review: New Collection.

Affected Public: Individuals and Households, Businesses and Organizations, State, Local or Tribal Government.

Average Expected Annual Number of Activities: 56.

Respondents: 6,665.

Annual Responses: 6,665.

Frequency of Response: Once per request, on occasion.

Average Minutes per Response: 32.25.

Burden Hours: 3,582.5.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number.

Dated at Rockville, Maryland, this 4th day of December 2013.

For the Nuclear Regulatory Commission.

Brenda Miles,

Acting NRC Clearance Officer, Office of Information Services.

[FR Doc. 2013–29430 Filed 12–9–13; 8:45 am]

BILLING CODE 7590–01–P

[1] The 60-day notice included the following estimate of the aggregate burden hours for this generic clearance federal-wide:

Average Expected Annual Number of Activities: 25,000.

Average Number of Respondents per Activity: 200.

Annual Responses: 5,000,000.

Frequency of Response: Once per request.

Average Minutes per Response: 30.

Burden Hours: 2,500,000.

NUCLEAR REGULATORY COMMISSION

[NRC–2013–0266]

Biweekly Notice; Applications and Amendments to Facility Operating Licenses and Combined Licenses Involving No Significant Hazards Considerations

Background

Pursuant to Section 189a.(2) of the Atomic Energy Act of 1954, as amended (the Act), the U.S. Nuclear Regulatory Commission (NRC) is publishing this regular biweekly notice. The Act requires the Commission to publish notice of any amendments issued, or proposed to be issued and grants the Commission the authority to issue and make immediately effective any amendment to an operating license or combined license, as applicable, upon a determination by the Commission that such amendment involves no significant hazards consideration, notwithstanding the pendency before the Commission of a request for a hearing from any person.

This biweekly notice includes all notices of amendments issued, or proposed to be issued from November 14, 2013 to November 27, 2013. The last biweekly notice was published on November 26, 2013 (78 FR 70589).

ADDRESSES: You may submit comment by any of the following methods (unless this document describes a different method for submitting comments on a specific subject):

- *Federal Rulemaking Web site:* Go to *http://www.regulations.gov* and search for Docket ID NRC–2013–0266. Address questions about NRC dockets to Carol Gallagher; telephone: 301–287–3422; email: *Carol.Gallagher@nrc.gov.* For technical questions, contact the individual(s) listed in the **FOR FURTHER INFORMATION CONTACT** section of this document.
- *Mail comments to:* Cindy Bladey, Chief, Rules, Announcements, and Directives Branch (RADB), Office of Administration, Mail Stop: 3WFN, 06–44M, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001.

For additional direction on accessing information and submitting comments, see "Accessing Information and Submitting Comments" in the **SUPPLEMENTARY INFORMATION** section of this document.

SUPPLEMENTARY INFORMATION:

I. Accessing Information and Submitting Comments

A. Accessing Information

Please refer to Docket ID NRC–2013–0266 when contacting the NRC about the availability of information regarding this document. You may access publicly-available information related to this action by the following methods:

- *Federal Rulemaking Web site:* Go to *http://www.regulations.gov* and search for Docket ID NRC–2013–0266.
- *NRC's Agencywide Documents Access and Management System (ADAMS):* You may access publicly-available documents online in the NRC Library at *http://www.nrc.gov/reading-rm/adams.html.* To begin the search, select "*ADAMS Public Documents*" and then select "*Begin Web-based ADAMS Search.*" For problems with ADAMS, please contact the NRC's Public Document Room (PDR) reference staff at 1–800–397–4209, 301–415–4737, or by email to *pdr.resource@nrc.gov.* The ADAMS accession number for each document referenced in this notice (if that document is available in ADAMS) is provided the first time that a document is referenced.
- *NRC's PDR:* You may examine and purchase copies of public documents at the NRC's PDR, Room O1–F21, One White Flint North, 11555 Rockville Pike, Rockville, Maryland 20852.

B. Submitting Comments

Please include Docket ID NRC–2013–0266 in the subject line of your comment submission, in order to ensure that the NRC is able to make your comment submission available to the public in this docket.

The NRC cautions you not to include identifying or contact information that you do not want to be publicly disclosed in your comment submission.

The NRC posts all comment submissions at *http://www.regulations.gov* as well as entering the comment submissions into ADAMS. The NRC does not routinely edit comment submissions to remove identifying or contact information.

If you are requesting or aggregating comments from other persons for submission to the NRC, then you should inform those persons not to include identifying or contact information that they do not want to be publicly disclosed in their comment submission. Your request should state that the NRC does not routinely edit comment submissions to remove such information before making the comment submissions available to the public or entering the comment submissions into ADAMS.

Notice of Consideration of Issuance of Amendments to Facility Operating Licenses and Combined Licenses, Proposed No Significant Hazards Consideration Determination, and Opportunity for a Hearing

The Commission has made a proposed determination that the following amendment requests involve no significant hazards consideration. Under the Commission's regulations in Section 50.92 of Title 10 of the *Code of Federal Regulations* (10 CFR), this means that operation of the facility in accordance with the proposed amendment would not (1) involve a significant increase in the probability or consequences of an accident previously evaluated; or (2) create the possibility of a new or different kind of accident from any accident previously evaluated; or (3) involve a significant reduction in a margin of safety. The basis for this proposed determination for each amendment request is shown below.

The Commission is seeking public comments on this proposed determination. Any comments received within 30 days after the date of publication of this notice will be considered in making any final determination.

Normally, the Commission will not issue the amendment until the expiration of 60 days after the date of publication of this notice. The Commission may issue the license amendment before expiration of the 60-day period provided that its final determination is that the amendment involves no significant hazards consideration. In addition, the Commission may issue the amendment prior to the expiration of the 30-day comment period should circumstances change during the 30-day comment period such that failure to act in a timely way would result, for example in derating or shutdown of the facility. Should the Commission take action prior to the expiration of either the comment period or the notice period, it will publish in the **Federal Register** a notice of issuance. Should the Commission make a final No Significant Hazards Consideration Determination; any hearing will take place after issuance. The Commission expects that the need to take this action will occur very infrequently.

Within 60 days after the date of publication of this notice, any person(s) whose interest may be affected by this action may file a request for a hearing and a petition to intervene with respect to issuance of the amendment to the subject facility operating license or combined license. Requests for a hearing and a petition for leave to intervene shall be filed in accordance with the Commission's "Agency Rules of Practice and Procedure" in 10 CFR part 2. Interested person(s) should consult a current copy of 10 CFR 2.309, which is available at the NRC's PDR, located at One White Flint North, Room O1–F21, 11555 Rockville Pike (first floor), Rockville, Maryland 20852. The NRC regulations are accessible electronically from the NRC Library on the NRC's Web site at *http://www.nrc.gov/reading-rm/doc-collections/cfr/*. If a request for a hearing or petition for leave to intervene is filed by the above date, the Commission or a presiding officer designated by the Commission or by the Chief Administrative Judge of the Atomic Safety and Licensing Board Panel, will rule on the request and/or petition; and the Secretary or the Chief Administrative Judge of the Atomic Safety and Licensing Board will issue a notice of a hearing or an appropriate order.

As required by 10 CFR 2.309, a petition for leave to intervene shall set forth with particularity the interest of the petitioner in the proceeding, and how that interest may be affected by the results of the proceeding. The petition should specifically explain the reasons why intervention should be permitted with particular reference to the following general requirements: (1) The name, address, and telephone number of the requestor or petitioner; (2) the nature of the requestor's/petitioner's right under the Act to be made a party to the proceeding; (3) the nature and extent of the requestor's/petitioner's property, financial, or other interest in the proceeding; and (4) the possible effect of any decision or order which may be entered in the proceeding on the requestor's/petitioner's interest. The petition must also identify the specific contentions which the requestor/petitioner seeks to have litigated at the proceeding.

Each contention must consist of a specific statement of the issue of law or fact to be raised or controverted. In addition, the requestor/petitioner shall provide a brief explanation of the bases for the contention and a concise statement of the alleged facts or expert opinion which support the contention and on which the requestor/petitioner intends to rely in proving the contention at the hearing. The requestor/petitioner must also provide references to those specific sources and documents of which the petitioner is aware and on which the requestor/petitioner intends to rely to establish those facts or expert opinion. The petition must include sufficient information to show that a genuine dispute exists with the applicant on a material issue of law or fact. Contentions shall be limited to matters within the scope of the amendment under consideration. The contention must be one which, if proven, would entitle the requestor/petitioner to relief. A requestor/petitioner who fails to satisfy these requirements with respect to at least one contention will not be permitted to participate as a party.

Those permitted to intervene become parties to the proceeding, subject to any limitations in the order granting leave to intervene, and have the opportunity to participate fully in the conduct of the hearing.

If a hearing is requested, the Commission will make a final determination on the issue of no significant hazards consideration. The final determination will serve to decide when the hearing is held. If the final determination is that the amendment request involves no significant hazards consideration, the Commission may issue the amendment and make it immediately effective, notwithstanding the request for a hearing. Any hearing held would take place after issuance of the amendment. If the final determination is that the amendment request involves a significant hazards consideration, then any hearing held would take place before the issuance of any amendment.

All documents filed in NRC adjudicatory proceedings, including a request for hearing, a petition for leave to intervene, any motion or other document filed in the proceeding prior to the submission of a request for hearing or petition to intervene, and documents filed by interested governmental entities participating under 10 CFR 2.315(c), must be filed in

accordance with the NRC's E-Filing rule (72 FR 49139; August 28, 2007). The E-Filing process requires participants to submit and serve all adjudicatory documents over the internet, or in some cases to mail copies on electronic storage media. Participants may not submit paper copies of their filings unless they seek an exemption in accordance with the procedures described below.

To comply with the procedural requirements of E-Filing, at least 10 days prior to the filing deadline, the participant should contact the Office of the Secretary by email at *hearing.docket@nrc.gov*, or by telephone at 301–415–1677, to request (1) a digital identification (ID) certificate, which allows the participant (or its counsel or representative) to digitally sign documents and access the E-Submittal server for any proceeding in which it is participating; and (2) advise the Secretary that the participant will be submitting a request or petition for hearing (even in instances in which the participant, or its counsel or representative, already holds an NRC-issued digital ID certificate). Based upon this information, the Secretary will establish an electronic docket for the hearing in this proceeding if the Secretary has not already established an electronic docket.

Information about applying for a digital ID certificate is available on the NRC's public Web site at *http://www.nrc.gov/site-help/e-submittals/apply-certificates.html*. System requirements for accessing the E-Submittal server are detailed in the NRC's "Guidance for Electronic Submission," which is available on the agency's public Web site at *http://www.nrc.gov/site-help/e-submittals.html*. Participants may attempt to use other software not listed on the Web site, but should note that the NRC's E-Filing system does not support unlisted software, and the NRC Meta System Help Desk will not be able to offer assistance in using unlisted software.

If a participant is electronically submitting a document to the NRC in accordance with the E-Filing rule, the participant must file the document using the NRC's online, Web-based submission form. In order to serve documents through the Electronic Information Exchange System, users will be required to install a Web browser plug-in from the NRC's Web site. Further information on the Web-based submission form, including the installation of the Web browser plug-in, is available on the NRC's public Web site at *http://www.nrc.gov/site-help/e-submittals.html*.

Once a participant has obtained a digital ID certificate and a docket has been created, the participant can then submit a request for hearing or petition for leave to intervene. Submissions should be in Portable Document Format (PDF) in accordance with the NRC's guidance available on the NRC's public Web site at *http://www.nrc.gov/site-help/e-submittals.html*. A filing is considered complete at the time the documents are submitted through the NRC's E-Filing system. To be timely, an electronic filing must be submitted to the E-Filing system no later than 11:59 p.m. Eastern Time on the due date. Upon receipt of a transmission, the E-Filing system time-stamps the document and sends the submitter an email notice confirming receipt of the document. The E-Filing system also distributes an email notice that provides access to the document to the NRC's Office of the General Counsel and any others who have advised the Office of the Secretary that they wish to participate in the proceeding, so that the filer need not serve the documents on those participants separately. Therefore, applicants and other participants (or their counsel or representative) must apply for and receive a digital ID certificate before a hearing request/petition to intervene is filed so that they can obtain access to the document via the E-Filing system.

A person filing electronically using the agency's adjudicatory E-Filing system may seek assistance by contacting the NRC Meta System Help Desk through the "Contact Us" link located on the NRC's Web site at *http://www.nrc.gov/site-help/e-submittals.html*, by email to *MSHD.Resource@nrc.gov*, or by a toll-free call at 1–866–672–7640. The NRC Meta System Help Desk is available between 8 a.m. and 8 p.m., Eastern Time, Monday through Friday, excluding government holidays.

Participants who believe that they have a good cause for not submitting documents electronically must file an exemption request, in accordance with 10 CFR 2.302(g), with their initial paper filing requesting authorization to continue to submit documents in paper format. Such filings must be submitted by: (1) First class mail addressed to the Office of the Secretary of the Commission, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001, Attention: Rulemaking and Adjudications Staff; or (2) courier, express mail, or expedited delivery service to the Office of the Secretary, Sixteenth Floor, One White Flint North, 11555 Rockville Pike, Rockville, Maryland 20852, Attention: Rulemaking and Adjudications Staff. Participants filing a document in this manner are responsible for serving the document on all other participants. Filing is considered complete by first-class mail as of the time of deposit in the mail, or by courier, express mail, or expedited delivery service upon depositing the document with the provider of the service. A presiding officer, having granted an exemption request from using E-Filing, may require a participant or party to use E-Filing if the presiding officer subsequently determines that the reason for granting the exemption from use of E-Filing no longer exists.

Documents submitted in adjudicatory proceedings will appear in the NRC's electronic hearing docket which is available to the public at *http://ehd1.nrc.gov/ehd/*, unless excluded pursuant to an order of the Commission, or the presiding officer. Participants are requested not to include personal privacy information, such as social security numbers, home addresses, or home phone numbers in their filings, unless an NRC regulation or other law requires submission of such information. However, a request to intervene will require including information on local residence in order to demonstrate a proximity assertion of interest in the proceeding. With respect to copyrighted works, except for limited excerpts that serve the purpose of the adjudicatory filings and would constitute a Fair Use application, participants are requested not to include copyrighted materials in their submission.

Petitions for leave to intervene must be filed no later than 60 days from the date of publication of this notice. Requests for hearing, petitions for leave to intervene, and motions for leave to file new or amended contentions that are filed after the 60-day deadline will not be entertained absent a determination by the presiding officer that the filing demonstrates good cause by satisfying the three factors in 10 CFR 2.309(c)(1)(i)–(iii).

For further details with respect to this license amendment application, see the application for amendment which is available for public inspection at the NRC's PDR, located at One White Flint North, Room O1–F21, 11555 Rockville Pike (first floor), Rockville, Maryland 20852. Publicly available documents created or received at the NRC are accessible electronically through ADAMS in the NRC's Library at *http://www.nrc.gov/reading-rm/adams.html*. Persons who do not have access to ADAMS or who encounter

problems in accessing the documents located in ADAMS should contact the NRC PDR's Reference staff at 1–800–397–4209, 301–415–4737, or by email to *pdr.resource@nrc.gov.*

Duke Energy Carolinas, LLC, Docket Nos. 50–369 and 50–370, McGuire Nuclear Station, Units 1 and 2, Mecklenburg County, North Carolina

Date of amendment request: September 12, 2013.

Description of amendment request: The proposed amendments revise technical specification 3.3.2, Emergency Safety Feature Actuation System (ESFAS) Instrumentation, to support planned plant modifications associated with NRC Order EA–12–049, Order Modifying Licenses with Regard to Requirements for Mitigation Strategies for Beyond-Design-Basis External Events. Specifically, the amendment modifies the Allowable Value and Nominal Trip Setpoints listed in Table 3.3.2–1, Function 6.f, Auxiliary Feedwater pump suction transfer on low suction pressure.

Basis for proposed no significant hazards consideration determination: As required by 10 CFR 50.91(a), the licensee has provided its analysis of the issue of no significant hazards consideration, which is presented below:

Criterion 1: Does the proposed amendment involve a significant increase in the probability or consequences of an accident previously evaluated?

Response: No.

The proposed TS changes are in support of a plant modification involving the installation of an AC-independent AFW Suction Transfer scheme and hardware to ensure a continuous AFW suction source during an Extended Loss of AC Power (ELAP) event. The purpose of Table 3.3.2–1 Function 6.f is to preserve the AFW pumps by ensuring a continuous suction supply to the pumps. The proposed change will cause the AFW pumps to align to the safety-related suction source sooner than under the current setpoint values for design basis events. The result of the proposed TS setpoint changes will be an increase in margin for AFW pump suction. The new TS setpoints were selected with sufficient margin for instrument uncertainty to ensure that the safety-related AFW suction transfer function actuates before the new AC independent AFW suction transfer function and to prevent any adverse interaction of the two schemes. In other words, the proposed change will ensure the safety-related suction transfer is initiated before the non-safety AC independent AFW suction transfer initiates. The specific TS changes are associated with 1) the specific Nominal Trip Setpoint and Allowable Values for the AFW Pump Suction Transfer on Suction Pressure—Low feature, 2) the addition of specific requirements to be taken if the as-found channel setpoint is outside its predefined as-found tolerance, and 3) the addition of specific requirements regarding resetting of an channel setpoint within an as-left tolerance.

The AFW Pump Suction Transfer on Suction Pressure—Low feature does not affect the probability of any accident being initiated. In addition, none of the abovementioned proposed TS changes affect the probability of any accident being initiated.

Actuation of the AFW Pump Suction Transfer on Suction Pressure—Low feature will continue to ensure that adequate AFW pump suction is maintained during design bases events. Transfer to the safety-related suction source will actually occur earlier due to the proposed change. The proposed changes to Nominal Trip Setpoints and Allowable Values are based on accepted industry standards and will preserve assumptions in the applicable accident analyses. None of the proposed changes alter any assumption previously made in the radiological consequences evaluations, nor do they affect mitigation of the radiological consequences of an accident previously evaluated.

In summary, the proposed changes will not involve any increase in the probability or consequences of an accident previously evaluated.

Criterion 2: Does the proposed amendment reate the possibility of a new or different kind of accident from any accident previously evaluated?

Response: No.

No new accident scenarios, failure mechanisms, or single failures are introduced as a result of any of the proposed changes. The AFW Pump Suction Transfer feature is not an accident initiator. No changes to the overall manner in which the plant is operated are being proposed. Therefore, none of the proposed changes will create the possibility of a new or different kind of accident from any accident previously evaluated.

Criterion 3: Does the proposed amendment involve a significant reduction in the margin of safety?

Response: No.

Margin of safety is related to the confidence in the ability of the fission product barriers to perform their intended functions. These barriers include the fuel cladding, the reactor coolant system pressure boundary, and the containment barriers. The proposed TS setpoints serve to ensure proper AFW system suction transfer for design bases events, whereby the proposed TS changes will not have any effect on the margin of safety of fission product barriers. In addition, the proposed TS changes will not have any impact on these barriers. No accident mitigating equipment will be adversely impacted as a result of the modification. Therefore, existing safety margins will be preserved. None of the proposed changes will involve a significant reduction in a margin of safety.

Based on the above, it is concluded that the proposed amendment presents no significant hazards consideration under the standards set forth in 10 CFR 50.92(c), and accordingly, a finding of "no significant hazards consideration" is justified.

The NRC staff has reviewed the licensee's analysis and, based on this review, it appears that the three standards of 10 CFR 50.92(c) are satisfied. Therefore, the NRC staff proposes to determine that the amendment request involves no significant hazards consideration.

Attorney for licensee: Lara S. Nichols, Associate General Counsel, Duke Energy Corporation, 526 South Church Street—EC07H, Charlotte, NC 28202.

NRC Branch Chief: Robert J. Pascarelli.

Duke Energy Progress, Inc., Docket No. 50–261, H. B. Robinson Steam Electric Plant, Unit 2, Darlington County, South Carolina

Date of amendment request: September 10, 2013.

Description of amendment request: The proposed change would revise Technical Specification Limiting Condition for Operation 3.8.1, Required Action (RA) B.3.2.2, "One DG [Diesel Generator] Inoperable—Perform SR [Surveillance Requirement] 3.8.1.2 for OPERABLE DG within 96 hours," by a NOTE clarifying RA B.3.2.2 that states, "Not required to be performed when the cause of the inoperable DG is pre-planned maintenance and testing."

Basis for proposed no significant hazards consideration determination: As required by 10 CFR 50.91(a), the licensee has provided its analysis of the issue of no significant hazards consideration, which is presented below:

1. Does the proposed amendment involve a significant increase in the probability or consequences of an accident previously evaluated?

Response: No.

The proposed change eliminates a conditional surveillance of the Operable EDG [emergency diesel generator] whenever the alternate division EDG is out of service for pre-planned maintenance and testing. The EDG are [is] not an initiator of any accident previously evaluated. As a result, the probability of any accident previously evaluated is not significantly increased.

The consequences of any accident previously evaluated are not increased, as the EDG will continue to meet its safety function to supply backup AC [alternating current] power as specified in the accident analysis, in a highly reliable manner, as a common cause problem between the two EDGs will have been precluded, the alternate division EDG will no longer be taken out of service for testing, and its normally scheduled surveillances will be met.

Therefore, the proposed change does not involve a significant increase in the probability or consequences of an accident previously evaluated.

2. Does the proposed amendment create the possibility of a new or different kind of accident from any accident previously evaluated?

Response: No.

No new or different accidents result from utilizing the proposed change. The changes do not involve a physical alteration of the plant (i.e., no new or different type of equipment will be installed) or a change in the methods governing normal plant operation. The changes do not alter assumptions made in the safety analysis for EDG performance.

Therefore, the proposed change does not create the possibility of a new or different kind of accident from any previously evaluated.

3. Does the proposed amendment involve a significant reduction in a margin of safety?

Response: No.

The proposed change eliminates a conditional surveillance of the Operable EDG whenever the alternate division EDG is out of service for pre-planned maintenance and testing. The EDG will continue to meet its specified safety function in the safety analysis to provide backup AC power, in a highly reliable manner, as a common cause problem between the two EDGs will have been precluded, the alternate division EDG will no longer be taken out of service for testing, and its normally scheduled surveillances will be met.

Therefore, the proposed change does not involve a significant reduction in a margin of safety.

The NRC staff has reviewed the licensee's analysis and, based on this review, it appears that the three standards of 10 CFR 50.92(c) are satisfied. Therefore, the NRC staff proposes to determine that the amendment request involves no significant hazards consideration.

Attorney for licensee: Lara S. Nichols, Deputy General Counsel, Duke Energy Corporation, 550 South Tryon Street, Charlotte, NC 28202.

NRC Branch Chief: Jessie F. Quichocho.

Duke Energy Progress, Inc., Docket No. 50–261, H. B. Robinson Steam Electric Plant, Unit 2, Darlington County, South Carolina

Date of amendment request: September 30, 2013.

Description of amendment request: The proposed amendment implements the Nuclear Regulatory Commission (NRC)-approved Technical Specification Task Force (TSTF) Standard Technical Specification Change Traveler, TSTF–491, "Removal of Main Steam and Main Feedwater Valve Isolation Times from Technical Specifications," via the Consolidated Line Item Improvement Process (CLIIP). This request will modify the current Unit 2 Technical Specifications (TSs) 3.7.2, Main Steam Isolation Valves and 3.7.3, Main Feedwater Isolation Valves, Main Feedwater Regulation Valves and Bypass Valves by relocating the specific isolation time for the isolation valves from the associated Surveillance Requirements (SRs). The isolation time in the TS SRs is replaced with the requirement to verify the valve isolation time is "within limits." The specific isolation times will be maintained in the Unit 2 Technical Requirements Manual.

The NRC staff published a notice of opportunity for comment in the **Federal Register** on October 5, 2006 (71 FR 58884), on possible amendments adopting TSTF–491, Revision 2, including a model safety evaluation and model no significant hazards consideration (NSHC) determination, using the CLIIP. The NRC staff subsequently issued a notice of availability of the models for referencing in license amendment applications in the **Federal Register** on December 29, 2006 (71 FR 78472). The licensee affirmed the applicability of the following NSHC determination in its application dated September 30, 2013.

Basis for proposed no significant hazards consideration determination: As required by 10 CFR 50.91(a), an analysis of the issue of no significant hazards consideration is presented below:

Criterion 1: The Proposed Change Does Not Involve a Significant Increase in the Probability or Consequences of an Accident Previously Evaluated

The proposed change allows relocating main steam and main feedwater valve isolation times to the Licensee Controlled Document that is referenced in the Bases. The proposed change is described in Technical Specification Task Force (TSTF) Standard TS Change Traveler TSTF–491 related to relocating the main steam and main feedwater valves isolation times to the Licensee Controlled Document that is referenced in the Bases and replacing the isolation time with the phase, "within limits."

The proposed change does not involve a physical alteration of the plant (no new or different type of equipment will be installed). The proposed changes relocate the main steam and main feedwater isolation valve times to the Licensee Controlled Document that is referenced in the Bases. The requirements to perform the testing of these isolation valves are retained in the TS. Future changes to the Bases or licensee-controlled document will be evaluated pursuant to the requirements of 10 CFR 50.59, "Changes, test and experiments," to ensure that such changes do not result in more than minimal increase in the probability or consequences of an accident previously evaluated.

The proposed changes do not adversely affect accident initiators or precursors nor alter the design assumptions, conditions, and configuration of the facility or the manner in which the plant is operated and maintained. The proposed changes do not adversely affect the ability of structures, systems and components (SSCs) to perform their intended safety function to mitigate the consequences of an initiating event within the assumed acceptance limits. The proposed changes do not affect the source term, containment isolation, or radiological consequences of any accident previously evaluated. Further, the proposed changes do not increase the types and the amounts of radioactive effluent that may be released, nor significantly increase individual or cumulative occupation/public radiation exposures.

Therefore, the changes do not involve a significant increase in the probability or consequences of any accident previously evaluated.

Criterion 2: The Proposed Change Does Not Create the Possibility of a New or Different Kind of Accident From Any Previously Evaluated

The proposed changes relocate the main steam and main feedwater valve isolation times to the Licensee Controlled Document that is referenced in the Bases. In addition, the valve isolation times are replaced in the TS with the phase "within limits." The changes do not involve a physical altering of the plant (i.e., no new or different type of equipment will be installed) or a change in methods governing normal pant operation. The requirements in the TS continue to require testing of the main steam and main feedwater isolation valves to ensure the proper functioning of these isolation valves.

Therefore, the changes do not create the possibility of a new or different kind of accident from any previously evaluated.

Criterion 3: The Proposed Change Does Not Involve a Significant Reduction in the Margin of Safety

The proposed changes relocate the main steam and main feedwater valve isolation times to the Licensee Controlled Document that is referenced in the Bases. In addition, the valve isolation times are replaced in the TS with the phase "within limits." Instituting the proposed changes will continue to ensure the testing of main steam and main feedwater isolation valves. Changes to the Bases or license controlled document are performed in accordance with 10 CFR 50.59. This approach provides an effective level of regulatory control and ensures that main steam and feedwater isolation valve testing is conducted such that there is no significant reduction in the margin of safety.

The margin of safety provided by the isolation valves is unaffected by the proposed changes since there continue to be TS requirements to ensure the testing of main steam and main feedwater isolation valves. The proposed changes maintain sufficient controls to preserve the current margins of safety.

The NRC staff proposes to determine that the amendment request involves NSHC.

Attorney for licensee: Lara S. Nichols, Deputy General Counsel, Duke Energy Corporation, 550 South Tryon Street, Charlotte, NC 28202.

NRC Branch Chief: Jessie F. Quichocho.

Entergy Gulf States Louisiana, LLC, and Entergy Operations, Inc., Docket No. 50–458, River Bend Station, Unit 1, West Feliciana Parish, Louisiana

Date of amendment request: July 29, 2013.

Description of amendment request: The amendment would add a permanent exception to the River Bend Station (RBS) Technical Requirements Manual (TRM) Section 3.9.14, "Crane Travel—Spent and New Fuel Storage, Transfer, and Upper Containment Fuel Pools," to allow for movement of fuel pool gates over fuel assemblies for maintenance. This exception will also be described by revision to the RBS Updated Safety Analysis Report (USAR) Section 9.1.2.2.2, "Fuel Building Fuel Storage," and Section 9.1.2.3.3, "Protection Features of Spent Fuel Storage Facilities."

Basis for proposed no significant hazards consideration determination: As required by 10 CFR 50.91(a), the licensee has provided its analysis of the issue of no significant hazards consideration, which is presented below:

1. Involved a significant increase in the probability or consequences of an accident previously evaluated.

Response: No.

The RBS fuel building fuel storage facilities consist of three interconnected stainless steel-lined concrete pools. The spent fuel storage pool is the largest of these pools. Adjacent to the fuel storage pool are the cask pool and the lower IFTS [inclined fuel transfer system] pool. Each of these two pools is separated from the fuel storage pool by a full-height wall encompassing a watertight gate. The watertight gates are normally open, but are closed to seal their respective pools during cask handling and equipment maintenance operations. It is necessary to lift the gates from the pools for maintenance or seal replacement. The total weight of the gate including the rigging equipment is 2000 pounds. This lift is considered as a heavy load lift since it is higher than the current analyzed light load limit of 1200 pounds for movement of loads over fuel assemblies. TRM 3.9.14 prohibits any load in excess of 1200 pounds from travel over fuel assemblies in the storage pool.

Each of the gates is designed with a pneumatic seal that, when pressurized, seals the respective pool from the spent fuel pool, forming a watertight barrier. No provisions for moving the gates over fuel assemblies were included in the current licensing basis for RBS heavy loads. However, the service life qualification of the gate seals necessitates that they be replaced several times over the life of the plant. Therefore, approval of an exception to the current prohibition is required to allow for replacement of the gate seals.

To perform the movement of the gate from its installed position to a position where the seal can be replaced, an engineering plan that meets the intent of the applicable regulatory guidance has been developed. RBS' program for control of heavy load movements complies with that guidance, and this will prevent the gate from dropping onto the spent fuel assemblies during the movement activity. The program features include the design of the lifting devices, design of the cask and fuel bridge cranes, crane operator training, and the use of written procedures. The regulatory guidance will be met in all respects, except that, in lieu of a single failure-proof crane, the method will employ redundant and diverse means to meet the intent of single-failure proof movements.

Entergy proposes to lift the spent fuel pool gate using a rigging method that complies with the intent of the guidance of References 10.c through 10.f [of the licensee's letter dated July 29, 2013]. The proposed method will be accomplished through the use of fuel building bridge crane and the cask crane at the same time to provide the redundancy required to make the lift single-failure proof and satisfy single-failure proof criteria.

In the proposed method, the fuel building bridge crane and the cask crane will be used to perform the gate lifting and movement. The intent of the applicable regulatory guidance is that in lieu of providing a single-failure-proof crane system, the control of heavy loads guidelines can be satisfied by establishing that the potential for a heavy load drop is extremely small. The gate lifting using the bridge crane and cask crane will conform to applicable regulatory guidelines, in that the probability of the gate drop over the spent fuel assemblies is extremely small. Both cranes have a rated capacity of 15 tons. The maximum weight of the gate and rigging is 2000 pounds. Therefore, there is ample safety factor margin for lifting and movements of the subject spent fuel pool gate. Special lifting devices, which have redundancy or ultimate strength of at least ten times the lifted load, will also be utilized during the rigging process. Even though neither the fuel building bridge crane or the cask crane is a single-failure proof crane, rigging the spent fuel pool gate using both cranes will provide the required redundancy that meets the intent of single-failure proof criteria.

The proposed load lift of the fuel pool gate for replacement of the seal conforms to all of the applicable regulatory guidelines. The design of the lifting lugs and associated rigging (e.g., chains, slings, shackles, hoists, etc.) conforms to the guidelines of NUREG–0612, ["Control of Heavy Loads at Nuclear Power Plants,"] Section 5.1.6, and "Single-Failure Proof Handling System," and References 10.d through 10.f [of the licensee's letter dated July 29, 2013]. The auxiliary hook of the cask crane has a rated capacity of 15 tons. The cask crane is not a single-failure-proof crane. However, it meets NUREG–0612 criteria of Section 5.1.1(6) and is designed for seismic loading. As discussed above, the cask crane, alone, will handle the gate only after the gate is located inside the cask pool where drop of the gate above the spent fuel rack is no longer a concern. The cask pool area has been evaluated for an accidental drop of the spent fuel cask. There is no safety-related equipment inside the cask pool. The analyzed maximum weight of the gate and rigging is 2500 pounds. Therefore, there is ample safety factor margin for lifting the gate with the cask crane.

The probability and consequences of a seismic event are not affected by the proposed gate lift. The consequences of a seismic event during the gate lifting are insignificant since both cranes, the fuel building bridge crane and the cask crane, are seismically qualified for the lifted load. In addition, the design of all rigging conforms to NUREG–0612 guidelines, with a safety factor of 10 for the weight of the load.

Consistent with the defense-in-depth approach outlined in the guidance, the movement will be conducted according to load handling instructions. Operator training will be conducted on the activity prior to the movement, and the equipment will be inspected before the movement will be performed. NUREG–0612 gives guidance that when a particular heavy load must be brought over spent fuel, alternative measures may be used. The combination of preventative measures, as proposed, minimizes the risks inherent in hauling large loads over spent fuel to permissible levels. Considering these provisions and the applicable regulatory guidance, the increase in probability of a load drop is negligible.

It is therefore concluded that the proposed gate lifting and movement does not involve a significant increase in the probability or consequences of an accident previously evaluated.

2. Create the possibility of a new or different kind of accident from any accident previously evaluated.

Response: No.

The lifting of the fuel pool gate in the spent fuel pool as described above minimizes the possibility of a heavy load drop onto spent fuel assemblies as not credible in accordance with single-failure-proof criteria. In addition, movement of the gate in the cask pool using the cask crane does not create the possibility of a new or different kind of accident. The cask drop accident scenario in the current RBS licensing basis (since the cask crane is not a single-failure-proof crane) envelops the accidental drop of the gate in the cask pool during handling by the cask crane. The analyzed weight of a cask is 125 tons, as compared to the 1 ton combined weight of the gate and the rigging.

It is therefore concluded that the proposed gate lifting does not create the possibility of a new or different kind of accident from any previously analyzed.

3. Invoke a significant reduction in a margin of safety.

Response: No.

By following the guidance of References 10.c through 10.f [of the licensee's letter dated July 29, 2013], the movement of the spent fuel pool gates will have no impact on the analyses of postulated design basis events for RBS. The NRC guidance provides an acceptable means of ensuring the appropriate level of safety and protection against load drop accidents. Therefore, there is no reduction in the margin of safety associated

with postulated design basis events at RBS in allowing the proposed change to the RBS licensing basis. RBS will continue to meet its commitment to comply with the applicable guidance.

The NRC staff has reviewed the licensee's analysis and, based on this review, it appears that the three standards of 10 CFR 50.92(c) are satisfied. Therefore, the NRC staff proposes to determine that the amendment request involves no significant hazards consideration.

Attorney for licensee: Joseph A. Aluise, Associate General Counsel—Nuclear, Entergy Services, Inc., 639 Loyola Avenue, New Orleans, Louisiana 70113.

NRC Branch Chief: Douglas A. Broaddus.

Exelon Generation Company, LLC, Docket Nos. 50–373 and 50–374, LaSalle County Station, Units 1 and 2, LaSalle County, Illinois

Date of amendment request: September 5, 2013.

Description of amendment request: The proposed amendments would revise Technical Specification 5.5.13, "Primary Containment Leakage Rate Testing Program," to increase the peak calculated primary containment internal pressure, P_a, from 39.9 psig to 42.6 psig. The proposed increase in P_a reflects a lower initial drywell temperature and a number of other modeling changes.

Basis for proposed no significant hazards consideration determination: As required by 10 CFR 50.91(a), the licensee provided on September 5, 2013, its analysis of the issue of no significant hazards consideration, which is presented below:

1. Does the proposed change involve a significant increase in the probability or consequences of an accident previously evaluated?

Response: No.

The proposed change to P_a does not alter the assumed initiators to any analyzed event. The probability of an accident previously evaluated will not be increased by this proposed change since this change does not modify the plant or how it is operated.

The change in P_a will not affect radiological dose consequence analyses. LSCS radiological dose consequence analyses are based on the maximum allowable containment leakage rate. Even though the test pressure at which leak rate testing is performed is P_a, the maximum allowable containment leakage rate is defined in terms of a percentage of weight of the original content of containment air, which is independent of the peak calculated primary containment internal pressure. The Appendix J containment leak rate testing program will continue to ensure that containment leakage remains within the leakage assumed in the offsite dose consequence analyses. The consequences of an accident previously evaluated will not be increased by this proposed change.

Therefore, operation of the facility in accordance with the proposed change to Pa will not involve a significant increase in the probability or consequences of an accident previously evaluated.

2. Does the proposed change create the possibility of a new or different kind of accident from any accident previously evaluated?

Response: No.

The proposed change provides a higher P_a than currently described in the TS. This change is the result of a LOCA-Drywell Temperature sensitivity analysis performed by General Electric Hitachi. The peak calculated primary containment internal pressure remains below the containment design pressure of 45 psig. This change does not involve any alteration in the plant configuration (no new or different type of equipment will be installed) or make changes in the methods governing normal plant operation. The change does not create the possibility of a new or different kind of accident from any accident previously evaluated.

Therefore, operation of the facility in accordance with the proposed change to TS 5.5.13 would not create the possibility of a new or different kind of accident from any previously evaluated.

3. Does the proposed change involve a significant reduction in a margin of safety?

Response: No.

The peak calculated primary containment internal pressure remains below the containment design pressure of 45 psig. LSCS radiological consequence analyses are based on the maximum allowable containment leakage rate. The change in the peak calculated primary containment internal pressure does not represent a significant change in the margin of safety. Operation of the facility in accordance with the proposed change to TS 5.5.13 does not involve a significant reduction in the margin of safety.

The NRC staff has reviewed the licensee's analysis and, based on this review, it appears that the three standards of 10 CFR 50.92(c) are satisfied. Therefore, the NRC staff proposes to determine that the requested amendments involve no significant hazards consideration.

Attorney for licensee: Ms. Tamra Domeyer, Associate General Counsel, Exelon Generation Company, LLC, 4300 Winfield Road, Warrenville, IL 60555.

NRC Branch Chief: Travis L. Tate.

Exelon Generation Company, LLC, Docket Nos. 50–373 and 50–374, LaSalle County Station, Units 1 and 2, LaSalle County, Illinois

Date of amendment request: September 20, 2013.

Description of amendment request: The proposed amendments would revise Technical Specification 3.3.8.1–1, "Loss of Power Instrumentation," Table 1, to change the allowable values to address non-conservative assumptions. The proposed change involves revising the surveillance requirements to modify the allowable values for the 4.16 kV emergency buses during loss of voltage testing and calibration to ensure that existing design requirements remain satisfied.

Basis for proposed no significant hazards consideration determination: As required by 10 CFR 50.91(a), the licensee provided on September 20, 2013, its analysis of the issue of no significant hazards consideration, which is presented below:

1. Does the proposed change involve a significant increase in the probability or consequences of an accident previously evaluated?

Response: No.

The proposed change to the 4.16 kV [engineered safety functions] ESF bus loss of voltage allowable values allow the protection scheme to function as originally designed. (This change will involve alteration of nominal trip setpoints in the field and will also be reflected in revisions to the calibration procedures.) The proposed change does not affect the probability or consequences of any accident. Analysis was conducted and demonstrates that the proposed allowable values will allow the normally operating safety-related motors to continue to operate without sustaining damage or tripping during the worst-case, non-accident degraded voltage condition for the maximum possible time-delay of 5.7 minutes. Thus, these safety-related loads will be available to perform their safety function if a loss-of-coolant accident (LOCA) concurrent with a loss-of-offsite power (LOOP) occurs following the degraded voltage condition.

The proposed changes do not adversely affect accident initiators or precursors, and do not alter the design assumptions, conditions, or configuration or the plant or the manner in which the plant is operated or maintained. The proposed allowable values ensure that the 4.16 kV distribution system remains connected to the offsite power system when adequate offsite voltage is available and motor starting transients are considered. The diesel start due to a LOCA signal is not adversely affected by this change. During an actual loss of voltage condition, the loss of voltage time delay will continue to isolate the 4.16 kV distribution system from offsite power before the diesel is ready to assume the emergency loads, which is the limiting time basis for mitigating system responses to the accident. For this reason, the existing loss of power/LOCA analysis continues to be valid.

Therefore, the proposed change does not involve a significant increase in the probability or consequences of an accident previously evaluated.

2. Does the proposed change create the possibility of a new or different kind of accident from any accident previously evaluated?

Response: No.

The proposed change involves the revision of 4.16 kV ESF bus loss of voltage allowable values to satisfy existing design requirements. The proposed change does not introduce any changes or mechanisms that create the possibility of a new or different kind of accident. The proposed change does not install any new or different type of equipment, and installed equipment is not being operated in a new or different manner. No new effects on existing equipment are created nor are any new malfunctions introduced.

Therefore, the proposed change does not create the possibility of a new or different kind of accident from any previously evaluated.

3. Does the proposed change involve a significant reduction in a margin of safety?

Response: No.

The proposed protection voltage allowable values are low enough to prevent inadvertent power supply transfer, but high enough to ensure that sufficient power is available to the required equipment. The diesel start due to a LOCA signal is not adversely affected by this change. During an actual loss of voltage condition, the loss of voltage time delays will continue to isolate the 4.16 kV distribution system from offsite power before the diesel is ready to assume the emergency loads.

Therefore, the proposed change does not involve a significant reduction in a margin of safety.

The NRC staff has reviewed the licensee's analysis and, based on this review, it appears that the three standards of 10 CFR 50.92(c) are satisfied. Therefore, the NRC staff proposes to determine that the requested amendments involve no significant hazards consideration.

Attorney for licensee: Ms. Tamra Domeyer, Associate General Counsel, Exelon Generation Company, LLC, 4300 Winfield Road, Warrenville, IL 60555.

NRC Branch Chief: Travis L. Tate.

Exelon Generation Company (EGC), LLC, Docket Nos. STN 50–456 and STN 50–457, Braidwood Station, Units 1 and 2, Will County, Illinois

Date of amendment request: October 10, 2013.

Description of amendment request: The proposed amendment would revise the date for the performance of the containment leakage rate Type A test from "no later than May 4, 2014," to "prior to entering MODE 4 at the start of Cycle 18." Additionally, EGC is proposing to establish a requirement for Braidwood Station, Unit 2, to exit the MODEs of applicability for Containment as described in Technical Specification 3.6.1, "Containment" (i.e., MODEs 1–4), no later than May 4, 2014.

Basis for proposed no significant hazards consideration determination: As required by 10 CFR 50.91(a), the licensee has provided its analysis of the issue of no significant hazards consideration, which is presented below:

EGC has evaluated the proposed change for Braidwood Station, Units 1 and 2 using the criteria in 10 CFR 50.92, and has determined that the proposed change does not involve a significant hazards consideration. The following information is provided to support a finding of no significant hazards consideration.

1. Does the proposed change involve a significant increase in the probability or consequences of an accident previously evaluated?

Response: No.

The proposed change to the Braidwood Station, Units 1 and 2 Containment Leakage Rate Testing Program does not involve a physical change to the plant or a change in the manner in which the plant is operated or controlled. The containment function is to provide an essentially leak tight barrier against the uncontrolled release of radioactivity to the environment for postulated accidents. As such, the containment itself, and the testing requirements to periodically demonstrate the integrity of the containment, exist to ensure the plant's ability to mitigate the consequences of an accident do not involve any accident precursors or initiators. Therefore, the probability of occurrence of an accident previously evaluated is not significantly increased by the proposed amendment. Implementation of the proposed change will continue to provide adequate assurance that during design basis accidents, the containment and its components would limit leakage rates to less than the values assumed in the plant safety analyses. Therefore, the consequences of an accident previously evaluated will not be increased by this proposed change.

Therefore, operation of the facility in accordance with the proposed administrative change to the date for the performance of the Unit 2, Type A containment leak rate test will not involve a significant increase in the probability or consequences of an accident previously evaluated.

2. Does the proposed change create the possibility of a new or different kind of accident from any accident previously evaluated?

Response: No.

The containment, and the testing requirements to periodically demonstrate the integrity of the containment, exist to ensure the plant's ability to mitigate the consequences of an accident, and do not involve any accident precursors or initiators. The proposed change does not involve a physical change to the plant (i.e., no new or different type of equipment will be installed) or a change to the manner in which the plant is currently operated or controlled.

Therefore, the proposed change does not create the possibility of a new or different kind of accident from any previously evaluated.

3. Does the proposed change involve a significant reduction in a margin of safety?

Response: No.

This proposed change does not alter the manner in which safety limits, limiting safety system setpoints, or limiting conditions for operation are determined. The specific requirements and conditions of the containment leakage rate testing program, as proposed, will continue to ensure that the degree of containment structural integrity and leak-tightness that is considered in the plant's safety analysis is maintained.

Therefore, the proposed change does not involve a significant reduction in a margin of safety.

Based on the above evaluation, EGC concludes that the proposed amendment does not involve a significant hazards consideration under the standards set forth in 10 CFR 50.92, paragraph (c), and accordingly, a finding of no significant hazards consideration is justified.

The NRC staff has reviewed the licensee's analysis and, based on this review, it appears that the three standards of 10 CFR 50.92(c) are satisfied. Therefore, the NRC staff proposes to determine that the requested amendments involve no significant hazards consideration.

Attorney for licensee: Mr. Bradley J. Fewell, Associate General Counsel, Exelon Nuclear, 4300 Winfield Road, Warrenville, IL 60555.

NRC Branch Chief: Travis L. Tate.

PPL Susquehanna, LLC, Docket Nos. 50–387 and 50–388, Susquehanna Steam Electric Station, Units 1 and 2, Luzerne County, Pennsylvania

Date of amendment request: June 6, 2013.

Description of amendment request: The proposed amendment would change the current requirement that "each ADS [Automatic Depressurization System] valve opens when manually actuated," to the requirement that "each ADS valve actuator strokes when manually actuated." Additionally, the surveillance frequency would change from "24 months on a STAGGERED TEST BASIS for each valve solenoid," to "24 months."

Basis for proposed no significant hazards consideration determination: As required by 10 CFR 50.91(a), the licensee has provided its analysis of the issue of no significant hazards consideration, which is presented below:

1. Do the proposed changes involve a significant increase in the probability or consequences of an accident previously evaluated?

Response: No.

The proposed change does not modify the method of demonstrating the operability of the Safety/Relief Valves (S/RVs) in both the safety and relief modes of operation. The proposed change does modify the method for demonstrating the proper mechanical functioning of the S/RVs. The S/RVs are required to function in the safety mode to prevent overpressurization of the reactor vessel and reactor coolant system pressure

boundary during various analyzed transients, including Main Steam Isolation Valve closure. S/RVs associated with the Automatic Depressurization System are also required to function in the relief mode to reduce reactor pressure to permit injection by low pressure Emergency Core Cooling System (ECCS) pumps during certain reactor coolant pipe break accidents. The current testing method demonstrates the proper mechanical functioning of the S/RVs in both modes through manual actuation of the S/RVs. The proposed testing method results in acceptable demonstration of the S/RV functions in both the safety and relief modes, and therefore provides assurance that the probability of S/RV failure will not increase. None of the accident safety analyses are affected by the requested [Technical Specification] TS changes and the consequences of accidents mitigated by the S/RVs will not increase.

Therefore, the proposed amendment does not result in a significant increase in the probability or consequences of any previously evaluated accident.

2. Do the proposed changes create the possibility of a new or different kind of accident from any accident previously evaluated?

Response: No.

The proposed change modifies the method of testing of the S/RVs, but does not alter the functions or functional capabilities of the S/RVs. Testing under the proposed method is performed in offsite test facilities and in the plant during outage periods when the S/RV functions are not required. Existing analyses address events involving an S/RV inadvertently opening or failing to reclose. Analyses also address the failure of one or more S/RVs to open. The proposed change does not introduce any new failure mode.

Therefore, it does not create the possibility of a new or different kind of accident from any accident previously evaluated.

3. Do the proposed changes involve a significant reduction in a margin of safety?

Response: No.

The proposed amendment provides for a complete verification of the functional capability of the S/RVs by performing tests, inspections, and maintenance activities without opening the valves while installed in the plant. This alternative testing and associated programmatic controls will provide an overall level of assurance that the S/RVs are capable of performing their intended accident mitigation safety functions. The proposed amendment does not affect the valve setpoints or adversely affect any other operational criteria assumed for accident mitigation. No changes are proposed that alter the setpoints at which protective actions are initiated, and there is no change to the operability requirements for equipment assumed to operate for accident mitigation. Moreover, it is expected that the alternative testing methodology will increase the margin of safety by reducing the potential for S/RV leakage resulting from testing. Additionally, the increased testing frequency of the manual actuation circuitry is beneficial since the valves will no longer be tested on a staggered test frequency.

Therefore, the proposed change does not involve a significant reduction in a margin of safety.

The NRC staff has reviewed the licensee's analysis and, based on this review, it appears that the three standards of 10 CFR 50.92(c) are satisfied. Therefore, the NRC staff proposes to determine that the amendment request involves no significant hazards consideration.

Attorney for licensee: Bryan A. Snapp, Esquire, Assoc. General Counsel, PPL Services Corporation, 2 North Ninth St., GENTW3, Allentown, PA 18101–1179.

Acting NRC Branch Chief: John G. Lamb.

PPL Susquehanna, LLC, Docket Nos. 50–387 and 50–388, Susquehanna Steam Electric Station, Units 1 and 2, Luzerne County, Pennsylvania

Date of amendment request: June 6, 2013.

Description of amendment request: This proposed change adds a footnote to Function 6c in Technical Specification Table 3.3.6.1–1. This change allows only one Trip System to be operable in MODES 4 and 5 for the Manual Initiation Function for Shutdown Cooling System isolation.

Basis for proposed no significant hazards consideration determination: As required by 10 CFR 50.91(a), the licensee has provided its analysis of the issue of no significant hazards consideration, which is presented below:

1. Do the proposed changes involve a significant increase in the probability or consequences of an accident previously evaluated?

Response: No.

The manual isolation function of the RHR [Residual Heat Removal] Shutdown Cooling System is not credited in any FSAR [Final Safety Analysis Report] safety analysis. The addition of Footnote (c) to the manual isolation function in TS [Technical Specification] Table 3.3.6.1–1 allows one of the two trip systems to be inoperable in MODES 4 and 5 and does not alter any equipment.

Therefore, this proposed change does not involve a significant increase in the probability or consequences of an accident previously evaluated.

2. Do the proposed changes create the possibility of a new or different kind of accident from any accident previously evaluated?

Response: No.

The addition of Footnote (c) to the manual isolation function in TS Table 3.3.6.1–1 allows one of the two trip systems to be inoperable in MODES 4 and 5 and is consistent with other isolation function required for isolation in MODES 4 and 5.

No new equipment is being introduced, and installed equipment is not being operated in a new or different manner. There are no set points, at which protective or mitigative actions are initiated, affected by this change. These changes do not alter the manner in which equipment operation is initiated, nor will the function demands on credited equipment be changed. No alterations in the procedures that ensure the plant remains within analyzed limits are being proposed, and no major changes are being made to the procedures relied upon to respond to an off-normal event as described in the FSAR. As such, no new failure modes are being introduced. The proposed change does not alter assumptions made in the safety analysis and licensing basis since the manual isolation function of the RHR Shutdown Cooling System is not credited in any FSAR safety analysis.

Therefore, the proposed change does not create the possibility of a new or different kind of accident from any previously evaluated.

3. Do the proposed changes involve a significant reduction in a margin of safety?

Response: No.

The margin of safety is established through equipment design, operating parameters, and the setpoints at which automatic actions are initiated. The proposed changes are acceptable since no automatic isolation functions are being changed. Since the manual isolation function of the RHR Shutdown Cooling System is not credited in any FSAR safety analysis, this change does not affect the margin of safety assumed by the safety analysis.

Therefore, the proposed change does not involve a significant reduction in a margin of safety.

The NRC staff has reviewed the licensee's analysis and, based on this review, it appears that the three standards of 10 CFR 50.92(c) are satisfied. Therefore, the NRC staff proposes to determine that the amendment request involves no significant hazards consideration.

Attorney for licensee: Bryan A. Snapp, Esquire, Assoc. General Counsel, PPL Services Corporation, 2 North Ninth St., GENTW3, Allentown, PA 18101–1179

Acting NRC Branch Chief: John G. Lamb.

Tennessee Valley Authority, Docket Nos. 50–327 and 50–328, Sequoyah Nuclear Plant, Units 1 and 2, Hamilton County, Tennessee

Date of amendment request: October 2, 2013 (TS–SQN–13–01 and 13–02).

Description of amendment request: The proposed amendments would revise Units 1 and 2 Technical Specifications (TSs) 3.7.5, "Ultimate Heat Sink," to place additional limitations on the maximum average Essential Raw Cooling Water (ERCW) System supply header water temperature during operation with one ERCW pump per loop and operation with one ERCW supply strainer per

loop. In addition, the one-time limitations on Unit 1 ultimate heat sink (UHS) temperature and the associated license condition requirements used for the Unit 2 steam generator replacement project are proposed to be deleted. The proposed changes would place additional temperature limitations on the UHS TS Limiting Condition for Operation 3.7.5 with associated required actions, to support maintenance on plant component without requiring a dual unit shutdown.

Basis for proposed no significant hazards consideration determination: As required by 10 CFR 50.91(a), the licensee has provided its analysis of the issue of no significant hazards consideration determination, which is presented below:

1. Does the proposed amendment involve a significant increase in the probability or consequence of an accident previously evaluated?

Response: No.

The proposed change to impose additional limits on UHS temperature while in certain ERCW system alignments does not result in any physical changes to plant safety-related structures, systems, or components (SSCs). The UHS and associated ERCW system function is to remove plant system heat loads during normal and accident conditions. As such, the UHS and ERCW system are not accident initiators, but instead perform accident mitigation functions by serving as the heat sink for safety-related equipment to ensure the conditions and assumptions credited in the accident analyses are preserved. During operation under the proposed change with only one ERCW pump operable in a loop a single failure could cause a total loss of ERCW flow in one loop whereas with two pumps per loop operable only a reduction in flow would occur. In either case, one pump or two pumps per loop operable, the other ERCW loop will continue to perform the design function of the ERCW system. Therefore, the proposed change does not involve a significant increase in the probability of an accident previously evaluated.

The purpose of this change is to modify the UHS TS to be consistent with the conditions and assumptions of the current design basis heat transfer and flow modeling analyses for the UHS and ERCW system. The proposed change provides assurance that the minimum conditions necessary for the UHS and ERCW system to perform their heat removal safety function is maintained. Accordingly, as demonstrated by TVA design heat transfer and flow modeling calculations, the proposed new requirements will provide the necessary assurance that fuel cladding, Reactor Coolant System (RCS) pressure boundary, and containment integrity limits are not challenged during worst-case post-accident conditions. Accordingly, the conclusions of the accident analyses will remain as previously evaluated such that there will be no significant increase in the post-accident dose consequences.

Therefore, the proposed change does not involve a significant increase in the probability or consequence of an accident previously evaluated.

2. Does the proposed amendment create the possibility of a new or different kind of accident from any accident previously evaluated?

Response: No.

The proposed change does not involve any physical changes to plant safety related SSCs or alter the modes of plant operation in a manner that is outside the bounds of the current UHS and ERCW system design heat transfer and flow modeling analyses. The proposed additional limits on UHS temperature for the specified ERCW system alignments provide assurance that the conditions and assumptions credited in the accident analyses are preserved. Thus, although the specified ERCW system alignments result in reduced heat transfer flow capability, the plant's overall ability to reject heat to the UHS during normal operation, normal shutdown, and hypothetical worst-case accident conditions will not be significantly affected by this proposed change. Since the safety and design requirements continue to be met and the integrity of the RCS pressure boundary is not challenged, no new credible failure mechanisms, malfunctions, or accident initiators are created, and there will be no effect on the accident mitigating systems in a manner that would significantly degrade the plant's response to an accident.

Therefore, the proposed change does not create the possibility of a new or different kind of accident from any accident previously evaluated.

3. Does the proposed amendment involve a significant reduction in a margin of safety?

Response: No.

The proposed change modifies the UHS TS to maintain the UHS temperature and associated ERCW system flows within the bounds of the conditions and assumptions credited in the accident analyses. As demonstrated by TVA design basis heat transfer and flow modeling calculations, the additional limits on UHS temperature for the specified ERCW system alignments will provide assurance that the design limits for fuel cladding, RCS pressure boundary, and containment integrity are not exceeded under both normal and post-accident conditions. As required, these calculations include evaluation of the worst-case combination of meteorology and operational parameters, and establish adequate margins to account for measurement and instrument uncertainties. While operating margins have been reduced by the proposed change in order to support necessary maintenance activities, the current limiting design basis accidents remain applicable and the analyses conclusions remain bounding such that the accident safety margins are maintained. Accordingly, the proposed change will not significantly degrade the margin of safety of any SSCs that rely on the UHS and ERCW system for heat removal to perform their safety related functions.

Therefore, the proposed change does not involve a significant reduction in a margin of safety.

The NRC staff has reviewed the licensee's analysis and, based on this review, it appears that the three standards of 50.92(c) are satisfied. Therefore, the NRC staff proposes to determine that the amendment request involves no significant hazards consideration.

Attorney for licensee: General Counsel, Tennessee Valley Authority, 400 West Summit Hill Drive, ET 11A, Knoxville, Tennessee 37902.

NRC Branch Chief: Jessie F. Quichocho.

Tennessee Valley Authority, Docket No. 50–390, Watts Bar Nuclear Plant (WBN), Unit 1, Rhea County, Tennessee

Date of amendment request: July 30, 2013.

Description of amendment request: The proposed amendment would modify Technical Specification (TS) 4.3.1.1, "Criticality," to clarify the requirements for storage of new and spent fuel assemblies in the spent fuel racks. This change is necessary to update the current WBN Unit 1 TS to ensure consistency with the proposed TS 4.3.1.1 for WBN Unit 2. In addition, editorial changes are being made to TS 4.3.1. The proposed changes also modify the current licensing basis, as described in Section 4.3.2.7 of the Updated Final Safety Analysis Report (UFSAR).

Basis for proposed no significant hazards consideration determination: As required by 10 CFR 50.91(a), the licensee has provided its analysis of the issue of no significant hazards consideration. The NRC staff has reviewed the licensee's analysis against the standards of 10 CFR 50.92(c). The NRC staff's review is presented below:

1. Does the proposed amendment involve a significant increase in the probability or consequence of an accident previously evaluated?

Response: No.

The proposed amendment directs the operators to directly use an existing control figure in the TS instead of a conflicting wording of slightly lower fuel storage enrichment limit in the same section of the TS. No change is being made to the parameters or methodology in evaluated accidents. As a result, there is no increase in the likelihood of existing event initiators.

This figure was supported by the original analyses that determines the subcriticality available in the spent fuel pool and the associated acceptable cell loading patterns have not been changed. Thus the acceptance criteria as stated in the UFSAR are met. Implementing the change involves no facility equipment, procedure, or process changes that could affect the radioactive material actually released during an event. As a result, no conditions have been created that could

significantly increase the consequences of any of the events evaluated in the UFSAR.

2. Does the proposed amendment create the possibility of a new or different kind of accident from any accident previously evaluated?

Response: No.

The proposed changes do not require any new or different accidents to be postulated because no changes are being made to the plant that would introduce any new accident causal mechanism. This license amendment request does not affect any plant systems that are potential accident initiators. The change in TS wording is consistent with an existing figure in the same section of the TS that is bounded by the original plant spent fuel pool criticality analysis. No change to the fuel, spent fuel racks, or spent fuel pool water chemistry are associated with this change.

3. Does the proposed amendment involve a significant reduction in a margin of safety?

Response: No.

The proposed amendment directs the operators to directly use an existing control figure in the TS instead of a conflicting wording of slightly lower fuel storage enrichment limit in the same section of the TS. The change in TS wording is consistent with an existing figure in the same section of the TS which is bounded the original plant spent fuel pool criticality analysis. The proposed changes do not alter the permanent plant design, including instrument set points.

Based on this review, it appears that the three standards of 10 CFR 50.92(c) are satisfied. Therefore, the NRC staff proposes to determine that the amendment request involves no significant hazards consideration.

Attorney for licensee: General Counsel, Tennessee Valley Authority, 400 West Summit Hill Drive, ET 11A, Knoxville, Tennessee 37902.

NRC Branch Chief: Jessie F. Quichocho.

Tennessee Valley Authority, Docket No. 50–390, Watts Bar Nuclear Plant (WBN), Unit 1, Rhea County, Tennessee

Date of amendment request: August 28, 2013.

Description of amendment request: The proposed changes would modify WBN, Unit 1 Technical Specifications (TS) requirements related to direct current (DC) electrical systems. In addition, a new "Battery Monitoring and Maintenance Program" is being proposed. The proposed TS changes place requirements on the battery itself rather than the battery cells as currently required.

Basis for proposed no significant hazards consideration determination: As required by 10 CFR 50.91(a), the licensee has provided its analysis of the issue of no significant hazards consideration, which is presented below:

1. Does the proposed amendment involve a significant increase in the probability or consequence of an accident previously evaluated?

Response: No.

The proposed changes restructure the Technical Specifications (TS) for the direct current (DC) electrical power system and are consistent with Technical Specifications Task Force (TSTF) change TSTF–360, Revision 1 and TSTF–500, Revision 2. The proposed changes modify TS Actions relating to battery and battery charger inoperability. The DC electrical power system, including associated battery chargers, is not an initiator of any accident sequence analyzed in the Updated Final Safety Analysis Report (UFSAR). Rather, the DC electrical power system supports equipment used to mitigate accidents. The proposed changes to restructure TS and change surveillances for batteries and chargers to incorporate the updates included in TSTF–360, Revision 1 as updated by TSTF–500, Revision 2, will maintain the same level of equipment performance required for mitigating accidents assumed in the UFSAR. Operation in accordance with the proposed TS would ensure that the DC electrical power system is capable of performing its specified safety function as described in the UFSAR. Therefore, the mitigating functions supported by the DC electrical power system will continue to provide the protection assumed by the analysis. The relocation of preventive maintenance surveillances, and certain operating limits and actions, to a licensee controlled Battery Monitoring and Maintenance Program will not challenge the ability of the DC electrical power system to perform its design function. Appropriate monitoring and maintenance that are consistent with industry standards will continue to be performed. In addition, the DC electrical power system is within the scope of 10 CFR 50.65, "Requirements for monitoring the effectiveness of maintenance at nuclear power plants," which will ensure the control of maintenance activities associated with the DC electrical power system.

The integrity of fission product barriers, plant configuration, and operating procedures as described in the UFSAR will not be affected by the proposed changes. Therefore, the consequences of previously analyzed accidents will not increase by implementing these changes.

Therefore, the proposed amendment does not involve a significant increase in the probability or consequences of an accident previously evaluated.

2. Does the proposed amendment create the possibility of a new or different kind of accident from any accident previously evaluated?

Response: No.

The proposed changes involve restructuring the TS for the DC electrical power system. The DC electrical power system, including associated battery chargers, is not an initiator to any accident sequence analyzed in the UFSAR. Rather, the DC electrical power system supports equipment used to mitigate accidents. The proposed changes to restructure the TS and change surveillances for batteries and chargers to incorporate the updates included in TSTF–360 Revision 1 as updated by TSTF–500, Revision 2, will maintain the same level of equipment performance required for mitigating accidents assumed in the UFSAR. Administrative and mechanical controls are in place to ensure the design and operation of the DC systems continues to meet the plant design basis describe in the UFSAR.

Therefore, the proposed amendment will not create the possibility of a new or different kind of accident from any accident previously evaluated.

3. Does the proposed amendment involve a significant reduction in a margin of safety?

Response: No.

The margin of safety is established through equipment design, operating parameters, and the setpoints at which automatic actions are initiated. The equipment margins will be maintained in accordance with the plant-specific design bases as a result of the proposed changes. The proposed changes will not adversely affect operation of plant equipment. These changes will not result in a change to the setpoints at which protective actions are initiated. Sufficient DC capacity to support operation of mitigation equipment is ensured. The changes associated with the new battery Maintenance and Monitoring Program will ensure that the station batteries are maintained in a highly reliable manner. The equipment fed by the DC electrical sources will continue to provide adequate power to safety-related loads in accordance with analysis assumptions. TS changes made to be consistent with the changes in TSTF–360, Revision 1, as updated by TSTF–500, Revision 2, maintain the same level of equipment performance stated in the UFSAR and the current TSs.

Therefore, the proposed changes do not involve a significant reduction in a margin of safety.

The NRC staff has reviewed the licensee's analysis and, based on this review, it appears that the three standards of 10 CFR 50.92(c) are satisfied. Therefore, the NRC staff proposes to determine that the amendment request involves no significant hazards consideration.

Attorney for licensee: General Counsel, Tennessee Valley Authority, 400 West Summit Hill Drive, ET 11A, Knoxville, Tennessee 37902.

NRC Branch Chief: Jessie F. Quichocho.

Wolf Creek Nuclear Operating Corporation, Docket No. 50–482, Wolf Creek Generating Station, Coffey County, Kansas

Date of amendment request: September 23, 2013.

Description of amendment request: The amendment would revise Technical Specification (TS) 5.6.5, "CORE OPERATING LIMITS REPORT (COLR)," to replace WCAP–11596–P–A, "Qualification of the Phoenix-P/ANC Nuclear Design System for Pressurized Water Reactor Cores," with WCAP–16045–P–A, "Qualification of the Two-

Dimensional Transport Code PARAGON," and WCAP–16045–P–A, Addendum 1–A, "Qualification of the NEXUS Nuclear Data Methodology," to determine core operating limits.

Basis for proposed no significant hazards consideration determination: As required by 10 CFR 50.91(a), the licensee has provided its analysis of the issue of no significant hazards consideration, which is presented below:

1. Does the proposed change involve a significant increase in the probability or consequences of an accident previously evaluated?

Response: No.

The analytical methodologies, which this license amendment proposes for determination of core operating limits, are improvements over the current methodologies in use at WCGS. The NRC staff reviewed and approved these methodologies and concluded that these analytical methods are acceptable as a replacement for the current analytical method. Thus core operating limits determined using the proposed analytical methods continue to assure that the reactor operates safely and, thus, the proposed changes do not involve an increase in the probability of an accident.

Operation of the reactor with core operating limits determined by use of the proposed analytical methods does not increase the reactor power level, does not increase the core fission product inventory, and does not change any transport assumptions. Therefore the proposed methodology and TS changes do not involve a significant increase in the consequences of an accident.

Therefore, it is concluded that this change does not involve a significant increase in the probability or consequences of an accident previously evaluated.

2. Does the proposed change create the possibility of a new or different kind of accident from any accident previously evaluated?

Response: No.

The proposed change provides revised analytical methods for determining core operating limits, and does not change any system functions or maintenance activities. The change does not involve physical alteration of the plant, that is, no new or different type of equipment will be installed. The change does not alter assumptions made in the safety analyses but ensure that the core will operate within safe limits. This change does not create new failure modes or mechanisms that are not identifiable during testing, and no new accident precursors are generated.

Therefore, it is concluded that this change does not create the possibility of a new or different kind of accident from any accident previously evaluated.

3. Does the proposed change involve a significant reduction in a margin of safety?

Response: No.

The margin of safety is established through equipment design, operating parameters, and the setpoints at which automatic actions are initiated. The proposed changes do not physically alter safety-related systems, nor does it affect the way in which safety related systems perform their functions. The setpoints at which protective actions are initiated are not altered by the proposed changes. Therefore, sufficient equipment remains available to actuate upon demand for the purpose of mitigating an analyzed event. The proposed analytical methodology is an improvement that allows more accurate modeling of core performance. The NRC has reviewed and approved this methodology for use in lieu of the current methodology; thus, the margin of safety is not reduced due to this change.

Therefore, it is concluded that the proposed change does not involve a significant reduction in a margin of safety.

The NRC staff has reviewed the licensee's analysis and, based on this review, it appears that the three standards of 10 CFR 50.92(c) are satisfied. Therefore, the NRC staff proposes to determine that the amendment request involves no significant hazards consideration.

Attorney for licensee: Jay Silberg, Esq., Pillsbury Winthrop Shaw Pittman LLP, 2300 N Street NW., Washington, DC 20037.

NRC Branch Chief: Michael T. Markley.

Notice of Issuance of Amendments to Facility Operating Licenses and Combined Licenses

During the period since publication of the last biweekly notice, the Commission has issued the following amendments. The Commission has determined for each of these amendments that the application complies with the standards and requirements of the Atomic Energy Act of 1954, as amended (the Act), and the Commission's rules and regulations. The Commission has made appropriate findings as required by the Act and the Commission's rules and regulations in 10 CFR Chapter I, which are set forth in the license amendment.

A notice of consideration of issuance of amendment to facility operating license or combined license, as applicable, proposed no significant hazards consideration determination, and opportunity for a hearing in connection with these actions, was published in the **Federal Register** as indicated.

Unless otherwise indicated, the Commission has determined that these amendments satisfy the criteria for categorical exclusion in accordance with 10 CFR 51.22. Therefore, pursuant to 10 CFR 51.22(b), no environmental impact statement or environmental assessment need be prepared for these amendments. If the Commission has prepared an environmental assessment under the special circumstances provision in 10 CFR 51.22(b) and has made a determination based on that assessment, it is so indicated.

For further details with respect to the action see (1) the applications for amendment, (2) the amendment, and (3) the Commission's related letter, Safety Evaluation and/or Environmental Assessment as indicated. All of these items are available for public inspection at the Commission's Public Document Room (PDR), located at One White Flint North, Room O1–F21, 11555 Rockville Pike (first floor), Rockville, Maryland 20852. Publicly available documents created or received at the NRC are accessible electronically through the Agencywide Documents Access and Management System (ADAMS) in the NRC Library at *http://www.nrc.gov/reading-rm/adams.html.* If you do not have access to ADAMS or if there are problems in accessing the documents located in ADAMS, contact the PDR's Reference staff at 1–800–397–4209, 301–415–4737 or by email to *pdr.resource@nrc.gov.*

Arizona Public Service Company, et al., Docket Nos. STN 50–528, STN 50–529; and STN 50–530, Palo Verde Nuclear Generating Station, Units 1, 2, and 3, Maricopa County, Arizona

Date of application for amendment: December 12, 2012.

Brief description of amendment: The amendments revised the Technical Specifications (TSs) relating to reactor coolant system (RCS) activity limits by replacing the current TS limits on primary coolant gross specific activity with limits on primary coolant noble gas activity. The noble gas activity would reflect a new DOSE EQUIVALENT XE–133 definition that would replace the current E-bar average disintegration energy definition. The changes are consistent with NRC-approved Industry/Technical Specifications Task Force (TSTF) Standard Technical Specification change traveler, TSTF–490, Revision 0, "Deletion of E-bar Definition and Revision to RCS [Reactor Coolant System] Specific Activity Technical Specifications," with deviations.

Date of issuance: November 25, 2013.

Effective date: As of the date of issuance and shall be implemented within 180 days from the date of issuance.

Amendment No.: Unit 1–192; Unit 2–192; Unit 3–192.

Renewed Facility Operating License Nos. NPF–41, NPF–51; and NPF–74: The

amendment revised the Operating Licenses and Technical Specifications.

Date of initial notice in ***Federal Register:*** March 4, 2013 (78 FR 14128).

The Commission's related evaluation of the amendments is contained in a Safety Evaluation dated November 25, 2013.

No significant hazards consideration comments received: No.

Dominion Nuclear Connecticut, Inc., Docket No. 50–336, Millstone Power Station, Unit 2, New London County, Connecticut

Date of amendment request: April 3, 2013.

Description of amendment request: The amendment would revise Technical Specification 3.9.16 "Shielded Cask," due to changes to the minimum decay time for fuel assemblies adjacent to the spent fuel pool cask laydown area.

Date of issuance: November 14, 2013.

Effective date: As of the date of issuance, and shall be implemented within 30 days.

Amendment No.: 316.

Renewed Facility Operating License No. DPR–65: Amendment revised the License and Technical Specifications.

Date of initial notice in ***Federal Register:*** June 11, 2013 (78 FR 35062).

The Commission's related evaluation of the amendment is contained in a Safety Evaluation dated November 14, 2013.

No significant hazards consideration comments received: No.

PSEG Nuclear LLC, Docket Nos. 50–272 and 50–311, Salem Nuclear Generating Station, Units 1 and 2, Salem County, New Jersey

Date of amendment requests: November 30, 2012, as supplemented by letter dated May 31, 2013.

Brief description of amendments: The amendments approve a change to the site Emergency Plan to remove the backup plant vent extended range noble gas radiation monitoring (R45) indication, recording, and alarm capability in the emergency response facilities. Although the R45B/C monitor equipment skid will be removed, the licensee will maintain a capability in its Emergency Plan to take post-accident samples from the plant vent stack, as specified by an earlier commitment to Regulatory Guide 1.97, "Instrumentation for Light-Water-Cooled Nuclear Power Plants to Assess Plant and Environs Conditions During and Following an Accident."

Date of issuance: November 27, 2013.

Effective date: As of the date of issuance and shall be implemented within 60 days.

Amendment Nos.: 305 and 287.

Renewed Facility Operating License Nos. DPR–70 and DPR–75: The amendments revised the Facility Operating License and approved revisions to the Emergency Plan.

Date of initial notice in ***Federal Register:*** May 14, 2013 (78 FR 28252). The supplemental letter dated May 31, 2013, provided information that clarified the application, did not expand the scope of the application as originally noticed, and did not change the staff's original proposed no significant hazards consideration determination as published in the **Federal Register.**

The Commission's related evaluation of the amendments is contained in a Safety Evaluation dated November 27, 2013.

No significant hazards consideration comments received: No.

Dated at Rockville, Maryland, this 2nd day of December 2013.

For the Nuclear Regulatory Commission.

Michele G. Evans,

Director, Division of Operating Reactor Licensing, Office of Nuclear Reactor Regulation.

[FR Doc. 2013–29168 Filed 12–9–13; 8:45 am]

BILLING CODE 7590–01–P

NUCLEAR REGULATORY COMMISSION

[NRC–2013–0001]

Sunshine Act Meetings Notice

DATE: Weeks of December 9, 16, 23, 30, 2013, January 6, 13, 2014.

PLACE: Commissioners' Conference Room, 11555 Rockville Pike, Rockville, Maryland.

STATUS: Public and Closed.

Week of December 9, 2013

There are no meetings scheduled for the week of December 9, 2013.

Week of December 16, 2013—Tentative

There are no meetings scheduled for the week of December 16, 2013.

Week of December 23, 2013—Tentative

There are no meetings scheduled for the week of December 23, 2013.

Week of December 30, 2013—Tentative

There are no meetings scheduled for the week of December 30, 2013.

Week of January 6, 2014—Tentative

Monday, January 6, 2014

9:00 a.m. Briefing on Spent Fuel Pool Safety and Consideration of Expedited Transfer of Spent Fuel to Dry Casks (Public Meeting) (Contact: Kevin Witt, 301–415–2145)

This meeting will be Web cast live at the Web address—*http://www.nrc.gov/.*

Monday, January 6, 2014

1:30 p.m. Briefing on Flooding and Other Extreme Weather Events (Public Meeting) (Contact: George Wilson, 301–415–1711)

This meeting will be Web cast live at the Web address—*http://www.nrc.gov/.*

Friday, January 10, 2014

9:00 a.m. Briefing on the NRC Staff's Recommendations to Disposition Fukushima Near-Term Task Force (NTTF) Recommendation 1 on Improving NRC's Regulatory Framework (Public Meeting) (Contact: Dick Dudley, 301–415–1116)

This meeting will be Web cast live at the Web address—*http://www.nrc.gov/.*

Week of January 13, 2014—Tentative

There are no meetings scheduled for the week of January 13, 2014.

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The schedule for Commission meetings is subject to change on short notice. To verify the status of meetings, call (recording)—301–415–1292. Contact person for more information: Rochelle Bavol, 301–415–1651.

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The NRC Commission Meeting Schedule can be found on the Internet at: *http://www.nrc.gov/public-involve/public-meetings/schedule.html.*

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The NRC provides reasonable accommodation to individuals with disabilities where appropriate. If you need a reasonable accommodation to participate in these public meetings, or need this meeting notice or the transcript or other information from the public meetings in another format (e.g. braille, large print), please notify Kimberly Meyer, NRC Disability Program Manager, at 301–287–0727, or by email at *Kimberly.Meyer-Chambers@nrc.gov.* Determinations on requests for reasonable accommodation will be made on a case-by-case basis.

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Members of the public may request to receive this information electronically. If you would like to be added to the distribution, please contact the Office of the Secretary, Washington, DC 20555 (301–415–1969), or send an email to *Darlene.Wright@nrc.gov.*

Dated: December 5, 2013.

Rochelle C. Bavol,

Policy Coordinator, Office of the Secretary.

[FR Doc. 2013–29557 Filed 12–6–13; 4:15 pm]

BILLING CODE 7590–01–P

SECURITIES AND EXCHANGE COMMISSION

[Investment Company Act Release No. 30817; File No. 812–14154]

Compass Efficient Model Portfolios, LLC, et al.; Notice of Application

December 4, 2013.

AGENCY: Securities and Exchange Commission ("Commission").

ACTION: Notice of an application for an order under section 6(c) of the Investment Company Act of 1940 (the "Act") for an exemption from sections 2(a)(32), 5(a)(1), 22(d), and 22(e) of the Act and rule 22c–1 under the Act, under sections 6(c) and 17(b) of the Act for an exemption from sections 17(a)(1) and 17(a)(2) of the Act, and under section 12(d)(1)(J) for an exemption from sections 12(d)(1)(A) and 12(d)(1)(B) of the Act.

SUMMARY OF APPLICATION: Applicants request an order that would permit (a) series of certain open-end management investment companies to issue shares ("Shares") redeemable in large aggregations only ("Creation Units"); (b) secondary market transactions in Shares to occur at negotiated market prices; (c) certain series to pay redemption proceeds, under certain circumstances, more than seven days after the tender of Shares for redemption; (d) certain affiliated persons of the series to deposit securities into, and receive securities from, the series in connection with the purchase and redemption of Creation Units; and (e) certain registered management investment companies and unit investment trusts outside of the same group of investment companies as the series to acquire Shares.

APPLICANTS: Compass Efficient Model Portfolios, LLC ("Initial Adviser"), Compass EMP Funds Trust ("Trust"), and Northern Lights Distributors, LLC ("NLD").

DATES: *Filing Dates:* The application was filed on May 10, 2013, and amended on November 1, 2013.

HEARING OR NOTIFICATION OF HEARING: An order granting the requested relief will be issued unless the Commission orders a hearing. Interested persons may request a hearing by writing to the Commission's Secretary and serving applicants with a copy of the request, personally or by mail. Hearing requests should be received by the Commission by 5:30 p.m. on December 30, 2013, and should be accompanied by proof of service on applicants, in the form of an affidavit, or for lawyers, a certificate of service. Hearing requests should state the nature of the writer's interest, the reason for the request, and the issues contested. Persons who wish to be notified of a hearing may request notification by writing to the Commission's Secretary.

ADDRESSES: Secretary, Securities and Exchange Commission, 100 F Street NE., Washington, DC 20549–1090; Applicants, 213 Overlook Circle, Suite A–1, Brentwood, TN 37027.

FOR FURTHER INFORMATION CONTACT: Courtney S. Thornton, Senior Counsel at (202) 551–6812, or David P. Bartels, Branch Chief, at (202) 551–6821 (Division of Investment Management, Chief Counsel's Office).

SUPPLEMENTARY INFORMATION: The following is a summary of the application. The complete application may be obtained via the Commission's Web site by searching for the file number, or for an applicant using the Company name box, at *http://www.sec.gov/search/search.htm* or by calling (202) 551–8090.

Applicants' Representations

1. The Trust is registered as an open-end management investment company under the Act and is organized as a Delaware statutory trust. Applicants request that the order apply to newly created series of the Trust described in the application (the "Initial Funds") and to other open-end management investment companies, or series thereof, that may be created in the future as well as future series of the Trust (collectively, "Future Funds"), each of which will be an exchanged-traded fund and will track a specified domestic and/or foreign securities index ("Underlying Index"). Any Future Fund will (a) be advised by the Initial Adviser or an entity controlling, controlled by, or under common control with the Initial Adviser (each, an "Adviser") and (b) comply with the terms and conditions of the application. The Initial Funds and Future Funds, together, are the "Funds." [1] Each Underlying Index will be comprised solely of equity and/or fixed income securities. The Funds will be based on Underlying Indexes comprised of equity and/or fixed income securities that trade in U.S. markets, or equity and/or fixed income securities that trade in non-U.S. markets ("Foreign Funds"), or a combination of domestic and foreign equity and/or fixed income securities ("Global Funds").

2. The Initial Adviser is registered as an investment adviser under the Investment Advisers Act of 1940 (the "Advisers Act") and will serve as investment adviser to the Initial Funds. Any Adviser to Future Funds will be registered as an investment adviser under the Advisers Act. The Adviser may enter into sub-advisory agreements with one or more investment advisers to act as sub-advisers to particular Funds (each, a "Sub-Adviser"). Any Sub-Adviser to a Fund will either be registered under the Advisers Act or will not be required to register thereunder. The distributor for the Initial Funds will be NLD, a Nebraska limited liability company. NLD is, and each distributor for a Future Fund will be, a broker-dealer ("Broker") registered under the Securities Exchange Act of 1934 (the "Exchange Act") and will act as distributor and principal underwriter ("Distributor") of one or more of the Funds. The Distributor of any Fund may be an Affiliated Person (as defined below), or a Second-Tier Affiliate (as defined below), of that Fund's Adviser and/or Sub-Advisers.

3. Each Fund will hold certain securities ("Portfolio Securities") consisting largely of some or all of the component securities ("Component Securities") of an Underlying Index selected to correspond before fees and expenses generally to the price and yield performance of such Underlying Index. Each Initial Fund and any Future Fund will be entitled to use its Underlying Index pursuant to either a licensing agreement with the entity that compiles, creates, sponsors or maintains an Underlying Index (each, an "Index Provider") or one or more sub-licensing arrangements pursuant to such licensing agreement with the Index Provider. Each Initial Fund will be a Fund based upon an Underlying Index that is created, compiled, sponsored or maintained by an Index Provider that is the Adviser or an affiliated person, as defined in section 2(a)(3) of the Act ("Affiliated Person") or an affiliated person of such Affiliated Person ("Second-Tier Affiliate") of the Trust, the Adviser, the Distributor, promoter or any Sub-Adviser to the Fund (each, a

[1] All existing entities that currently intend to rely on the requested order have been named as applicants. Any other existing or future entity that subsequently relies on the order will comply with the terms and conditions of the application. An Investing Fund (as defined below) may rely on the order only to invest in Funds and not in any other registered investment company.

"Self-Indexing Fund").[2] Each Future Fund may be a Self-Indexing Fund, or it may be a Fund based upon an Underlying Index that is created, compiled, sponsored or maintained by an Index Provider who is not and will not be an Affiliated Person, or a Second-Tier Affiliate, of the Trust, the Adviser, the Distributor, promoter or any Sub-Adviser to the Fund.

4. The Index Provider of each Self-Indexing Fund will create and/or own a proprietary, rules based methodology ("Rules-Based Process") to create indexes for use by the Self-Indexing Funds and other equity or fixed income investors.[3] Applicants contend that any potential conflicts of interest arising from the fact that the Index Provider of each Self-Indexing Fund will be an "affiliated person" of the Adviser will not have any impact on the operation of the Self-Indexing Funds because the Underlying Indexes will maintain transparency, the Self-Indexing Funds' portfolios will be transparent, and the Index Provider, the Adviser, any Sub-Adviser and the Self-Indexing Funds each will adopt policies and procedures to address any potential conflicts of interest ("Policies and Procedures"). The Index Provider will publish in the public domain, including on the Self-Indexing Funds' Web site, the rules that govern the construction and maintenance of each of its Underlying Indexes. Applicants believe that this will prevent the Adviser from possessing any advantage over other market participants by virtue of its affiliation with the Index Provider. Applicants note that the identity and weightings of the Component Securities for a Self-Indexing Fund will be readily ascertainable by anyone, since the Rules-Based Process will be publicly available.

5. While the Index Provider does not presently contemplate specific changes to the Rules-Based Process, it could be modified, for example, to reflect changes in the underlying market tracked by an Underlying Index, the way in which the Rules-Based Process takes into account market events or to change the way a corporate action, such as a stock split, is handled. Such changes would not take effect until the Index Group[4] has given (a) the Calculation Agent (defined below) reasonable prior written notice of such rule changes and (b) the investing public at least sixty (60) days published notice that such changes will be implemented. Each Underlying Index for a Self-Indexing Fund will be reconstituted or rebalanced on at least an annual basis, but no more frequently than monthly.

6. As owner of the Underlying Indexes, the Index Provider of each Self-Indexing Fund will enter into an agreement with a third party to act as "Calculation Agent." The Calculation Agent will be solely responsible for the calculation and maintenance of each Self-Indexing Fund's Underlying Index, as well as the dissemination of the values of each such Underlying Index. The Calculation Agent is not, and will not be, an Affiliated Person or a Second-Tier Affiliate of the Self-Indexing Funds, the Adviser, any Sub-Adviser, any promoter or the Distributor.

7. The Adviser and the Index Provider of each Self-Indexing Fund will adopt and implement Policies and Procedures to minimize or eliminate any potential conflicts of interest. Among other things, the Policies and Procedures will be designed to limit or prohibit communication with respect to issues/information related to the maintenance, calculation and reconstitution of the Underlying Indexes between the Index Administrator,[5] the Index Group, and the employees of the Adviser.[6] As employees of the Index Provider, the Index Administrator and members of the Index Group (i) will not have any responsibility for the management of the Self-Indexing Funds or the Affiliated Accounts, (ii) will be expressly prohibited from sharing this information with any employees of the Adviser or those of any Sub-Adviser, including those persons that have responsibility for the management of the Self-Indexing Funds or the Affiliated Accounts until such information is publicly announced, and (iii) will be expressly prohibited from sharing or using this non-public information in any way except in connection with the performance of their respective duties. In addition, the Adviser has adopted and any Sub-Adviser will have adopted, pursuant to rule 206(4)–7 under the Advisers Act, written policies and procedures designed to prevent violations of the Advisers Act and the rules under the Advisers Act. Also, the Adviser has adopted, and any Sub-Adviser will be required to adopt, a Code of Ethics pursuant to rule 17j–1 under the Act and rule 204A–1 under the Advisers Act.

8. Applicants assert that certain potential conflicts of interest discussed in the application do not exist where the Funds are not Self-Indexing Funds. Applicants assert that the representations and undertakings in the application designed to prevent such potential conflicts of interest shall only apply to the Initial Funds and any Future Funds that are Self-Indexing Funds.

9. The investment objective of each Fund will be to provide investment returns that correspond, before fees and expenses, generally to the price and yield performance of its Underlying Index.[7] Each Fund will sell and redeem Creation Units only on a "Business Day," which is defined as any day that the NYSE, the relevant Listing Exchange (as defined below), the Trust and the custodian are open for business and includes any day that a Fund is required to be open under section 22(e) of the

[2] The licenses for the Self-Indexing Funds will specifically state that the Adviser must provide the use of the Underlying Indexes and related intellectual property at no cost to the Trust and the Self-Indexing Funds.

[3] The Underlying Indexes may be made available to registered investment companies, as well as separately managed accounts of institutional investors and privately offered funds that are not deemed to be "investment companies" in reliance on section 3(c)(1) or 3(c)(7) of the Act for which the Adviser acts as adviser or subadviser ("Affiliated Accounts") as well as other such registered investment companies, separately managed accounts and privately offered funds for which it does not act either as adviser or subadviser ("Unaffiliated Accounts"). The Affiliated Accounts and the Unaffiliated Accounts (collectively referred to herein as "Accounts"), like the Funds, would seek to track the performance of one or more Underlying Index(es) by investing in the constituents of such Underlying Index(es) or a representative sample of such constituents of the Underlying Index. Consistent with the relief requested from section 17(a), the Affiliated Accounts will not engage in Creation Unit transactions with a Fund.

[4] The "Index Group" refers to those employees of the Index Provider appointed to assist the Index Administrator (as defined below) in the performance of his/her duties.

[5] The "Index Administrator" refers to the employee of the Index Provider with ultimate responsibility for the Underlying Indexes and Rules-Based Process.

[6] If the Index Administrator or the Index Group includes employees of the Adviser (such as when the Index Provider is a division of the Adviser), such limits or prohibitions on communication will apply between those employees and the other employees of the Adviser. In the event that the Adviser serves as the Index Provider for a Self-Indexing Fund, the term 'Index Provider,' with respect to that Fund, will refer to the employees of the Adviser that are responsible for creating, compiling, and maintaining the relevant Underlying Index.

[7] Applicants represent that at least 80% of each Fund's total assets (excluding securities lending collateral) ("80% Basket") will be invested in Component Securities that comprise its Underlying Index or TBA Transactions (as defined below), or in the case of Foreign Funds and Global Funds, the 80% Basket requirement may also include Depositary Receipts (defined below) representing Component Securities. Depositary receipts representing foreign securities ("Depositary Receipts") include American Depositary Receipts ("ADRs") and Global Depositary Receipts ("GDRs"). Each Fund may also invest up to 20% of its total assets in a broad variety of other instruments, including securities not included in its Underlying Index, which the Adviser believes will help the Fund track its Underlying Index.

Act. A Fund will utilize either a replication or representative sampling strategy to track its Underlying Index. A Fund using a replication strategy will invest in the Component Securities of its Underlying Index in the same approximate proportions as in such Underlying Index. A Fund using a representative sampling strategy will hold some, but not necessarily all of the Component Securities of its Underlying Index. Applicants state that a Fund using a representative sampling strategy will not be expected to track the performance of its Underlying Index with the same degree of accuracy as would an investment vehicle that invested in every Component Security of the Underlying Index with the same weighting as the Underlying Index. Applicants expect that each Fund will have an annual tracking error relative to the performance of its Underlying Index of less than 5%.

10. Creation Units will consist of specified large aggregations of Shares, e.g., 25,000 or 100,000 Shares, and it is expected that the initial price of a Creation Unit will range from $1 million to $10 million. All orders to purchase Creation Units must be placed with the Distributor by or through a party that has entered into an agreement with the Distributor ("Authorized Participant"). The Distributor will be responsible for transmitting the orders to the Funds. An Authorized Participant must be either (a) a Broker or other participant in the continuous net settlement system of the National Securities Clearing Corporation ("NSCC"), a clearing agency registered with the Commission, or (b) a participant in the Depository Trust Company ("DTC," and such participant, "DTC Participant").

11. The Shares will be purchased and redeemed in Creation Units and generally on an in-kind basis. Except where the purchase or redemption will include cash under the limited circumstances specified below, purchasers will be required to purchase Creation Units by making an in-kind deposit of specified instruments ("Deposit Instruments"), and shareholders redeeming their Shares will receive an in-kind transfer of specified instruments ("Redemption Instruments").[8] On any given Business Day, the names and quantities of the instruments that constitute the Deposit Instruments and the names and quantities of the instruments that constitute the Redemption Instruments will be identical, unless the Fund is Rebalancing (as defined below). In addition, the Deposit Instruments and the Redemption Instruments will each correspond pro rata to the positions in the Fund's portfolio (including cash positions)[9] except: (a) In the case of bonds, for minor differences when it is impossible to break up bonds beyond certain minimum sizes needed for transfer and settlement; (b) for minor differences when rounding is necessary to eliminate fractional shares or lots that are not tradeable round lots;[10] (c) TBA Transactions[11] and other positions that cannot be transferred in kind[12] will be excluded from the Deposit Instruments and the Redemption Instruments,[13] (d) to the extent the Fund determines, on a given Business Day, to use a representative sampling of the Fund's portfolio;[14] or (e) for temporary periods, to effect changes in the Fund's portfolio as a result of the rebalancing of its Underlying Index (any such change, a "Rebalancing"). If there is a difference between the net asset value ("NAV") attributable to a Creation Unit and the aggregate market value of the Deposit Instruments or Redemption Instruments exchanged for the Creation Unit, the party conveying instruments with the lower value will also pay to the other an amount in cash equal to that difference (the "Balancing Amount").

12. Purchases and redemptions of Creation Units may be made in whole or in part on a cash basis, rather than in kind, solely under the following circumstances: (a) To the extent there is a Balancing Amount; (b) if, on a given Business Day, the Fund announces before the open of trading that all purchases, all redemptions or all purchases and redemptions on that day will be made entirely in cash; (c) if, upon receiving a purchase or redemption order from an Authorized Participant, the Fund determines to require the purchase or redemption, as applicable, to be made entirely in cash;[15] (d) if, on a given Business Day, the Fund requires all Authorized Participants purchasing or redeeming Shares on that day to deposit or receive (as applicable) cash in lieu of some or all of the Deposit Instruments or Redemption Instruments, respectively, solely because: (i) Such instruments are not eligible for transfer through either the NSCC or DTC; or (ii) in the case of Global Funds and Foreign Funds, such instruments are not eligible for trading due to local trading restrictions, local restrictions on securities transfers or other similar circumstances; or (e) if the Fund permits an Authorized Participant to deposit or receive (as applicable) cash in lieu of some or all of the Deposit Instruments or Redemption Instruments, respectively, solely because: (i) Such instruments are, in the case of the purchase of a Creation Unit, not available in sufficient quantity; (ii) such instruments are not eligible for trading by an Authorized Participant or the investor on whose behalf the Authorized Participant is acting; or (iii) a holder of Shares of a Global Fund or Foreign Fund would be subject to unfavorable income tax treatment if the holder receives redemption proceeds in kind.[16]

13. Each Business Day, before the open of trading on a national securities exchange, as defined in section 2(a)(26) of the Act ("Exchange") on which Shares are listed ("Listing Exchange"),

[8] The Funds must comply with the federal securities laws in accepting Deposit Instruments and satisfying redemptions with Redemption Instruments, including that the Deposit Instruments and Redemption Instruments are sold in transactions that would be exempt from registration under the Securities Act of 1933 ("Securities Act"). In accepting Deposit Instruments and satisfying redemptions with Redemption Instruments that are restricted securities eligible for resale pursuant to rule 144A under the Securities Act, the Funds will comply with the conditions of rule 144A.

[9] The portfolio used for this purpose will be the same portfolio used to calculate the Fund's NAV for the Business Day.

[10] A tradeable round lot for a security will be the standard unit of trading in that particular type of security in its primary market.

[11] A "TBA Transaction" is a method of trading mortgage-backed securities. In a TBA Transaction, the buyer and seller agree upon general trade parameters such as agency, settlement date, par amount and price. The actual pools delivered generally are determined two days prior to the settlement date.

[12] This includes instruments that can be transferred in kind only with the consent of the original counterparty to the extent the Fund does not intend to seek such consents.

[13] Because these instruments will be excluded from the Deposit Instruments and the Redemption Instruments, their value will be reflected in the determination of the Balancing Amount (as defined below).

[14] A Fund may only use sampling for this purpose if the sample: (i) Is designed to generate performance that is highly correlated to the performance of the Fund's portfolio; (ii) consists entirely of instruments that are already included in the Fund's portfolio; and (iii) is the same for all Authorized Participants on a given Business Day.

[15] In determining whether a particular Fund will sell or redeem Creation Units entirely on a cash or in-kind basis (whether for a given day or a given order), the key consideration will be the benefit that would accrue to the Fund and its investors. For instance, in bond transactions, the Adviser may be able to obtain better execution than Share purchasers because of the Adviser's size, experience and potentially stronger relationships in the fixed income markets. Purchases of Creation Units either on an all cash basis or in-kind are expected to be neutral to the Funds from a tax perspective. In contrast, cash redemptions typically require selling portfolio holdings, which may result in adverse tax consequences for the remaining Fund shareholders that would not occur with an in-kind redemption. As a result, tax consideration may warrant in-kind redemptions.

[16] A "custom order" is any purchase or redemption of Shares made in whole or in part on a cash basis in reliance on clause (e)(i) or (e)(ii).

each Fund will cause to be published through the NSCC the names and quantities of the instruments comprising the Deposit Instruments and the Redemption Instruments, as well as the estimated Balancing Amount (if any), for that day. The list of Deposit Instruments and Redemption Instruments will apply until a new list is announced on the following Business Day, and there will be no intra-day changes to the list except to correct errors in the published list. Each Listing Exchange will disseminate, every 15 seconds during regular Exchange trading hours, through the facilities of the Consolidated Tape Association, an amount for each Fund stated on a per individual Share basis representing the sum of (i) the estimated Balancing Amount and (ii) the current value of the Portfolio Securities and other assets of the Fund.

14. An investor acquiring or redeeming a Creation Unit from a Fund will be charged a fee ("Transaction Fee") to prevent the dilution of the interests of the remaining shareholders resulting from costs in connection with the purchase or redemption of Creation Units.[17] All orders to purchase Shares of a Fund in Creation Units must be placed with the Distributor by or through an Authorized Participant, and it will be the Distributor's responsibility to transmit such orders to the Fund. The Distributor also will be responsible for delivering the Fund's prospectus to those persons acquiring Shares in Creation Units and for maintaining records of both the orders placed with it and the confirmations of acceptance furnished by it. In addition, the Distributor will maintain a record of the instructions given to the applicable Fund to implement the delivery of its Shares.

15. Shares of each Fund will be listed and traded individually on a Listing Exchange. It is expected that one or more member firms of a Listing Exchange will be designated to act as a market maker (each, a "Market Maker") and maintain a market for Shares trading on that Listing Exchange. Prices of Shares trading on an Exchange will be based on the current bid/offer market. Transactions involving the sale of Shares on an Exchange will be subject to customary brokerage commissions and charges.

16. Applicants expect that purchasers of Creation Units will include institutional investors and arbitrageurs. Market Makers may also purchase or redeem Creation Units in connection with their market-making activities. Applicants expect that secondary market purchasers of Shares will include both institutional and retail investors.[18] The price at which Shares trade will be disciplined by arbitrage opportunities created by the option to continually purchase or redeem Creation Units at their NAV, which should ensure that Shares will not trade at a material discount or premium in relation to their NAV.

17. Shares will not be individually redeemable, and owners of Shares may acquire those Shares from the Fund, or tender such Shares for redemption to the Fund, in Creation Units only. To redeem, an investor must accumulate enough Shares to constitute a Creation Unit. Redemption requests must be placed by or through an Authorized Participant. A redeeming investor may pay a Transaction Fee, calculated in the same manner as a Transaction Fee payable in connection with purchases of Creation Units.

18. Neither the Trust nor any Fund will be advertised or marketed or otherwise held out as a traditional open-end investment company or a "mutual fund." Instead, each such Fund will be marketed as an "ETF" or "exchange-traded fund." All advertising materials that describe the features or method of obtaining, buying or selling Creation Units, or Shares traded on an Exchange, or refer to redeemability, will prominently disclose that Shares are not individually redeemable and will disclose that the owners of Shares may acquire those Shares from the Fund or tender such Shares for redemption to the Fund in Creation Units only. The Funds will provide copies of their annual and semi-annual shareholder reports to DTC Participants for distribution to beneficial owners of Shares.

Applicants' Legal Analysis

1. Applicants request an order under section 6(c) of the Act granting an exemption from sections 2(a)(32), 5(a)(1), 22(d) and 22(e) of the Act and rule 22c–1 under the Act, under sections 6(c) and 17(b) of the Act granting an exemption from sections 17(a)(1) and (2) of the Act, and under section 12(d)(1)(J) for an exemption from sections 12(d)(1)(A) and (B) of the Act.

2. Section 6(c) of the Act provides that the Commission may exempt any person, security or transaction, or any class of persons, securities or transactions, from any provision of the Act, if and to the extent that such exemption is necessary or appropriate in the public interest and consistent with the protection of investors and the purposes fairly intended by the policy and provisions of the Act. Section 17(b) of the Act authorizes the Commission to exempt a proposed transaction from section 17(a) of the Act if evidence establishes that the terms of the transaction, including the consideration to be paid or received, are reasonable and fair and do not involve overreaching on the part of any person concerned, and the proposed transaction is consistent with the policies of the registered investment company and the general provisions of the Act. Section 12(d)(1)(J) of the Act provides that the Commission may exempt any person, security, or transaction, or any class or classes of persons, securities or transactions, from any provision of section 12(d)(1) if the exemption is consistent with the public interest and the protection of investors.

Sections 5(a)(1) and 2(a)(32) of the Act

3. Section 5(a)(1) of the Act defines an "open-end company" as a management investment company that is offering for sale or has outstanding any redeemable security of which it is the issuer. Section 2(a)(32) of the Act defines a redeemable security as any security, other than short-term paper, under the terms of which the holder, upon its presentation to the issuer, is entitled to receive approximately a proportionate share of the issuer's current net assets, or the cash equivalent. Because Shares will not be individually redeemable, applicants request an order that would permit the Trust and each Fund to redeem Shares in Creation Units only. Applicants state that investors may purchase Shares in Creation Units from each Fund and redeem Creation Units according to the provisions of the Act. Applicants further state that because the market price of Shares will be disciplined by arbitrage opportunities, investors should be able to sell Shares in the secondary market at prices that do not vary materially from their NAV per Share.

Section 22(d) of the Act and Rule 22c–1 under the Act

4. Section 22(d) of the Act, among other things, prohibits a dealer from selling a redeemable security that is currently being offered to the public by or through an underwriter, except at a

[17] Where a Fund permits an in-kind purchaser to substitute cash-in-lieu of depositing one or more of the requisite Deposit Instruments, the purchaser may be assessed a higher Transaction Fee to cover the cost of purchasing such Deposit Instruments.

[18] Shares will be registered in book-entry form only. DTC or its nominee will be the record or registered owner of all outstanding Shares. Beneficial ownership of Shares will be shown on the records of DTC or the DTC Participants.

current public offering price described in the prospectus. Rule 22c–1 under the Act generally requires that a dealer selling, redeeming, or repurchasing a redeemable security do so only at a price based on its NAV. Applicants state that secondary market trading in Shares will take place at negotiated prices, not at a current offering price described in a Fund's prospectus and not at a price based on NAV. Thus, purchases and sales of Shares in the secondary market will not comply with section 22(d) of the Act and rule 22c–1 under the Act. Applicants request an exemption under section 6(c) from these provisions.

5. Applicants assert that the concerns sought to be addressed by section 22(d) of the Act and rule 22c–1 under the Act with respect to pricing are equally satisfied by the proposed method of pricing Shares. Applicants maintain that, while there is little legislative history regarding section 22(d), its provisions, as well as those of rule 22c–1, appear to have been designed to (a) prevent dilution caused by certain riskless-trading schemes by principal underwriters and contract dealers, (b) prevent unjust discrimination or preferential treatment among buyers, and (c) ensure an orderly distribution system of investment company shares by eliminating price competition from non-contract dealers offering shares at less than the published sales price and repurchasing shares at more than the published redemption price.

6. Applicants believe that none of these purposes will be thwarted by permitting Shares to trade in the secondary market at negotiated prices. Applicants state that (a) secondary market trading in Shares does not involve the Funds as parties and cannot result in dilution of an investment in Shares, and (b) to the extent different prices exist during a given trading day, or from day to day, such variances occur as a result of third-party market forces, such as supply and demand. Therefore, applicants assert that secondary market transactions in Shares will not lead to discrimination or preferential treatment among purchasers. Finally, applicants contend that the proposed distribution system will be orderly because arbitrage activity will ensure that the Shares do not trade at a material discount or premium in relation to their NAV.

Section 22(e) of the Act

7. Section 22(e) of the Act generally prohibits a registered investment company from suspending the right of redemption or postponing the date of payment of redemption proceeds for more than seven days after the tender of a security for redemption. Applicants state that settlement of redemptions for Foreign Funds and Global Funds will be contingent not only on the settlement cycle of the U.S. securities markets but also on the delivery cycles in local markets for underlying foreign Portfolio Securities held by the Foreign Funds and Global Funds. Applicants state that current delivery cycles for transferring Redemption Instruments to redeeming investors, coupled with local market holiday schedules, in certain circumstances will require a delivery process for the Foreign Funds and Global Funds of up to 14 calendar days. Applicants request relief under section 6(c) of the Act from section 22(e) to allow Foreign Funds and Global Funds to pay redemption proceeds up to 14 calendar days after the tender of the Creation Units for redemption. Except as disclosed in the relevant Foreign Fund's or Global Fund's Statement of Additional Information ("SAI"), applicants expect that each Foreign Fund and Global Fund will be able to deliver redemption proceeds within seven days.[19]

8. Applicants state that Congress adopted section 22(e) to prevent unreasonable, undisclosed and unforeseen delays in the actual payment of redemption proceeds. Applicants state that allowing redemption payments for Creation Units of a Foreign Fund or Global Fund to be made within the number of days indicated above would not be inconsistent with the spirit and intent of section 22(e). Applicants state that the SAI will disclose those local holidays (over the period of at least one year following the date of the SAI), if any, that are expected to prevent the delivery of in kind redemption proceeds in seven calendar days, and the maximum number of days (up to 14 calendar days) needed to deliver the proceeds for each affected Foreign Fund and Global Fund.

9. Applicants are not seeking relief from section 22(e) with respect to Foreign Funds or Global Funds that do not effect creations and redemptions of Creation Units in-kind.

Section 12(d)(1) of the Act

10. Section 12(d)(1)(A) of the Act prohibits a registered investment company from acquiring shares of an investment company if the securities represent more than 3% of the total outstanding voting stock of the acquired company, more than 5% of the total assets of the acquiring company, or, together with the securities of any other investment companies, more than 10% of the total assets of the acquiring company. Section 12(d)(1)(B) of the Act prohibits a registered open-end investment company, its principal underwriter, or any other broker or dealer registered under the Exchange Act from selling the investment company's shares to another investment company if the sale would cause the acquiring company to own more than 3% of the acquired company's voting stock, or if the sale would cause more than 10% of the acquired company's voting stock to be owned by investment companies generally.

11. Applicants request an exemption to permit management investment companies ("Investing Management Companies") and unit investment trusts ("Investing Trusts") registered under the Act that are not sponsored or advised by the Adviser or an entity controlling, controlled by, or under common control with the Adviser and are not part of the same "group of investment companies," as defined in section 12(d)(1)(G)(ii) of the Act, as the Funds (collectively, "Investing Funds") to acquire Shares beyond the limits of section 12(d)(1)(A). In addition, applicants seek relief to permit a Fund, any Distributor, and/or any Broker registered under the Exchange Act to sell Shares to Investing Funds in excess of the limits of section 12(d)(1)(B).

12. Each Investing Management Company's investment adviser within the meaning of section 2(a)(20)(A) of the Act is the "Investing Funds Adviser" and each Investing Management Company's investment adviser within the meaning of section 2(a)(20)(B) of the Act is the "Investing Funds Sub-Adviser." Any investment adviser to an Investing Fund will be registered under the Advisers Act. Each Investing Trust's sponsor is the "Sponsor."

13. Applicants submit that the proposed conditions to the requested relief adequately address the concerns underlying the limits in sections 12(d)(1)(A) and (B), which include concerns about undue influence by a fund of funds over underlying funds, excessive layering of fees and overly complex fund structures. Applicants believe that the requested exemption is consistent with the public interest and the protection of investors.

14. Applicants believe that neither an Investing Fund nor an Investing Funds Affiliate would be able to exert undue

[19] Rule 15c6–1 under the Exchange Act requires that most securities transactions be settled within three business days of the trade date. Applicants acknowledge that relief obtained from the requirements of section 22(e) will not affect any obligations that they have under rule 15c6–1.

influence over a Fund.[20] To limit the control that an Investing Fund may have over a Fund, applicants propose a condition prohibiting the Investing Funds Adviser, Sponsor, any person controlling, controlled by, or under common control with the Investing Funds Adviser or Sponsor, and any investment company and any issuer that would be an investment company but for section 3(c)(1) or 3(c)(7) of the Act that is advised or sponsored by the Investing Funds Adviser, the Sponsor, or any person controlling, controlled by, or under common control with the Investing Funds Adviser or Sponsor ("Investing Funds' Advisory Group") from controlling (individually or in the aggregate) a Fund within the meaning of section 2(a)(9) of the Act. The same prohibition would apply to any Investing Funds Sub-Adviser, any person controlling, controlled by or under common control with the Investing Funds Sub-Adviser, and any investment company or issuer that would be an investment company but for section 3(c)(1) or 3(c)(7) of the Act (or portion of such investment company or issuer) advised or sponsored by the Investing Funds Sub-Adviser or any person controlling, controlled by or under common control with the Investing Funds Sub-Adviser ("Investing Funds' Sub-Advisory Group"). Applicants propose other conditions to limit the potential for undue influence over the Funds, including that no Investing Fund or Investing Funds Affiliate (except to the extent it is acting in its capacity as an investment adviser to a Fund) will cause a Fund to purchase a security in an offering of securities during the existence of an underwriting or selling syndicate of which a principal underwriter is an Underwriting Affiliate ("Affiliated Underwriting"). An "Underwriting Affiliate" is a principal underwriter in any underwriting or selling syndicate that is an officer, director, member of an advisory board, Investing Funds Adviser, Investing Funds Sub-Adviser, Sponsor or employee of the Investing Funds, or a person of which any such officer, director, member of an advisory board, Investing Funds Adviser, Investing Funds Sub-Adviser, Sponsor or employee is an affiliated person (except any person whose relationship to the Fund is covered by section 10(f) of the Act is not an Underwriting Affiliate).

15. Applicants do not believe that the proposed arrangement will involve excessive layering of fees. The board of directors or trustees of any Investing Management Company, including a majority of the directors or trustees who are not "interested persons" within the meaning of section 2(a)(19) of the Act ("non-interested directors or trustees"), will find that the advisory fees charged under the contract are based on services provided that will be in addition to, rather than duplicative of, services provided under the advisory contract of any Fund in which the Investing Management Company may invest. In addition, under condition B.5, an Investing Funds Adviser, or trustee or Sponsor of an Investing Trust, as applicable, will waive fees otherwise payable to it by the Investing Fund in an amount at least equal to any compensation (including fees received pursuant to any plan adopted by a Fund under rule 12b–1 under the Act) received from a Fund by the Investing Funds Adviser, or trustee or Sponsor of the Investing Trust, or an affiliated person of the Investing Funds Adviser, or trustee or Sponsor of the Investing Trust, in connection with the investment by the Investing Fund in the Fund. Applicants also state that any sales charges or service fees charged with respect to shares of an Investing Fund will not exceed the limits applicable to a fund of funds as set forth in Conduct Rule 2830 of the NASD.[21]

16. Applicants submit that the proposed arrangement will not create an overly complex fund structure. Applicants note that a Fund will be prohibited from acquiring securities of any investment company or company relying on section 3(c)(1) or 3(c)(7) of the Act in excess of the limits contained in section 12(d)(1)(A) of the Act, except to the extent permitted by exemptive relief from the Commission permitting the Fund to purchase shares for short-term cash management purposes. To ensure that an Investing Fund is aware of the terms and conditions of the requested order, the Investing Funds must enter into an agreement with the respective Funds ("Investing Fund Participation Agreement"). The Investing Fund Participation Agreement will include an acknowledgement from the Investing Fund that it may rely on the order only to invest in the Funds and not in any other investment company.

17. Applicants also note that a Fund may choose to reject a direct purchase of Shares in Creation Units by an Investing Fund. To the extent that an Investing Fund purchases Shares in the secondary market, a Fund would still retain its ability to reject initial purchases of Shares made in reliance on the requested order by declining to enter into the Investing Fund Participation Agreement prior to any investment by an Investing Fund in excess of the limits of section 12(d)(1)(A).

Section 17 of the Act

18. Section 17(a) of the Act generally prohibits an Affiliated Person or a Second-Tier Affiliate, from selling any security to or purchasing any security from a registered investment company. Section 2(a)(3) of the Act defines "affiliated person" of another person to include any person directly or indirectly owning, controlling, or holding with power to vote 5% or more of the outstanding voting securities of the other person and any person directly or indirectly controlling, controlled by, or under common control with, the other person. Section 2(a)(9) of the Act defines "control" as the power to exercise a controlling influence over the management or policies of a company, and provides that a control relationship will be presumed where one person owns more than 25% of a company's voting securities. The Funds may be deemed to be controlled by the Adviser or an entity controlling, controlled by or under common control with the Adviser and hence Affiliated Persons of each other. In addition, the Funds may be deemed to be under common control with any other registered investment company (or series thereof) advised by the Adviser or an entity controlling, controlled by or under common control with the Adviser (an "Affiliated Fund"). Applicants also state that any investor, including Market Makers, owning 5% or holding in excess of 25% of the Trust or such Funds, may be deemed affiliated persons of the Trust or such Funds. In addition, an investor could own 5% or more, or in excess of 25%, of the outstanding shares of one or more Affiliated Funds making that investor a Second-Tier Affiliate of the Funds.

19. Applicants request an exemption under sections 6(c) and 17(b) of the Act from sections 17(a)(1) and 17(a)(2) of the Act in order to permit in-kind purchases and redemptions of Creation Units from the Funds by persons that are Affiliated Persons or Second-Tier Affiliates of the Funds solely by virtue of one or more of the following: (a) Holding 5% or

[20] An "Investing Funds Affiliate" is any Investing Funds Adviser, Investing Funds Sub-Adviser, Sponsor, promoter, or principal underwriter of the Investing Funds, and any person controlling, controlled by, or under common control with any of those entities. A "Fund Affiliate" is the Adviser, Sub-Adviser, promoter or principal underwriter of a Fund, or any person controlling, controlled by, or under common control with any of those entities.

[21] All references to Conduct Rule 2830 of the NASD include any successor or replacement rule that may be adopted by FINRA.

more, or more than 25%, of the Shares of the Trust or one or more Funds; (b) having an affiliation with a person with an ownership interest described in (a); or (c) holding 5% or more, or more than 25%, of the shares of one or more Affiliated Funds. Applicants also request an exemption in order to permit each Fund to sell Shares to and redeem Shares from, and engage in the in-kind transactions that would accompany such sales and redemptions with, any Investing Fund of which the Fund is an Affiliated Person or Second-Tier Affiliate.[22]

20. Applicants contend that no useful purpose would be served by prohibiting such affiliated persons from making in-kind purchases or in-kind redemptions of Shares of a Fund in Creation Units. Deposit Instruments and Redemption Instruments for each Fund will be valued in the same manner as the Portfolio Securities currently held by such Fund, and will be valued in this same manner, regardless of the identity of the purchaser or redeemer. Portfolio Securities, Deposit Instruments, Redemption Instruments, and Balancing Amounts will be the same regardless of the identity of the purchaser or redeemer. Therefore, applicants state that in kind purchases and redemptions will afford no opportunity for the specified affiliated persons of a Fund to effect a transaction detrimental to the other holders of Shares. Applicants also believe that in kind purchases and redemptions will not result in abusive self-dealing or overreaching of the Fund. Applicants also submit that the sale of Shares to and redemption of Shares from an Investing Fund satisfies the standards for relief under sections 17(b) and 6(c) of the Act. Applicants note that any consideration paid for the purchase or redemption of Shares directly from a Fund will be based on the NAV of the Fund in accordance with policies and procedures set forth in the Fund's registration statement.[23] Applicants also state that the proposed transactions are consistent with the general purposes of the Act and appropriate in the public interest.

Applicants' Conditions

Applicants agree that any order of the Commission granting the requested relief will be subject to the following conditions:

A. ETF Relief

1. As long as a Fund operates in reliance on the requested order, the Shares of such Fund will be listed on an Exchange.

2. Neither the Trust nor any Fund will be advertised or marketed as an open-end investment company or a mutual fund. Any advertising material that describes the purchase or sale of Creation Units or refers to redeemability will prominently disclose that Shares are not individually redeemable and that owners of Shares may acquire those Shares from the Fund and tender those Shares for redemption to a Fund in Creation Units only.

3. The Web site maintained for each Fund, which is and will be publicly accessible at no charge, will contain, on a per Share basis for each Fund, the prior Business Day's NAV and the market closing price or the midpoint of the bid/ask spread at the time of the calculation of such NAV ("Bid/Ask Price"), and a calculation of the premium or discount of the market closing price or Bid/Ask Price against such NAV.

4. The requested relief to permit ETF operations will expire on the effective date of any Commission rule under the Act that provides relief permitting the operation of index-based exchange-traded funds.

B. Section 12(d)(1) Relief

1. The members of an Investing Funds' Advisory Group will not control (individually or in the aggregate) a Fund within the meaning of section 2(a)(9) of the Act. The members of an Investing Funds' Sub-Advisory Group will not control (individually or in the aggregate) a Fund within the meaning of section 2(a)(9) of the Act. If, as a result of a decrease in the outstanding voting securities of a Fund, the Investing Funds' Advisory Group or the Investing Funds' Sub-Advisory Group, each in the aggregate, becomes a holder of more than 25 percent of the outstanding voting securities of a Fund, it will vote its Shares of the Fund in the same proportion as the vote of all other holders of the Fund's Shares. This condition does not apply to the Investing Funds' Sub-Advisory Group with respect to a Fund for which the Investing Funds Sub-Adviser or a person controlling, controlled by or under common control with the Investing Funds Sub-Adviser acts as the investment adviser within the meaning of section 2(a)(20)(A) of the Act.

2. No Investing Fund or Investing Funds Affiliate will cause any existing or potential investment by the Investing Fund in a Fund to influence the terms of any services or transactions between the Investing Fund or an Investing Funds Affiliate and the Fund or a Fund Affiliate.

3. The board of directors or trustees of an Investing Management Company, including a majority of the non-interested directors or trustees, will adopt procedures reasonably designed to ensure that the Investing Funds Adviser and any Investing Funds Sub-Adviser are conducting the investment program of the Investing Management Company without taking into account any consideration received by the Investing Management Company or an Investing Funds Affiliate from a Fund or a Fund Affiliate in connection with any services or transactions.

4. Once an investment by an Investing Fund in the securities of a Fund exceeds the limit in section 12(d)(1)(A)(i) of the Act, the Board, including a majority of the non-interested directors or trustees of the Board, will determine that any consideration paid by the Fund to the Investing Fund or an Investing Funds Affiliate in connection with any services or transactions: (i) Is fair and reasonable in relation to the nature and quality of the services and benefits received by the Fund; (ii) is within the range of consideration that the Fund would be required to pay to another unaffiliated entity in connection with the same services or transactions; and (iii) does not involve overreaching on the part of any person concerned. This condition does not apply with respect to any services or transactions between a Fund and its investment adviser(s), or any person controlling, controlled by or under common control with such investment adviser(s).

5. The Investing Funds Adviser, or trustee or Sponsor of an Investing Trust, as applicable, will waive fees otherwise payable to it by the Investing Fund in an amount at least equal to any compensation (including fees received pursuant to any plan adopted by a Fund under rule 12b–1 under the Act) received from a Fund by the Investing

[22] To the extent that purchases and sales of Shares of a Fund occur in the secondary market (and not through principal transactions directly between an Investing Fund and a Fund), relief from section 17(a) would not be necessary. The requested relief is intended to cover, however, transactions directly between Funds and Investing Funds. Applicants are not seeking relief from section 17(a) for, and the requested relief will not apply to, transactions where a Fund could be deemed an Affiliated Person or Second-Tier Affiliate of an Investing Fund because the Adviser or an entity controlling, controlled by or under common control with the Adviser is also an investment adviser to the Investing Fund.

[23] Applicants acknowledge that receipt of compensation by (a) an Affiliated Person of an Investing Fund, or a Second-Tier Affiliate, for the purchase by the Investing Funds of Shares or (b) an Affiliated Person of a Fund, or Second-Tier Affiliate, for the sale by the Fund of its Shares to an Investing Fund may be prohibited by section 17(e)(1) of the Act. The Investing Fund Participation Agreement will include this acknowledgement.

Funds Adviser, or trustee or Sponsor of the Investing Trust, or an affiliated person of the Investing Funds Adviser, or trustee or Sponsor of the Investing Trust, other than any advisory fees paid to the Investing Funds Adviser, or trustee or Sponsor of an Investing Trust, or its affiliated person by the Fund, in connection with the investment by the Investing Fund in the Fund. Any Investing Funds Sub-Adviser will waive fees otherwise payable to the Investing Funds Sub-Adviser, directly or indirectly, by the Investing Management Company in an amount at least equal to any compensation received from a Fund by the Investing Funds Sub-Adviser, or an affiliated person of the Investing Funds Sub-Adviser, other than any advisory fees paid to the Investing Funds Sub-Adviser or its affiliated person by the Fund, in connection with the investment by the Investing Management Company in the Fund made at the direction of the Investing Funds Sub-Adviser. In the event that the Investing Funds Sub-Adviser waives fees, the benefit of the waiver will be passed through to the Investing Management Company.

6. No Investing Fund or Investing Funds Affiliate (except to the extent it is acting in its capacity as an investment adviser to a Fund) will cause a Fund to purchase a security in an Affiliated Underwriting.

7. The Board, including a majority of the non-interested Board members, will adopt procedures reasonably designed to monitor any purchases of securities by a Fund in an Affiliated Underwriting, once an investment by an Investing Fund in the securities of the Fund exceeds the limit of section 12(d)(1)(A)(i) of the Act, including any purchases made directly from an Underwriting Affiliate. The Board will review these purchases periodically, but no less frequently than annually, to determine whether the purchases were influenced by the investment by the Investing Fund in the Fund. The Board will consider, among other things: (i) Whether the purchases were consistent with the investment objectives and policies of the Fund; (ii) how the performance of securities purchased in an Affiliated Underwriting compares to the performance of comparable securities purchased during a comparable period of time in underwritings other than Affiliated Underwritings or to a benchmark such as a comparable market index; and (iii) whether the amount of securities purchased by the Fund in Affiliated Underwritings and the amount purchased directly from an Underwriting Affiliate have changed significantly from prior years. The Board will take any appropriate actions based on its review, including, if appropriate, the institution of procedures designed to ensure that purchases of securities in Affiliated Underwritings are in the best interest of shareholders of the Fund.

8. Each Fund will maintain and preserve permanently in an easily accessible place a written copy of the procedures described in the preceding condition, and any modifications to such procedures, and will maintain and preserve for a period of not less than six years from the end of the fiscal year in which any purchase in an Affiliated Underwriting occurred, the first two years in an easily accessible place, a written record of each purchase of securities in Affiliated Underwritings once an investment by an Investing Fund in the securities of the Fund exceeds the limit of section 12(d)(1)(A)(i) of the Act, setting forth from whom the securities were acquired, the identity of the underwriting syndicate's members, the terms of the purchase, and the information or materials upon which the Board's determinations were made.

9. Before investing in a Fund in excess of the limits in section 12(d)(1)(A), any Investing Fund and the Fund will execute an Investing Fund Participation Agreement stating, without limitation, that their respective boards of directors or trustees and their investment advisers, or trustee and Sponsor, as applicable, understand the terms and conditions of the order, and agree to fulfill their responsibilities under the order. At the time of its investment in Shares of a Fund in excess of the limit in section 12(d)(1)(A)(i), an Investing Fund will notify the Fund of the investment. At such time, the Investing Fund will also transmit to the Fund a list of the names of each Investing Funds Affiliate and Underwriting Affiliate. The Investing Fund will notify the Fund of any changes to the list of the names as soon as reasonably practicable after a change occurs. The Fund and the Investing Fund will maintain and preserve a copy of the order, the Investing Fund Participation Agreement, and the list with any updated information for the duration of the investment and for a period of not less than six years thereafter, the first two years in an easily accessible place.

10. Before approving any advisory contract under section 15 of the Act, the board of directors or trustees of each Investing Management Company including a majority of the non-interested directors or trustees, will find that the advisory fees charged under such contract are based on services provided that will be in addition to, rather than duplicative of, the services provided under the advisory contract(s) of any Fund in which the Investing Management Company may invest. These findings and their basis will be recorded fully in the minute books of the appropriate Investing Management Company.

11. Any sales charges and/or service fees with respect to shares of an Investing Fund will not exceed the limits applicable to a fund of funds as set forth in Conduct Rule 2830 of the NASD.

12. No Fund will acquire securities of an investment company or company relying on section 3(c)(1) or 3(c)(7) of the Act in excess of the limits contained in section 12(d)(1)(A) of the Act, except to the extent permitted by exemptive relief from the Commission permitting the Fund to purchase shares of other investment companies for short-term cash management purposes.

For the Commission, by the Division of Investment Management, under delegated authority.

Kevin M. O'Neill,

Deputy Secretary.

[FR Doc. 2013–29387 Filed 12–9–13; 8:45 am]

BILLING CODE 8011–01–P

SECURITIES AND EXCHANGE COMMISSION

Sunshine Act Meeting

Notice is hereby given, pursuant to the provisions of the Government in the Sunshine Act, Public Law 94–409, that the Securities and Exchange Commission will hold a Closed Meeting on Thursday, December 12, 2013 at 2:00 p.m.

Commissioners, Counsel to the Commissioners, the Secretary to the Commission, and recording secretaries will attend the Closed Meeting. Certain staff members who have an interest in the matters also may be present.

The General Counsel of the Commission, or her designee, has certified that, in her opinion, one or more of the exemptions set forth in 5 U.S.C. 552b(c)(3), (5), (7), 9(B) and (10) and 17 CFR 200.402(a)(3), (5), (7), 9(ii) and (10), permit consideration of the scheduled matter at the Closed Meeting.

Commissioner Aguilar, as duty officer, voted to consider the items listed for the Closed Meeting in a closed session.

The subject matter of the Closed Meeting will be:

Institution and settlement of injunctive actions;

Institution and settlement of administrative proceedings; an opinion; and

Other matters relating to enforcement proceedings.

At times, changes in Commission priorities require alterations in the scheduling of meeting items.

For further information and to ascertain what, if any, matters have been added, deleted or postponed, please contact the Office of the Secretary at (202) 551–5400.

Dated: December 5, 2013.

Elizabeth M. Murphy,

Secretary.

[FR Doc. 2013–29474 Filed 12–6–13; 11:15 am]

BILLING CODE 8011–01–P

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–70982; File No. SR–NYSEMKT–2013–97]

Self-Regulatory Organizations; NYSE MKT LLC; Notice of Filing and Immediate Effectiveness of Proposed Rule Change Amending the NYSE MKT Equities Price List and the NYSE Amex Options Fee Schedule in Order To Provide for Fees for a Lower-Latency 10 Gigabit Liquidity Center Network Connection in the Exchange's Data Center

December 4, 2013.

Pursuant to Section 19(b)(1) [1] of the Securities Exchange Act of 1934 (the "Act") [2] and Rule 19b–4 thereunder,[3] notice is hereby given that, on November 20, 2013, NYSE MKT LLC (the "Exchange" or "NYSE MKT") filed with the Securities and Exchange Commission (the "Commission") the proposed rule change as described in Items I, II and III below, which Items have been prepared by the self-regulatory organization. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Exchange proposes to amend the NYSE MKT Equities Price List ("Price List") and the NYSE Amex Options Fee Schedule ("Fee Schedule") in order to provide for fees for a lower-latency 10 gigabit ("Gb") Liquidity Center Network ("LCN") connection in the Exchange's data center. The Exchange proposes to implement the fee change effective December 3, 2013. The text of the proposed rule change is available on the Exchange's Web site at *www.nyse.com*, at the principal office of the Exchange, and at the Commission's Public Reference Room.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the self-regulatory organization included statements concerning the purpose of, and basis for, the proposed rule change and discussed any comments it received on the proposed rule change. The text of those statements may be examined at the places specified in Item IV below. The Exchange has prepared summaries, set forth in sections A, B, and C below, of the most significant parts of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

The Exchange proposes to amend the Price List and the Fee Schedule in order to provide for fees for a new lower-latency 10 Gb LCN connection, referred to as the "LCN 10 Gb LX," in the Exchange's data center, and remove obsolete text.[4] The Exchange proposes to implement the fee change effective December 3, 2013.

Users are currently able to purchase access to the Exchange's LCN, a local area network that is available in the data center and that provides Users with access to the Exchange's trading and execution systems and to the Exchange's proprietary market data products.[5] LCN access is currently available in one, 10 and 40 Gb bandwidth capacities,[6] for which Users incur an initial and monthly fee per connection. The Exchange also recently submitted a proposal to expand its co-location services to include lower-latency LCN 10 Gb LX connections.[7] By utilizing ultra low-latency switches, the LCN 10 Gb LX connection would provide faster processing of messages sent to it in comparison to the existing, standard 10 Gb LCN connection.[8] The Exchange proposed to expand its co-location services to include LCN 10 Gb LX connections in order to make an additional service available to its co-location Users and thereby satisfy demand for more efficient, lower latency connections. The LCN 10 Gb LX is expected to have latency levels similar to those of the existing 40 Gb LCN connection. Both the proposed LCN 10 Gb LX connection and the 40 Gb LCN connection represent the lowest latency currently available to Users.

The Exchange hereby proposes to establish the following fees for LCN 10 Gb LX connections:

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[1] 15 U.S.C. 78s(b)(1).

[2] 15 U.S.C. 78a.

[3] 17 CFR 240.19b–4.

[4] The Securities and Exchange Commission ("Commission") initially approved the Exchange's co-location services in Securities Exchange Act Release No. 62961 (September 21, 2010), 75 FR 59299 (September 27, 2010) (SR–NYSEAmex–2010–80) (the "Original Co-location Approval"). The Exchange operates a data center in Mahwah, New Jersey (the "data center") from which it provides co-location services to Users. The Exchange's co-location services allow Users to rent space in the data center so they may locate their electronic servers in close physical proximity to the Exchange's trading and execution system. See *id.* at 59299.

[5] For purposes of the Exchange's co-location services, the term "User" includes (i) member organizations, as that term is defined in the definitions section of the General and Floor Rules of the NYSE MKT Equities Rules, and ATP Holders, as that term is defined in NYSE Amex Options Rule 900.2NY(5); (ii) Sponsored Participants, as that term is defined in Rule 123B.30(a)(ii)(B)—Equities and NYSE Amex Options Rule 900.2NY(77); and (iii) non-member organization and non-ATP Holder broker-dealers and vendors that request to receive co-location services directly from the Exchange. See, e.g., Securities Exchange Act Release Nos. 65974 (December 15, 2011), 76 FR 79249 (December 21, 2011) (SR–NYSEAmex–2011–81) and 65975 (December 15, 2011), 76 FR 79233 (December 21, 2011) (SR–NYSEAmex–2011–82). As specified in the Price List and the Fee Schedule, a User that incurs co-location fees for a particular co-location service pursuant thereto would not be subject to co-location fees for the same co-location service charged by the Exchange's affiliates New York Stock Exchange LLC and NYSE Arca, Inc. *See* Securities Exchange Act Release No. 70176 (August 13, 2013), 78 FR 50471 (August 19, 2013) (SR–NYSEMKT–2013–67).

[6] *See id.*

[7] See Securities Exchange Act Release No. 70886 (November 15, 2013) (SR–NYSEMKT–2013–92). The Exchange did not propose making low-latency LCN connections available for 10 Gb CSP connections because, at least initially, User demand was not anticipated to exist. Also, the Exchange noted that, for a 10 Gb LX "Bundle," SFTI and optic connections would be at standard 10 Gb latencies and only the LCN connections would be lower latency. The Exchange proposes to include language in the Price List and the Fee Schedule to reflect this fact. The Exchange's affiliates have filed substantially the same proposed rule change to expand their co-location services to include LCN 10 Gb LX connections. See Securities Exchange Act Release Nos. 70888 (November 15, 2013) (SR–NYSE–2013–73) and 70887 (November 15, 2013) (SR–NYSEArca–2013–123).

[8] A switch is a type of network hardware that acts as the "gatekeeper" for a User's messaging (e.g., orders and quotes) sent to the Exchange's trading and execution system from the data center. *See* SR–NYSEMKT–2013–92, *supra* note 7.

Type of service	Description	Amount of charge
LCN Access	10 Gb LX Circuit	$15,000 per connection initial charge plus $20,000 monthly per connection.
Bundled Network Access, Option 1 (2 LCN connections, 2 SFTI connections, and 2 optic connections to outside access center).	10 Gb LX Bundle (LCN connections at 10 Gb LX; SFTI and optic connections at standard 10 Gb).	$60,000 initial charge plus $64,500 monthly charge.
Bundled Network Access, Option 2 (2 LCN connections, 2 SFTI connections, 1 optic connection to outside access center, and 1 optic connection in data center).	10 Gb LX Bundle (LCN connections at 10 Gb LX; SFTI and optic connections at standard 10 Gb).	$60,000 initial charge plus $71,000 monthly charge.
Bundled Network Access, Option 3 (2 LCN connections, 2 SFTI connections, and 2 optic connections in data center).	10 Gb LX Bundle (LCN connections at 10 Gb LX; SFTI and optic connections at standard 10 Gb).	$60,000 initial charge plus $77,500 monthly charge.

As with the pricing for existing LCN connections, Users of the LCN 10 Gb LX connections would be subject to an initial charge plus a monthly recurring charge per connection. However, in order to incentivize Users to upgrade to the proposed LCN 10 Gb LX connections, the Exchange proposes that a User that submits a written order for an LCN 10 Gb LX Circuit or 10 Gb LX Bundle between December 3, 2013 and January 31, 2014 would not be subject to the portion of the initial charge related to the LCN 10 Gb LX connections.[9]

As is the case with all Exchange co-location arrangements, (i) neither a User nor any of the User's customers would be permitted to submit orders directly to the Exchange unless such User or customer is a member organization, an ATP Holder, a Sponsored Participant or an agent thereof (e.g., a service bureau providing order entry services); (ii) use of the co-location services proposed herein would be completely voluntary and available to all Users on a non-discriminatory basis;[10] and (iii) a User would only incur one charge for the particular co-location service described herein, regardless of whether the User connects only to the Exchange or to the Exchange and one or both of its affiliates.[11]

Finally, the Exchange proposes to revise the Price List and the Fee Schedule to remove obsolete text. More specifically, a User that submitted a written order for a 40 Gb LCN circuit between September 3, 2013 and September 30, 2013 was not subject to the portion of the initial charge related to the LCN connection.[12] The Exchange proposes to delete text that refers to such period, as it has since expired.

The proposed change is not otherwise intended to address any other issues relating to co-location services and/or related fees, and the Exchange is not aware of any problems that Users would have in complying with the proposed change.

2. Statutory Basis

The Exchange believes that the proposed rule change is consistent with Section 6(b) of the Act,[13] in general, and furthers the objectives of Sections 6(b)(4) and 6(b)(5) of the Act,[14] in particular, because it provides for the equitable allocation of reasonable dues, fees, and other charges among its members, issuers and other persons using its facilities and does not unfairly discriminate between customers, issuers, brokers or dealers.

The Exchange believes that the proposed change is reasonable because the Exchange proposes to offer the additional services described herein (i.e., the LCN 10 Gb LX connection) as a convenience to Users, but in doing so will incur certain costs, including costs related to the data center facility, hardware and equipment and costs related to personnel required for initial installation and ongoing monitoring, support and maintenance of such services.

The Exchange further believes that the proposed change is reasonable because the proposed fees relate to the level of services provided by the Exchange and, in turn, received by the User. The fees proposed for LCN 10 Gb LX connections would be the same as the fees for 40 Gb LCN connections. The Exchange notes that it will incur the same costs related to a User with an LCN 10 Gb LX connection as it does related to a 40 Gb LCN connection, largely due to the cost of the ultra-low latency switches. Accordingly, the Exchange believes that it is reasonable to assess the same fees for both services. The LCN 10 Gb LX connection and the 40 Gb LCN connection represent the lowest latency currently available to Users. The 40 Gb LCN provides the greatest bandwidth available on the Exchange, which is important for Users that have high order flow and ingest large amounts of market data and demand the greatest bandwidth possible to handle such message flow. Some Users, however, have systems that are not compatible with a 40 Gb LCN connection, or do not have bandwidth demands that would require a 40 Gb LCN connection, but still put a premium on reducing latency. The LCN 10 Gb LX is designed to meet this demand. The Exchange believes that this supports a finding that the proposed pricing is reasonable.

The Exchange also believes that not charging the initial charge to a User that submits a written order for an LCN 10 Gb LX Circuit or LCN 10 Gb LX Bundle between December 3, 2013 and January 31, 2014 is reasonable because the Exchange believes it will incentivize Users to upgrade to low-latency connections during the first two months that they are available, which will assist Users in meeting the growing needs of their business operations. The Exchange notes that when introducing the 40 Gb

[9] For a Bundle, this would mean that a User would not be subject to the $30,000 LCN 10 Gb LX portion of the initial charge. The Exchange notes that each 10 Gb LX Bundle would include two LCN 10 Gb LX connections. The initial charge proposed for a non-Bundled LCN 10 Gb LX Circuit is $15,000. Therefore, the LCN 10 Gb LX portion of the initial Bundle charge would be $30,000. A User would remain subject to the remaining $30,000 non-LCN 10 Gb LX portion of the initial Bundle charge, i.e. for SFTI and optic connections.

[10] As is currently the case, Users that receive co-location services from the Exchange will not receive any means of access to the Exchange's trading and execution systems that is separate from, or superior to, that of other Users. In this regard, all orders sent to the Exchange enter the Exchange's trading and execution systems through the same order gateway, regardless of whether the sender is co-located in the data center or not. In addition, co-located Users do not receive any market data or data service product that is not available to all Users, although Users that receive co-location services normally would expect reduced latencies in sending orders to, and receiving market data from, the Exchange.

[11] *See* SR–NYSEMKT–2013–67, *supra* note 5 at 50471. The Exchange's affiliates have also submitted the same proposed rule change to provide for fees for LCN 10 Gb LX connections. *See* SR–NYSE–2013–77 and SR–NYSEArca–2013–131.

[12] *See* Securities Exchange Act Release No. 70285 (August 29, 2013), 78 FR 54697 (September 5, 2013) (SR–NYSEMKT–2013–71).

[13] 15 U.S.C. 78f(b).

[14] 15 U.S.C. 78f(b)(4) and (5).

LCN connection it also did not charge the initial charge for a limited period.[15]

As with fees for existing co-location services, the fees proposed herein would be charged only to those Users that voluntarily select the related services, which would be available to all Users. Accordingly, the Exchange believes that the proposed change is equitable and not unfairly discriminatory. Furthermore, the Exchange believes that the services and fees proposed herein are not unfairly discriminatory and are equitably allocated because, in addition to the services being completely voluntary, they are available to all Users on an equal basis (i.e., the same products and services are available to all Users). Additionally, the Exchange believes that the proposed fees are not unfairly discriminatory because, depending on preference or hardware configurations, a User whose system is not compatible with a 40 Gb LCN connection, or does not have bandwidth demands that would require a 40 Gb LCN connection, but that puts a premium on reducing latency would be able to choose between the LCN 10 Gb LX connection or the existing 40 Gb LCN connection to achieve comparable overall latency levels and would be charged the same fees regardless of connection type chosen.

The Exchange also believes that it is equitable and not unfairly discriminatory to not charge the initial charge to a User that submits a written order for an LCN 10 Gb LX Circuit or 10 Gb LCN Bundle between December 3, 2013 and January 31, 2014 because not charging such fee will incentivize Users to upgrade to low-latency connections during the first two months that they are available, which will assist Users in meeting the growing needs of their business operations. In this regard, all Users would have the option to submit a written order for an LCN 10 Gb LX Circuit or LCN 10 Gb LX Bundle and, if done so between December 3, 2013 and January 31, 2014, any such User would not be charged the initial charge related thereto.

The Exchange also believes that the removal of the text stating that a User that submitted a written order for a 40 Gb LCN circuit between September 3, 2013 and September 30, 2013 was not subject to the portion of the initial charge related to the LCN connection is reasonable, equitable and not unfairly discriminatory because it would result in the removal of obsolete text from the Price List and the Fee Schedule and add greater clarity regarding the applicable fees.

For the reasons above, the proposed change would not unfairly discriminate between or among market participants that are otherwise capable of satisfying any applicable co-location fees, requirements, terms and conditions established from time to time by the Exchange.

Finally, the Exchange believes that it is subject to significant competitive forces, as described below in the Exchange's statement regarding the burden on competition.

For these reasons, the Exchange believes that the proposal is consistent with the Act.

B. Self-Regulatory Organization's Statement on Burden on Competition

In accordance with Section 6(b)(8) of the Act,[16] the Exchange believes that the proposed rule change would not impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act because any market participants that are otherwise capable of satisfying any applicable co-location fees, requirements, terms and conditions established from time to time by the Exchange could have access to the co-location services provided in the data center. This is also true because, in addition to the services being completely voluntary, they are available to all Users on an equal basis (i.e., the same range of products and services are available to all Users).

The Exchange also believes that the proposed LCN 10 Gb LX connection fees will not impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act because LCN 10 Gb LX connections will satisfy User demand for more efficient, lower-latency connections, but Users that do not require the lower latency could continue to request an existing LCN connection and pay the corresponding fees. Additionally, the Exchange believes that the proposed change will enhance competition between competing marketplaces by enabling the Exchange to provide a low-latency connectivity option to Users that is similar to a service available on other markets. For example, The NASDAQ Stock Market LLC ("NASDAQ") also makes a low-latency 10 Gb fiber connection option available to users of its co-location facilities.[17]

Finally, the Exchange notes that it operates in a highly competitive market in which market participants can readily favor competing venues if they deem fee levels at a particular venue to be excessive. In such an environment, the Exchange must continually review, and consider adjusting, its fees and credits to remain competitive with other exchanges. For the reasons described above, the Exchange believes that the proposed rule change reflects this competitive environment.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

No written comments were solicited or received with respect to the proposed rule change.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

The foregoing rule change is effective upon filing pursuant to Section 19(b)(3)(A)[18] of the Act and subparagraph (f)(2) of Rule 19b–4[19] thereunder, because it establishes a due, fee, or other charge imposed by the Exchange.

At any time within 60 days of the filing of such proposed rule change, the Commission summarily may temporarily suspend such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act. If the Commission takes such action, the Commission shall institute proceedings under Section 19(b)(2)(B)[20] of the Act to determine whether the proposed rule change should be approved or disapproved.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet comment form (*http://www.sec.gov/rules/sro.shtml*); or
- Send an email to *rule-comments@sec.gov*. Please include File Number SR–NYSEMKT–2013–97 on the subject line.

[15] *See supra* note 12.

[16] 15 U.S.C. 78f(b)(8).

[17] *See* NASDAQ Rule 7034. NASDAQ refers to this connectivity option as the "10 Gb Ultra" connection. *See also* Securities Exchange Act Release No. 70129 (August 7, 2013), 78 FR 49308 (August 13, 2013) (SR–NASDAQ–2013–099).

[18] 15 U.S.C. 78s(b)(3)(A).

[19] 17 CFR 240.19b–4(f)(2).

[20] 15 U.S.C. 78s(b)(2)(B).

Paper Comments

• Send paper comments in triplicate to Elizabeth M. Murphy, Secretary, Securities and Exchange Commission, 100 F Street NE., Washington, DC 20549–1090.

All submissions should refer to File Number SR–NYSEMKT–2013–97. This file number should be included on the subject line if email is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for Web site viewing and printing in the Commission's Public Reference Room, 100 F Street NE., Washington, DC 20549, on official business days between the hours of 10:00 a.m. and 3:00 p.m. Copies of the filing also will be available for inspection and copying at the principal office of the Exchange. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–NYSEMKT–2013–97 and should be submitted on or before December 31, 2013.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[21]

Kevin M. O'Neill,

Deputy Secretary.

[FR Doc. 2013–29384 Filed 12–9–13; 8:45 am]

BILLING CODE 8011–01–P

[21] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–70979; File No. SR–NYSE–2013–77]

Self-Regulatory Organizations; New York Stock Exchange LLC; Notice of Filing and Immediate Effectiveness of Proposed Rule Change Amending Its Price List in Order To Provide for Fees for a Lower-Latency 10 Gigabit Liquidity Center Network Connection in the Exchange's Data Center

December 4, 2013.

Pursuant to Section 19(b)(1)[1] of the Securities Exchange Act of 1934 (the "Act")[2] and Rule 19b–4 thereunder,[3] notice is hereby given that, on November 20, 2013, New York Stock Exchange LLC ("NYSE" or the "Exchange") filed with the Securities and Exchange Commission (the "Commission") the proposed rule change as described in Items I, II and III below, which Items have been prepared by the self-regulatory organization. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Exchange proposes to amend its Price List in order to provide for fees for a lower-latency 10 gigabit ("Gb") Liquidity Center Network ("LCN") connection in the Exchange's data center. The Exchange proposes to implement the fee change effective December 3, 2013. The text of the proposed rule change is available on the Exchange's Web site at *www.nyse.com*, at the principal office of the Exchange, and at the Commission's Public Reference Room.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the self-regulatory organization included statements concerning the purpose of, and basis for, the proposed rule change and discussed any comments it received on the proposed rule change. The text of those statements may be examined at the places specified in Item IV below. The Exchange has prepared summaries, set forth in sections A, B, and C below, of the most significant parts of such statements.

[1] 15 U.S.C. 78s(b)(1).

[2] 15 U.S.C. 78a.

[3] 17 CFR 240.19b–4.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

The Exchange proposes to amend its Price List in order to provide for fees for a new lower-latency 10 Gb LCN connection, referred to as the "LCN 10 Gb LX," in the Exchange's data center, and remove obsolete text.[4] The Exchange proposes to implement the fee change effective December 3, 2013.

Users are currently able to purchase access to the Exchange's LCN, a local area network that is available in the data center and that provides Users with access to the Exchange's trading and execution systems and to the Exchange's proprietary market data products.[5] LCN access is currently available in one, 10 and 40 Gb bandwidth capacities,[6] for which Users incur an initial and monthly fee per connection. The Exchange also recently submitted a proposal to expand its co-location services to include lower-latency LCN 10 Gb LX connections.[7] By utilizing

[4] The Securities and Exchange Commission ("Commission") initially approved the Exchange's co-location services in Securities Exchange Act Release No. 62960 (September 21, 2010), 75 FR 59310 (September 27, 2010) (SR–NYSE–2010–56) (the "Original Co-location Approval"). The Exchange operates a data center in Mahwah, New Jersey (the "data center") from which it provides co-location services to Users. The Exchange's co-location services allow Users to rent space in the data center so they may locate their electronic servers in close physical proximity to the Exchange's trading and execution system. *See id.* at 59310.

[5] For purposes of the Exchange's co-location services, the term "User" includes (i) member organizations, as that term is defined in NYSE Rule 2(b); (ii) Sponsored Participants, as that term is defined in NYSE Rule 123B.30(a)(ii)(B); and (iii) non-member organization broker-dealers and vendors that request to receive co-location services directly from the Exchange. *See, e.g.*, Securities Exchange Act Release No. 65973 (December 15, 2011), 76 FR 79232 (December 21, 2011) (SR–NYSE–2011–53). As specified in the Price List, a User that incurs co-location fees for a particular co-location service pursuant thereto would not be subject to co-location fees for the same co-location service charged by the Exchange's affiliates NYSE MKT LLC and NYSE Arca, Inc. *See* Securities Exchange Act Release No. 70206 (August 15, 2013), 78 FR 51765 (August 21, 2013) (SR–NYSE–2013–59).

[6] *See id.*

[7] *See* Securities Exchange Act Release No. 70888 (November 15, 2013) (SR–NYSE–2013–73). The Exchange did not propose making low-latency LCN connections available for 10 Gb CSP connections because, at least initially, User demand was not anticipated to exist. Also, the Exchange noted that, for a 10 Gb LX "Bundle," SFTI and optic connections would be at standard 10 Gb latencies and only the LCN connections would be lower latency. The Exchange proposes to include language in the Price List to reflect this fact. The Exchange's affiliates have filed substantially the same proposed rule change to expand their co-location services to include LCN 10 Gb LX connections. *See* Securities

ultra low-latency switches, the LCN 10 Gb LX connection would provide faster processing of messages sent to it in comparison to the existing, standard 10 Gb LCN connection.[8] The Exchange proposed to expand its co-location services to include LCN 10 Gb LX connections in order to make an additional service available to its co-location Users and thereby satisfy demand for more efficient, lower latency connections. The LCN 10 Gb LX is expected to have latency levels similar to those of the existing 40 Gb LCN connection. Both the proposed LCN 10 Gb LX connection and the 40 Gb LCN connection represent the lowest latency currently available to Users.

The Exchange hereby proposes to establish the following fees for LCN 10 Gb LX connections:

Type of service	Description	Amount of charge
LCN Access	10 Gb LX Circuit	$15,000 per connection initial charge plus $20,000 monthly per connection.
Bundled Network Access, Option 1 (2 LCN connections, 2 SFTI connections, and 2 optic connections to outside access center).	10 Gb LX Bundle (LCN connections at 10 Gb LX; SFTI and optic connections at standard 10 Gb).	$60,000 initial charge plus $64,500 monthly charge.
Bundled Network Access, Option 2 (2 LCN connections, 2 SFTI connections, 1 optic connection to outside access center, and 1 optic connection in data center).	10 Gb LX Bundle (LCN connections at 10 Gb LX; SFTI and optic connections at standard 10 Gb).	$60,000 initial charge plus $71,000 monthly charge.
Bundled Network Access, Option 3 (2 LCN connections, 2 SFTI connections, and 2 optic connections in data center).	10 Gb LX Bundle (LCN connections at 10 Gb LX; SFTI and optic connections at standard 10 Gb).	$60,000 initial charge plus $77,500 monthly charge.

As with the pricing for existing LCN connections, Users of the LCN 10 Gb LX connections would be subject to an initial charge plus a monthly recurring charge per connection. However, in order to incentivize Users to upgrade to the proposed LCN 10 Gb LX connections, the Exchange proposes that a User that submits a written order for an LCN 10 Gb LX Circuit or 10 Gb LX Bundle between December 3, 2013 and January 31, 2014 would not be subject to the portion of the initial charge related to the LCN 10 Gb LX connections.[9]

As is the case with all Exchange co-location arrangements, (i) neither a User nor any of the User's customers would be permitted to submit orders directly to the Exchange unless such User or customer is a member organization, a Sponsored Participant or an agent thereof (e.g., a service bureau providing order entry services); (ii) use of the co-location services proposed herein would be completely voluntary and available to all Users on a non-discriminatory basis;[10] and (iii) a User would only incur one charge for the particular co-location service described herein, regardless of whether the User connects only to the Exchange or to the Exchange and one or both of its affiliates.[11]

Finally, the Exchange proposes to revise the Price List to remove obsolete text. More specifically, a User that submitted a written order for a 40 Gb LCN circuit between September 3, 2013 and September 30, 2013 was not subject to the portion of the initial charge related to the LCN connection.[12] The Exchange proposes to delete text that refers to such period, as it has since expired.

The proposed change is not otherwise intended to address any other issues relating to co-location services and/or related fees, and the Exchange is not aware of any problems that Users would have in complying with the proposed change.

2. Statutory Basis

The Exchange believes that the proposed rule change is consistent with Section 6(b) of the Act,[13] in general, and furthers the objectives of Sections 6(b)(4) and 6(b)(5) of the Act,[14] in particular, because it provides for the equitable allocation of reasonable dues, fees, and other charges among its members, issuers and other persons using its facilities and does not unfairly discriminate between customers, issuers, brokers or dealers.

The Exchange believes that the proposed change is reasonable because the Exchange proposes to offer the additional services described herein (i.e., the LCN 10 Gb LX connection) as a convenience to Users, but in doing so will incur certain costs, including costs related to the data center facility, hardware and equipment and costs related to personnel required for initial installation and ongoing monitoring, support and maintenance of such services.

The Exchange further believes that the proposed change is reasonable because the proposed fees relate to the level of services provided by the Exchange and, in turn, received by the User. The fees proposed for LCN 10 Gb LX connections would be the same as the fees for 40 Gb LCN connections. The Exchange notes that it will incur the same costs related to a User with an LCN 10 Gb LX connection as it does related to a 40 Gb LCN connection, largely due to the cost of the ultra-low latency switches. Accordingly, the Exchange believes that it is reasonable to assess the same fees for both services. The LCN 10 Gb LX connection and the 40 Gb LCN

Exchange Act Release Nos. 70886 (November 15, 2013) (SR–NYSEMKT–2013–92) and 70887 (November 15, 2013) (SR–NYSEArca–2013–123).

[8] A switch is a type of network hardware that acts as the "gatekeeper" for a User's messaging (e.g., orders and quotes) sent to the Exchange's trading and execution system from the data center. *See* SR–NYSE–2013–73, *supra* note 7.

[9] For a Bundle, this would mean that a User would not be subject to the $30,000 LCN 10 Gb LX portion of the initial charge. The Exchange notes that each 10 Gb LX Bundle would include two LCN 10 Gb LX connections. The initial charge proposed for a non-Bundled LCN 10 Gb LX Circuit is $15,000. Therefore, the LCN 10 Gb LX portion of the initial Bundle charge would be $30,000. A User would remain subject to the remaining $30,000 non-LCN 10 Gb LX portion of the initial Bundle charge, i.e. for SFTI and optic connections.

[10] As is currently the case, Users that receive co-location services from the Exchange will not receive any means of access to the Exchange's trading and execution systems that is separate from, or superior to, that of other Users. In this regard, all orders sent to the Exchange enter the Exchange's trading and execution systems through the same order gateway, regardless of whether the sender is co-located in the data center or not. In addition, co-located Users do not receive any market data or data service product that is not available to all Users, although Users that receive co-location services normally would expect reduced latencies in sending orders to, and receiving market data from, the Exchange.

[11] *See* SR–NYSE–2013–59, *supra* note 5 at 51766. The Exchange's affiliates have also submitted the same proposed rule change to provide for fees for LCN 10 Gb LX connections. *See* SR–NYSEMKT–2013–97 and SR–NYSEArca–2013–131.

[12] *See* Securities Exchange Act Release No. 70287 (August 29, 2013), 78 FR 54704 (September 5, 2013) (SR–NYSE–2013–60).

[13] 15 U.S.C. 78f(b).

[14] 15 U.S.C. 78f(b)(4) and (5).

connection represent the lowest latency currently available to Users. The 40 Gb LCN provides the greatest bandwidth available on the Exchange, which is important for Users that have high order flow and ingest large amounts of market data and demand the greatest bandwidth possible to handle such message flow. Some Users, however, have systems that are not compatible with a 40 Gb LCN connection, or do not have bandwidth demands that would require a 40 Gb LCN connection, but still put a premium on reducing latency. The LCN 10 Gb LX is designed to meet this demand. The Exchange believes that this supports a finding that the proposed pricing is reasonable.

The Exchange also believes that not charging the initial charge to a User that submits a written order for an LCN 10 Gb LX Circuit or LCN 10 Gb LX Bundle between December 3, 2013 and January 31, 2014 is reasonable because the Exchange believes it will incentivize Users to upgrade to low-latency connections during the first two months that they are available, which will assist Users in meeting the growing needs of their business operations. The Exchange notes that when introducing the 40 Gb LCN connection it also did not charge the initial charge for a limited period.[15]

As with fees for existing co-location services, the fees proposed herein would be charged only to those Users that voluntarily select the related services, which would be available to all Users. Accordingly, the Exchange believes that the proposed change is equitable and not unfairly discriminatory. Furthermore, the Exchange believes that the services and fees proposed herein are not unfairly discriminatory and are equitably allocated because, in addition to the services being completely voluntary, they are available to all Users on an equal basis (i.e., the same products and services are available to all Users). Additionally, the Exchange believes that the proposed fees are not unfairly discriminatory because, depending on preference or hardware configurations, a User whose system is not compatible with a 40 Gb LCN connection, or does not have bandwidth demands that would require a 40 Gb LCN connection, but that puts a premium on reducing latency would be able to choose between the LCN 10 Gb LX connection or the existing 40 Gb LCN connection to achieve comparable overall latency levels and would be charged the same fees regardless of connection type chosen.

[15] *See supra* note 12.

The Exchange also believes that it is equitable and not unfairly discriminatory to not charge the initial charge to a User that submits a written order for an LCN 10 Gb LX Circuit or 10 Gb LCN Bundle between December 3, 2013 and January 31, 2014 because not charging such fee will incentivize Users to upgrade to low-latency connections during the first two months that they are available, which will assist Users in meeting the growing needs of their business operations. In this regard, all Users would have the option to submit a written order for an LCN 10 Gb LX Circuit or LCN 10 Gb LX Bundle and, if done so between December 3, 2013 and January 31, 2014, any such User would not be charged the initial charge related thereto.

The Exchange also believes that the removal of the text stating that a User that submitted a written order for a 40 Gb LCN circuit between September 3, 2013 and September 30, 2013 was not subject to the portion of the initial charge related to the LCN connection is reasonable, equitable and not unfairly discriminatory because it would result in the removal of obsolete text from the Price List and add greater clarity regarding the applicable fees.

For the reasons above, the proposed change would not unfairly discriminate between or among market participants that are otherwise capable of satisfying any applicable co-location fees, requirements, terms and conditions established from time to time by the Exchange.

Finally, the Exchange believes that it is subject to significant competitive forces, as described below in the Exchange's statement regarding the burden on competition.

For these reasons, the Exchange believes that the proposal is consistent with the Act.

B. Self-Regulatory Organization's Statement on Burden on Competition

In accordance with Section 6(b)(8) of the Act,[16] the Exchange believes that the proposed rule change would not impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act because any market participants that are otherwise capable of satisfying any applicable co-location fees, requirements, terms and conditions established from time to time by the Exchange could have access to the co-location services provided in the data center. This is also true because, in addition to the services being completely voluntary, they are available to all Users on an equal basis (i.e., the same range of products and services are available to all Users).

The Exchange also believes that the proposed LCN 10 Gb LX connection fees will not impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act because LCN 10 Gb LX connections will satisfy User demand for more efficient, lower-latency connections, but Users that do not require the lower latency could continue to request an existing LCN connection and pay the corresponding fees. Additionally, the Exchange believes that the proposed change will enhance competition between competing marketplaces by enabling the Exchange to provide a low-latency connectivity option to Users that is similar to a service available on other markets. For example, The NASDAQ Stock Market LLC ("NASDAQ") also makes a low-latency 10 Gb fiber connection option available to users of its co-location facilities.[17]

Finally, the Exchange notes that it operates in a highly competitive market in which market participants can readily favor competing venues if they deem fee levels at a particular venue to be excessive. In such an environment, the Exchange must continually review, and consider adjusting, its fees and credits to remain competitive with other exchanges. For the reasons described above, the Exchange believes that the proposed rule change reflects this competitive environment.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

No written comments were solicited or received with respect to the proposed rule change.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

The foregoing rule change is effective upon filing pursuant to Section 19(b)(3)(A)[18] of the Act and subparagraph (f)(2) of Rule 19b–4[19] thereunder, because it establishes a due, fee, or other charge imposed by the Exchange.

At any time within 60 days of the filing of such proposed rule change, the Commission summarily may temporarily suspend such rule change if

[16] 15 U.S.C. 78f(b)(8).

[17] *See* NASDAQ Rule 7034. NASDAQ refers to this connectivity option as the "10 Gb Ultra" connection. *See also* Securities Exchange Act Release No. 70129 (August 7, 2013), 78 FR 49308 (August 13, 2013) (SR–NASDAQ–2013–099).

[18] 15 U.S.C. 78s(b)(3)(A).

[19] 17 CFR 240.19b–4(f)(2).

it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act. If the Commission takes such action, the Commission shall institute proceedings under Section 19(b)(2)(B)[20] of the Act to determine whether the proposed rule change should be approved or disapproved.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet comment form (*http://www.sec.gov/rules/sro.shtml*); or
- Send an email to *rule-comments@sec.gov*. Please include File Number SR–NYSE–2013–77 on the subject line.

Paper Comments

- Send paper comments in triplicate to Elizabeth M. Murphy, Secretary, Securities and Exchange Commission, 100 F Street NE., Washington, DC 20549–1090.

All submissions should refer to File Number SR–NYSE–2013–77. This file number should be included on the subject line if email is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for Web site viewing and printing in the Commission's Public Reference Room, 100 F Street NE., Washington, DC 20549, on official business days between the hours of 10:00 a.m. and 3:00 p.m. Copies of the filing also will be available for inspection and copying at the principal office of the Exchange. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–NYSE–2013–77 and should be submitted on or before December 31, 2013.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[21]

Kevin M. O'Neill,

Deputy Secretary.

[FR Doc. 2013–29382 Filed 12–9–13; 8:45 am]

BILLING CODE 8011–01–P

[20] 15 U.S.C. 78s(b)(2)(B).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–70981; File No. SR–NYSEARCA–2013–131]

Self-Regulatory Organizations; NYSE Arca, Inc.; Notice of Filing and Immediate Effectiveness of Proposed Rule Change Amending the NYSE Arca Options Fee Schedule and the NYSE Arca Equities Schedule of Fees and Charges for Exchange Services in Order To Provide for Fees for a Lower-Latency 10 Gigabit Liquidity Center Network Connection in the Exchange's Data Center

December 4, 2013.

Pursuant to Section 19(b)(1)[1] of the Securities Exchange Act of 1934 (the "Act")[2] and Rule 19b–4 thereunder,[3] notice is hereby given that, on November 20, 2013, NYSE Arca, Inc. (the "Exchange" or "NYSE Arca") filed with the Securities and Exchange Commission (the "Commission") the proposed rule change as described in Items I, II and III below, which Items have been prepared by the self-regulatory organization. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Exchange proposes to amend the NYSE Arca Options Fee Schedule and, through its wholly owned subsidiary NYSE Arca Equities, Inc. ("NYSE Arca Equities"), the NYSE Arca Equities Schedule of Fees and Charges for Exchange Services (the "Equities Fee Schedule" and, together with the Options Fee Schedule, the "Fee Schedules") in order to provide for fees for a lower-latency 10 gigabit ("Gb") Liquidity Center Network ("LCN") connection in the Exchange's data center. The Exchange proposes to implement the fee change effective December 3, 2013. The text of the proposed rule change is available on the Exchange's Web site at *www.nyse.com*, at the principal office of the Exchange, and at the Commission's Public Reference Room.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the self-regulatory organization included statements concerning the purpose of, and basis for, the proposed rule change and discussed any comments it received on the proposed rule change. The text of those statements may be examined at the places specified in Item IV below. The Exchange has prepared summaries, set forth in sections A, B, and C below, of the most significant parts of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

The Exchange proposes to amend the Fee Schedules in order to provide for fees for a new lower-latency 10 Gb LCN connection, referred to as the "LCN 10 Gb LX," in the Exchange's data center, and remove obsolete text.[4] The Exchange proposes to implement the fee change effective December 3, 2013.

Users are currently able to purchase access to the Exchange's LCN, a local area network that is available in the data center and that provides Users with access to the Exchange's trading and execution systems and to the Exchange's proprietary market data products.[5] LCN

[21] 17 CFR 200.30–3(a)(12).

[1] 15 U.S.C. 78s(b)(1).

[2] 15 U.S.C. 78a.

[3] 17 CFR 240.19b–4.

[4] The Securities and Exchange Commission ("Commission") initially approved the Exchange's co-location services in Securities Exchange Act Release No. 63275 (November 8, 2010), 75 FR 70048 (November 16, 2010) (SR–NYSEArca–2010–100) (the "Original Co-location Approval"). The Exchange operates a data center in Mahwah, New Jersey (the "data center") from which it provides co-location services to Users. The Exchange's co-location services allow Users to rent space in the data center so they may locate their electronic servers in close physical proximity to the Exchange's trading and execution system. *See id.* at 70049.

[5] For purposes of the Exchange's co-location services, the term "User" includes (i) ETP Holders and Sponsored Participants that are authorized to obtain access to the NYSE Arca Marketplace pursuant to NYSE Arca Equities Rule 7.29 (*see* NYSE Arca Equities Rule 1.1(yy)); (ii) OTP Holders, OTP Firms and Sponsored Participants that are authorized to obtain access to the NYSE Arca System pursuant to NYSE Arca Options Rule 6.2A

Continued

access is currently available in one, 10 and 40 Gb bandwidth capacities,[6] for which Users incur an initial and monthly fee per connection. The Exchange also recently submitted a proposal to expand its co-location services to include lower-latency LCN 10 Gb LX connections.[7] By utilizing ultra low-latency switches, the LCN 10 Gb LX connection would provide faster processing of messages sent to it in comparison to the existing, standard 10 Gb LCN connection.[8] The Exchange proposed to expand its co-location services to include LCN 10 Gb LX connections in order to make an additional service available to its co-location Users and thereby satisfy demand for more efficient, lower latency connections. The LCN 10 Gb LX is expected to have latency levels similar to those of the existing 40 Gb LCN connection. Both the proposed LCN 10 Gb LX connection and the 40 Gb LCN connection represent the lowest latency currently available to Users.

The Exchange hereby proposes to establish the following fees for LCN 10 Gb LX connections:

Type of service	Description	Amount of charge
LCN Access	10 Gb LX Circuit	$15,000 per connection initial charge plus $20,000 monthly per connection.
Bundled Network Access, Option 1 (2 LCN connections, 2 SFTI connections, and 2 optic connections to outside access center).	10 Gb LX Bundle (LCN connections at 10 Gb LX; SFTI and optic connections at standard 10 Gb).	$60,000 initial charge plus $64,500 monthly charge.
Bundled Network Access, Option 2 (2 LCN connections, 2 SFTI connections, 1 optic connection to outside access center, and 1 optic connection in data center).	10 Gb LX Bundle (LCN connections at 10 Gb LX; SFTI and optic connections at standard 10 Gb).	$60,000 initial charge plus $71,000 monthly charge.
Bundled Network Access, Option 3 (2 LCN connections, 2 SFTI connections, and 2 optic connections in data center).	10 Gb LX Bundle (LCN connections at 10 Gb LX; SFTI and optic connections at standard 10 Gb).	$60,000 initial charge plus $77,500 monthly charge.

As with the pricing for existing LCN connections, Users of the LCN 10 Gb LX connections would be subject to an initial charge plus a monthly recurring charge per connection. However, in order to incentivize Users to upgrade to the proposed LCN 10 Gb LX connections, the Exchange proposes that a User that submits a written order for an LCN 10 Gb LX Circuit or 10 Gb LX Bundle between December 3, 2013 and January 31, 2014 would not be subject to the portion of the initial charge related to the LCN 10 Gb LX connections.[9]

As is the case with all Exchange co-location arrangements, (i) neither a User nor any of the User's customers would be permitted to submit orders directly to the Exchange unless such User or customer is an ETP Holder, an OTP Holder or OTP Firm, a Sponsored Participant or an agent thereof (e.g., a service bureau providing order entry services); (ii) use of the co-location services proposed herein would be completely voluntary and available to all Users on a non-discriminatory basis;[10] and (iii) a User would only incur one charge for the particular co-location service described herein, regardless of whether the User connects only to the Exchange or to the Exchange and one or both of its affiliates.[11]

Finally, the Exchange proposes to revise the Fee Schedules to remove obsolete text. More specifically, a User that submitted a written order for a 40 Gb LCN circuit between September 3, 2013 and September 30, 2013 was not subject to the portion of the initial charge related to the LCN connection.[12] The Exchange proposes to delete text that refers to such period, as it has since expired.

The proposed change is not otherwise intended to address any other issues relating to co-location services and/or related fees, and the Exchange is not aware of any problems that Users would have in complying with the proposed change.

2. Statutory Basis

The Exchange believes that the proposed rule change is consistent with Section 6(b) of the Act,[13] in general, and furthers the objectives of Sections 6(b)(4) and 6(b)(5) of the Act,[14] in particular, because it provides for the

(see NYSE Arca Options Rule 6.1A(a)(19)); and (iii) non-ETP Holder, non-OTP Holder and non-OTP Firm broker-dealers and vendors that request to receive co-location services directly from the Exchange. *See, e.g.*, Securities Exchange Act Release Nos. 65970 (December 15, 2011), 76 FR 79242 (December 21, 2011) (SR–NYSEArca–2011–74) and 65971 (December 15, 2011), 76 FR 79267 (December 21, 2011) (SR–NYSEArca–2011–75). As specified in the Fee Schedules, a User that incurs co-location fees for a particular co-location service pursuant thereto would not be subject to co-location fees for the same co-location service charged by the Exchange's affiliates NYSE MKT LLC and New York Stock Exchange LLC. *See* Securities Exchange Act Release No. 70173 (August 13, 2013), 78 FR 50459 (August 19, 2013) (SR–NYSEArca–2013–80).

[6] *See id.*

[7] *See* Securities Exchange Act Release No. 70887 (November 15, 2013) (SR–NYSEArca–2013–123). The Exchange did not propose making low-latency LCN connections available for 10 Gb CSP connections because, at least initially, User demand was not anticipated to exist. Also, the Exchange noted that, for a 10 Gb LX "Bundle," SFTI and optic connections would be at standard 10 Gb latencies and only the LCN connections would be lower latency. The Exchange proposes to include language in the Fee Schedules to reflect this fact. The Exchange's affiliates have filed substantially the same proposed rule change to expand their co-location services to include LCN 10 Gb LX connections. *See* Securities Exchange Act Release Nos. 70886 (November 15, 2013) (SR–NYSEMKT–2013–92) and 70888 (November 15, 2013) (SR–NYSE–2013–73).

[8] A switch is a type of network hardware that acts as the "gatekeeper" for a User's messaging (e.g., orders and quotes) sent to the Exchange's trading and execution system from the data center. *See* SR–NYSEArca–2013–123, *supra* note 7.

[9] For a Bundle, this would mean that a User would not be subject to the $30,000 LCN 10 Gb LX portion of the initial charge. The Exchange notes that each 10 Gb LX Bundle would include two LCN 10 Gb LX connections. The initial charge proposed for a non-Bundled LCN 10 Gb LX Circuit is $15,000. Therefore, the LCN 10 Gb LX portion of the initial Bundle charge would be $30,000. A User would remain subject to the remaining $30,000 non-LCN 10 Gb LX portion of the initial Bundle charge, i.e. for SFTI and optic connections.

[10] As is currently the case, Users that receive co-location services from the Exchange will not receive any means of access to the Exchange's trading and execution systems that is separate from, or superior to, that of other Users. In this regard, all orders sent to the Exchange enter the Exchange's trading and execution systems through the same order gateway, regardless of whether the sender is co-located in the data center or not. In addition, co-located Users do not receive any market data or data service product that is not available to all Users, although Users that receive co-location services normally would expect reduced latencies in sending orders to, and receiving market data from, the Exchange.

[11] *See* SR–NYSEArca–2013–80, *supra* note 5 at 50459. The Exchange's affiliates have also submitted the same proposed rule change to provide for fees for LCN 10 Gb LX connections. *See* SR–NYSEMKT–2013–97 and SR–NYSE–2013–77.

[12] *See* Securities Exchange Act Release No. 70286 (August 29, 2013), 78 FR 54710 (September 5, 2013) (SR–NYSEArca–2013–82).

[13] 15 U.S.C. 78f(b).

[14] 15 U.S.C. 78f(b)(4) and (5).

equitable allocation of reasonable dues, fees, and other charges among its members, issuers and other persons using its facilities and does not unfairly discriminate between customers, issuers, brokers or dealers.

The Exchange believes that the proposed change is reasonable because the Exchange proposes to offer the additional services described herein (i.e., the LCN 10 Gb LX connection) as a convenience to Users, but in doing so will incur certain costs, including costs related to the data center facility, hardware and equipment and costs related to personnel required for initial installation and ongoing monitoring, support and maintenance of such services.

The Exchange further believes that the proposed change is reasonable because the proposed fees relate to the level of services provided by the Exchange and, in turn, received by the User. The fees proposed for LCN 10 Gb LX connections would be the same as the fees for 40 Gb LCN connections. The Exchange notes that it will incur the same costs related to a User with an LCN 10 Gb LX connection as it does related to a 40 Gb LCN connection, largely due to the cost of the ultra-low latency switches. Accordingly, the Exchange believes that it is reasonable to assess the same fees for both services. The LCN 10 Gb LX connection and the 40 Gb LCN connection represent the lowest latency currently available to Users. The 40 Gb LCN provides the greatest bandwidth available on the Exchange, which is important for Users that have high order flow and ingest large amounts of market data and demand the greatest bandwidth possible to handle such message flow. Some Users, however, have systems that are not compatible with a 40 Gb LCN connection, or do not have bandwidth demands that would require a 40 Gb LCN connection, but still put a premium on reducing latency. The LCN 10 Gb LX is designed to meet this demand. The Exchange believes that this supports a finding that the proposed pricing is reasonable.

The Exchange also believes that not charging the initial charge to a User that submits a written order for an LCN 10 Gb LX Circuit or LCN 10 Gb LX Bundle between December 3, 2013 and January 31, 2014 is reasonable because the Exchange believes it will incentivize Users to upgrade to low-latency connections during the first two months that they are available, which will assist Users in meeting the growing needs of their business operations. The Exchange notes that when introducing the 40 Gb LCN connection it also did not charge the initial charge for a limited period.[15]

As with fees for existing co-location services, the fees proposed herein would be charged only to those Users that voluntarily select the related services, which would be available to all Users. Accordingly, the Exchange believes that the proposed change is equitable and not unfairly discriminatory. Furthermore, the Exchange believes that the services and fees proposed herein are not unfairly discriminatory and are equitably allocated because, in addition to the services being completely voluntary, they are available to all Users on an equal basis (i.e., the same products and services are available to all Users). Additionally, the Exchange believes that the proposed fees are not unfairly discriminatory because, depending on preference or hardware configurations, a User whose system is not compatible with a 40 Gb LCN connection, or does not have bandwidth demands that would require a 40 Gb LCN connection, but that puts a premium on reducing latency would be able to choose between the LCN 10 Gb LX connection or the existing 40 Gb LCN connection to achieve comparable overall latency levels and would be charged the same fees regardless of connection type chosen.

The Exchange also believes that it is equitable and not unfairly discriminatory to not charge the initial charge to a User that submits a written order for an LCN 10 Gb LX Circuit or 10 Gb LCN Bundle between December 3, 2013 and January 31, 2014 because not charging such fee will incentivize Users to upgrade to low-latency connections during the first two months that they are available, which will assist Users in meeting the growing needs of their business operations. In this regard, all Users would have the option to submit a written order for an LCN 10 Gb LX Circuit or LCN 10 Gb LX Bundle and, if done so between December 3, 2013 and January 31, 2014, any such User would not be charged the initial charge related thereto.

The Exchange also believes that the removal of the text stating that a User that submitted a written order for a 40 Gb LCN circuit between September 3, 2013 and September 30, 2013 was not subject to the portion of the initial charge related to the LCN connection is reasonable, equitable and not unfairly discriminatory because it would result in the removal of obsolete text from the Fee Schedules and add greater clarity regarding the applicable fees.

[15] *See supra* note 12.

For the reasons above, the proposed change would not unfairly discriminate between or among market participants that are otherwise capable of satisfying any applicable co-location fees, requirements, terms and conditions established from time to time by the Exchange.

Finally, the Exchange believes that it is subject to significant competitive forces, as described below in the Exchange's statement regarding the burden on competition.

For these reasons, the Exchange believes that the proposal is consistent with the Act.

B. Self-Regulatory Organization's Statement on Burden on Competition

In accordance with Section 6(b)(8) of the Act,[16] the Exchange believes that the proposed rule change would not impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act because any market participants that are otherwise capable of satisfying any applicable co-location fees, requirements, terms and conditions established from time to time by the Exchange could have access to the co-location services provided in the data center. This is also true because, in addition to the services being completely voluntary, they are available to all Users on an equal basis (i.e., the same range of products and services are available to all Users).

The Exchange also believes that the proposed LCN 10 Gb LX connection fees will not impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act because LCN 10 Gb LX connections will satisfy User demand for more efficient, lower-latency connections, but Users that do not require the lower latency could continue to request an existing LCN connection and pay the corresponding fees. Additionally, the Exchange believes that the proposed change will enhance competition between competing marketplaces by enabling the Exchange to provide a low-latency connectivity option to Users that is similar to a service available on other markets. For example, The NASDAQ Stock Market LLC ("NASDAQ") also makes a low-latency 10 Gb fiber connection option available to users of its co-location facilities.[17]

Finally, the Exchange notes that it operates in a highly competitive market

[16] 15 U.S.C. 78f(b)(8).

[17] *See* NASDAQ Rule 7034. NASDAQ refers to this connectivity option as the "10 Gb Ultra" connection. *See also* Securities Exchange Act Release No. 70129 (August 7, 2013), 78 FR 49308 (August 13, 2013) (SR–NASDAQ–2013–099).

in which market participants can readily favor competing venues if they deem fee levels at a particular venue to be excessive. In such an environment, the Exchange must continually review, and consider adjusting, its fees and credits to remain competitive with other exchanges. For the reasons described above, the Exchange believes that the proposed rule change reflects this competitive environment.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

No written comments were solicited or received with respect to the proposed rule change.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

The foregoing rule change is effective upon filing pursuant to Section 19(b)(3)(A)[18] of the Act and subparagraph (f)(2) of Rule 19b–4[19] thereunder, because it establishes a due, fee, or other charge imposed by the Exchange.

At any time within 60 days of the filing of such proposed rule change, the Commission summarily may temporarily suspend such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act. If the Commission takes such action, the Commission shall institute proceedings under Section 19(b)(2)(B)[20] of the Act to determine whether the proposed rule change should be approved or disapproved.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet comment form (*http://www.sec.gov/rules/sro.shtml*); or
- Send an email to *rule-comments@sec.gov*. Please include File Number SR–NYSEARCA–2013–131 on the subject line.

Paper Comments

- Send paper comments in triplicate to Elizabeth M. Murphy, Secretary, Securities and Exchange Commission, 100 F Street NE., Washington, DC 20549–1090.

All submissions should refer to File Number SR–NYSEARCA–2013–131. This file number should be included on the subject line if email is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for Web site viewing and printing in the Commission's Public Reference Room. 100 F Street NE., Washington, DC 20549, on official business days between the hours of 10:00 a.m. and 3:00 p.m. Copies of the filing also will be available for inspection and copying at the principal office of the Exchange. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–NYSEARCA–2013–131 and should be submitted on or before December 31, 2013.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[21]

Kevin M. O'Neill,

Deputy Secretary.

[FR Doc. 2013–29383 Filed 12–9–13; 8:45 am]

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[18] 15 U.S.C. 78s(b)(3)(A).
[19] 17 CFR 240.19b–4(f)(2).
[20] 15 U.S.C. 78s(b)(2)(B).
[21] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–70985; File No. SR–NASDAQ–2013–145]

Self-Regulatory Organizations; The NASDAQ Stock Market LLC; Notice of Filing and Immediate Effectiveness of Proposed Rule Change Relating to Acceptable Trade Range

December 4, 2013.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 ("Act"),[1] and Rule 19b–4 thereunder,[2] notice is hereby given that on November 21, 2013, The NASDAQ Stock Market LLC ("NASDAQ" or "Exchange") filed with the Securities and Exchange Commission ("SEC" or "Commission") the proposed rule change as described in Items I and II, below, which Items have been prepared by NASDAQ. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

NASDAQ proposes to amend rule text related to Acceptable Trade Range.

The text of the proposed rule change is available on the Exchange's Web site at *http://www.nasdaq.cchwallstreet.com*, at the principal office of the Exchange, at the Commission's Public Reference Room, and on the Commission's Web site at *http://www.sec.gov*.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the Exchange included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. The Exchange has prepared summaries, set forth in sections A, B, and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

The purpose of the proposed rule change is to amend rule text in Chapter VI, Section 10 entitled "Book

[1] 15 U.S.C. 78s(b)(1).
[2] 17 CFR 240.19b–4.

Processing" to add additional rule text regarding Acceptable Trade Range. The Acceptable Trade Range is a mechanism to prevent the system [3] [sic] from experiencing dramatic price swings by creating a level of protection that prevents the market from moving beyond set thresholds. The thresholds consist of a Reference Price plus (minus) set dollar amounts based on the nature of the option and the premium of the option.

Currently, the rule provides that the system will calculate an Acceptable Trade Range to limit the range of prices at which an order will be allowed to execute. The Acceptable Trade Range is calculated by taking the reference price, plus or minus a value to be determined by the Exchange (i.e., the reference price − (x) for sell orders and the reference price + (x) for buy orders).[4] Upon receipt of a new order, the reference price is the National Best Bid (NBB) for sell orders and the National Best Offer (NBO) for buy orders or the last price at which the order is posted whichever is higher for a buy order or lower for a sell order. If an order reaches the outer limit of the Acceptable Trade Range (the "Threshold Price") without being fully executed, it will be posted at the Threshold Price for a brief period, not to exceed one second ("Posting Period"), to allow more liquidity to be collected. Upon posting, either the current Threshold Price of the order or an updated NBB for buy orders or the NBO for sell orders (whichever is higher for a buy order/lower for a sell order) then becomes the reference price for calculating a new Acceptable Trade Range. If the order remains unexecuted, a New [sic] Acceptable Trade Range will be calculated and the order will execute, route, or post up to the new Acceptable Trade Range Threshold Price. Today, this process will repeat until the order is executed, cancelled, or posted at its limit price.

The Exchange proposes to amend this rule to provide that this process will repeat until either (i) the order/quote is executed, cancelled, or posted at its limit price or (ii) the order has been subject to a configurable number of instances of the Acceptable Trade Range as determined by the Exchange.[5] Once the maximum number of instances has been reached, the order is returned. The Exchange will establish a maximum number of Acceptable Trade Range iterations, until the order is cancelled. The Exchange will update the Trading System Settings page located on the *NASDAQTrader.com* Web site to display the maximum number of Acceptable Trade Range iterations and will provide updates to the table via an Options Trader Alert, generally the prior day, to its membership via Options Trader Alerts. The Exchange will provide sufficient advanced notice of changes. This is the same process which currently exists on NASDAQ OMX PHLX LLC ("Phlx").[6]

2. Statutory Basis

The Exchange believes that its proposal is consistent with Section 6(b) of the Act [7] in general, and furthers the objectives of Section 6(b)(5) of the Act [8] in particular, in that it is designed to prevent fraudulent and manipulative acts and practices, to promote just and equitable principles of trade, to foster cooperation and coordination with persons engaged in facilitating transactions in securities, to remove impediments to and perfect the mechanism of a free and open market and a national market system and, in general, to protect investors and the public interest.

The proposed rule change is consistent with these requirements in that it will continue to reduce the negative impacts of sudden, unanticipated volatility in individual options, and serve to preserve an orderly market in a transparent and uniform manner, enhance the price-discovery process, increase overall market confidence, and promote fair and orderly markets and the protection of investors. This functionality should continue to result in greater continuity in prices as it is designed to prevent immediate or rapid executions at far away prices; thereby protecting investors and the public interest. The Exchange believes that the addition of [sic] configurable number of iterations when the Acceptable Trade Range would apply will provide NOM Participants with more certainty as to the application of the Rule. Overall the Acceptable Trade Range Rule should reduce the negative impacts of sudden, unanticipated volatility in and enhance the price-discovery process.

B. Self-Regulatory Organization's Statement on Burden on Competition

The proposed rule change does not impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act. The Exchange believes this proposed rule change would provide NOM Participants greater certainty when transacting orders on the Exchange and continue to reduce the negative impacts of sudden, unanticipated volatility in and enhance the price-discovery process.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

No written comments were either solicited or received.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

The Exchange has filed the proposed rule change pursuant to Section 19(b)(3)(A) of the Act [9] and Rule 19b–4(f)(6) thereunder.[10] Because the proposed rule change does not: (i) Significantly affect the protection of investors or the public interest; (ii) impose any significant burden on competition; and (iii) become operative prior to 30 days from the date on which it was filed, or such shorter time as the Commission may designate, if consistent with the protection of investors and the public interest, the proposed rule change has become effective pursuant to Section 19(b)(3)(A) of the Act [11] and Rule 19b–4(f)(6) thereunder.[12]

At any time within 60 days of the filing of such proposed rule change, the Commission summarily may temporarily suspend such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

[3] The term "System" shall mean the automated system for order execution and trade reporting owned and operated by The Nasdaq Options Market LLC. *See* NOM Rules at Chapter VI, Section 1(a).

[4] The Acceptable Trade Range settings are tied to the option premium.

[5] NOM Participants may elect to have their orders cancelled by the System after the first iteration.

[6] *See* Phlx Rule 1080(p).

[7] 15 U.S.C. 78f(b).

[8] 15 U.S.C. 78f(b)(5).

[9] 15 U.S.C. 78s(b)(3)(A).

[10] 17 CFR 240.19b–4(f)(6).

[11] 15 U.S.C. 78s(b)(3)(A).

[12] 17 CFR 240.19b–4(f)(6). In addition, Rule 19b–4(f)(6) requires the Exchange to give the Commission written notice of the Exchange's intent to file the proposed rule change, along with a brief description and text of the proposed rule change, at least five business days prior to the date of filing of the proposed rule change, or such shorter time as designated by the Commission. The Exchange has satisfied this requirement.

Electronic Comments

- Use the Commission's Internet comment form (*http://www.sec.gov/rules/sro.shtml*); or
- Send an email to *rule-comments@sec.gov*. Please include File Number SR–NASDAQ–2013–145 on the subject line.

Paper Comments

- Send paper comments in triplicate to Elizabeth M. Murphy, Secretary, Securities and Exchange Commission, 100 F Street NE., Washington, DC 20549–1090.

All submissions should refer to File Number SR–NASDAQ–2013–145. This file number should be included on the subject line if email is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for Web site viewing and printing in the Commission's Public Reference Room, 100 F Street NE., Washington, DC 20549, on official business days between the hours of 10:00 a.m. and 3:00 p.m. Copies of the filing also will be available for inspection and copying at the principal office of the Exchange. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–NASDAQ–2013–145 and should be submitted on or before December 31, 2013.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[13]

Kevin M. O'Neill,

Deputy Secretary.

[FR Doc. 2013–29385 Filed 12–9–13; 8:45 am]

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[13] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–70977; File No. SR–NYSEARCA–2013–129]

Self-Regulatory Organizations; NYSE Arca, Inc.; Notice of Filing and Immediate Effectiveness of Proposed Rule Change Amending Rule 6.37A To Eliminate the Requirement That Market Makers Comply With the Bid-Ask Differential Requirements Specified in Rule 6.37(b)(1)(A)–(F) When Electronically Bidding and Offering on the Exchange System During the Opening Auction Process

December 4, 2013.

Pursuant to Section 19(b)(1)[1] of the Securities Exchange Act of 1934 (the "Act")[2] and Rule 19b–4 thereunder,[3] notice is hereby given that, on November 20, 2013, NYSE Arca, Inc. (the "Exchange" or "NYSE Arca") filed with the Securities and Exchange Commission (the "Commission") the proposed rule change as described in Items I, II, and III below, which Items have been prepared by the self-regulatory organization. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Exchange proposes to amend Rule 6.37A to eliminate the requirement that Market Makers comply with the bid-ask differential requirements specified in Rule 6.37(b)(1)(A)–(F) when electronically bidding and offering on the Exchange system during the opening auction process ("Auction"). The text of the proposed rule change is available on the Exchange's Web site at *www.nyse.com*, at the principal office of the Exchange, and at the Commission's Public Reference Room.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the self-regulatory organization included statements concerning the purpose of, and basis for, the proposed rule change and discussed any comments it received on the proposed rule change. The text of those statements may be examined at the places specified in Item IV below. The Exchange has prepared summaries, set forth in sections A, B, and C below, of the most significant parts of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and the Statutory Basis for, the Proposed Rule Change

1. Purpose

The Exchange proposes to amend Rule 6.37A(b)(4) to eliminate the requirement that Market Makers, when electronically bidding and offering on the OX system ("System")[4] during an Auction, must comply with the bid-ask differentials specified in Rule 6.37(b)(1)(A)–(F) and instead make the bid-ask differential specified in Rule 6.37A(b)(4) applicable at all times, including during an Auction.

Current Rule 6.37A(b)(4) provides that options traded on the System during core trading hours may be quoted with a difference not to exceed $5 between the bid and offer regardless of the price of the bid ("standard-width quote"), except with respect to an Auction, in which case Rule 6.37A(b)(6) governs bidding and offering quote differentials. Rule 6.37(b)(1)(A)–(F) set out Auction bid-ask differentials that vary depending on the price of the bid. Under Rule 6.37(b)(1)(A)–(F), the quote widths may not be more than: $0.25 if the bid is less than $2; $0.40 if the bid is at least $2 but does not exceed $5; $0.50 if the bid is more than $5 but does not exceed $10; $0.80 if the bid is more than $10 but does not exceed $20; and $1 if the bid is more than $20. The Exchange now proposes to replace the varying narrow-width bid-ask differentials that apply to Market Maker quotations during an Auction with the $5 quote differential that is in place at all other times.

The Exchange notes that the narrow-width bid-ask differentials applicable to Market Maker quotations during an Auction, which the current proposal would replace, were previously deleted from Rule 6.37A in 2010,[5] and reinstituted in 2011.[6] The Exchange found that at times the absence of more narrow quotes during an Auction prevented series from opening promptly, and could unnecessarily delay the execution of orders. At that time, the Exchange believed that setting

[1] 15 U.S.C. 78s(b)(1).

[2] 15 U.S.C. 78a.

[3] 17 CFR 240.19b–4.

[4] The term "OX" refers to the Exchange's electronic order delivery, execution and reporting system through which orders and quotes for listed options are consolidated for execution and/or display. *See* NYSE Arca Options Rule 6.1A(a)(13).

[5] *See* Securities Exchange Act Release No. 62019 (Apr. 30, 2010), 75 FR 25889 (May 10, 2010) (SR–NYSEArca–2010–16).

[6] *See* Securities Exchange Act Release No. 63747 (January 20, 2011), 75 FR 4965 (Jan. 27, 2011) (SR–NYSEArca–2011–03).

a narrower differential for Auction quotes would expedite the opening of all option series on the Exchange promptly after the opening of the underlying security.

The Exchange now believes, however, that the rationales[7] under which it first eliminated the narrow-width quoting obligations for Auctions in 2010 are once again evident to such an extent that the narrow-width quoting obligations are no longer necessary for Auctions, and thus the Exchange proposes to eliminate them again. The Exchange no longer has the concerns it had in 2011 regarding potential delays, both in the opening of series and in the execution of orders. In particular, the Exchange's 2012 amendment to Rule 6.64 allows for series to open on the wider, standard-width quote when an Auction is not to take place,[8] which is currently the case in a majority of series openings on the Exchange.

Additionally, it is no longer necessary to require Market Makers to submit narrow, traditional bid-ask quotations to encourage a narrower Exchange market during the auction process, as was the original intent of the limitations on bid-ask differentials. Since the time of the original introduction of the System, the Exchange has instituted increased functionality to define price parameters during the auction process. The system will not conduct an Auction in a series until one of two conditions is met: (i) A Market Maker submits a narrow-width quote, or (ii) a narrow-width NBBO is received from OPRA. This is a systemic solution which renders the rules-based narrow bid-ask differential moot. Further, in light of the lowering of the Lead Market Maker quoting obligation to 90% in 2008,[9] there is no requirement for a Market Maker to submit a quotation for an Auction, and thus the Auction quote-width requirement imposes limits on a non-existent obligation.

Finally, the opening auction parameters described in Rule 6.64, under which an Auction will not be conducted unless the composite NYSE Arca bid-ask is within an acceptable range (identical to the bid-ask parameters pursuant to Rule 6.37(b)(1)(A)–(F)) would remain in effect under the Exchange's current proposal.

The Exchange thus believes that the current proposal is appropriate and further notes that the proposal would more closely align the Exchange's rules with the rules of other options exchanges that do not require narrow-width quotes during an opening auction. Neither BATS Exchange, Inc. ("BATS") nor NASDAQ Stock Market LLC ("NOM") imposes narrow-width quote requirements during an opening auction.[10]

2. Statutory Basis

The Exchange believes that the proposal is consistent with Section 6(b) of the Act,[11] in general, and furthers the objectives of Section 6(b)(5) of the Act,[12] in particular, because it is designed to prevent fraudulent and manipulative acts and practices, to promote just and equitable principles of trade, to foster cooperation and coordination with persons engaged in facilitating transactions in securities, and to remove impediments to, and perfect the mechanism of a free and open market and a national market system.

The proposed rule change is designed to remove impediments to, and perfect the mechanism of a free and open market and a national market system by setting price parameters for the opening Auction rather than relying on a restriction that does not have obligatory performance. The wider quote differential requirement for openings when an Auction is conducted will implement a less burdensome quoting obligation in a way that benefits market participants and enables them to safely execute their orders on the Exchange because the proposal maintains the price protection parameters established under Rule 6.64. This will reduce the likelihood of disadvantageous pricing for orders executed during an Auction, which also contributes to the protection of investors and the public interest generally. The Exchange believes that by maintaining these price protection parameters within the Auction process, rather than just as a requirement for submitted quotes, Customers and other market participants will continue to be afforded price protection on executions occurring during an Auction. The proposed rule is also designed to promote just and equitable principles of trade because it would permit Market Makers to provide opening quotes more consistent with those provided by market makers on other options exchanges.[13]

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed rule change will impose any burden on competition not necessary or appropriate in furtherance of the purposes of the Act. To the contrary, the Exchange believes that the proposal will result in the Exchange operating in a more efficient way. The adoption of a less burdensome quoting obligation on NYSE Arca Market Makers during the auction process will allow them to compete more effectively with their counterparts on other options exchanges that are similarly not subject to a narrow-width bid-ask differential applicable during auctions. In addition, the proposed rule change is pro-competitive on both an inter-market and intra-market basis in that it is not only designed to help the Exchange compete more effectively with other options exchanges with similar rules, but could also lead to increased participation by a greater number of Market Makers on the Exchange during the auction process because of the more flexible quoting obligations it would impose.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

No written comments were solicited or received with respect to the proposed rule change.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

The Exchange has filed the proposed rule change pursuant to Section 19(b)(3)(A)(iii) of the Act[14] and Rule 19b–4(f)(6) thereunder.[15] Because the

[7] The obligation for Market Makers to provide opening quotes at the widths described in Rule 6.37(b)(1)(A)–(F) had been adapted from the era when the Exchange conducted open outcry rotations, had only open outcry quotes available to respond to an order, and did not disseminate Firm Quotes. Further, an open outcry opening rotation only required a response from a single Market Maker. The opening market represented the firm quote for all Market Makers in a trading crowd, and any such Market Maker could be held to fill orders at the quoted market. The original intent of maintaining the obligation for Market Makers to submit narrow, traditional bid-ask quotations was to encourage a narrower aggregated Exchange market during the opening auction. This was especially necessary as NYSE Arca was often the first market to open a series, there was not necessarily an accurate National Best Bid/Offer ("NBBO") available, and the Exchange did not have a systemically enforced narrow-width bid-ask differential applicable to the auction process. Since the time of the original introduction of the System, however, NYSE Arca has instituted increased functionality to define price parameters during the auction process.

[8] *See* Securities Exchange Act Release No. 68290 (Nov. 26, 2012), 77 FR 71469 (Nov. 30, 2012) (SR–NYSEArca–2012–126).

[9] *See* Securities Exchange Act Release No. 57186 (Jan. 22, 2008) 73 FR 4931 (January 28, 2008) (SR–NYSEArca–2007–121).

[10] *See* BATS Rule 22.5; NOM Rules Chapter VII, Sections 5–6.

[11] 15 U.S.C. 78f(b).

[12] 15 U.S.C. 78f(b)(5).

[13] *See* note 10, *supra*.

[14] 15 U.S.C. 78s(b)(3)(A)(iii).

[15] 17 CFR 240.19b–4(f)(6). In addition, Rule 19b–4(f)(6) requires a self-regulatory organization to give

Continued

proposed rule change does not: (i) Significantly affect the protection of investors or the public interest; (ii) impose any significant burden on competition; and (iii) become operative prior to 30 days from the date on which it was filed, or such shorter time as the Commission may designate, if consistent with the protection of investors and the public interest, the proposed rule change has become effective pursuant to Section 19(b)(3)(A) of the Act and Rule 19b–4(f)(6)(iii) thereunder.

At any time within 60 days of the filing of such proposed rule change, the Commission summarily may temporarily suspend such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act. If the Commission takes such action, the Commission shall institute proceedings under Section 19(b)(2)(B) [16] of the Act to determine whether the proposed rule change should be approved or disapproved.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet comment form (*http://www.sec.gov/rules/sro.shtml*); or
- Send an email to *rule-comments@sec.gov*. Please include File Number SR–NYSEARCA–2013–129 on the subject line.

Paper Comments

- Send paper comments in triplicate to Elizabeth M. Murphy, Secretary, Securities and Exchange Commission, 100 F Street NE., Washington, DC 20549–1090.

All submissions should refer to File Number SR–NYSEARCA–2013–129. This file number should be included on the subject line if email is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for Web site viewing and printing in the Commission's Public Reference Room, 100 F Street NE., Washington, DC 20549, on official business days between the hours of 10:00 a.m. and 3:00 p.m. Copies of the filing will also be available for inspection and copying at the NYSE's principal office and on its Internet Web site at *www.nyse.com*. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–NYSEARCA–2013–129 and should be submitted on or before December 31, 2013.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[17]

Kevin M. O'Neill,

Deputy Secretary.

[FR Doc. 2013–29380 Filed 12–9–13; 8:45 am]

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SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–70978; File No. SR–NYSEMKT–2013–96]

Self-Regulatory Organizations; NYSE MKT LLC; Notice of Filing and Immediate Effectiveness of Proposed Rule Change Amending Rule 925NY To Eliminate the Requirement That Market Makers Comply With the Bid-Ask Differential Requirements Specified in Rule 925NY(b)(4)(A)–(E) When Electronically Bidding and Offering on the Exchange System During the Opening Auction Process

December 4, 2013.

Pursuant to Section 19(b)(1) [1] of the Securities Exchange Act of 1934 (the "Act") [2] and Rule 19b–4 thereunder,[3] notice is hereby given that on November 20, 2013, NYSE MKT LLC (the "Exchange" or "NYSE MKT") filed with the Securities and Exchange Commission (the "Commission") the proposed rule change as described in Items I, II, and III below, which Items have been prepared by the self-regulatory organization. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Exchange proposes to amend Rule 925NY to eliminate the requirement that Market Makers comply with the bid-ask differential requirements specified in Rule 925NY(b)(4)(A)–(E) when electronically bidding and offering on the Exchange system during the opening auction process ("Auction"). The text of the proposed rule change is available on the Exchange's Web site at *www.nyse.com*, at the principal office of the Exchange, and at the Commission's Public Reference Room.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the self-regulatory organization included statements concerning the purpose of, and basis for, the proposed rule change and discussed any comments it received on the proposed rule change. The text of those statements may be examined at the places specified in Item IV below. The Exchange has prepared summaries, set forth in sections A, B, and C below, of the most significant parts of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and the Statutory Basis for, the Proposed Rule Change

1. Purpose

The Exchange proposes to amend Rule 925NY(b)(5) to eliminate the requirement that Market Makers, when electronically bidding and offering on the Exchange system ("System") [4] during an Auction, must comply with the bid-ask differentials specified in Rule 925NY(b)(4)(A)–(E) and instead make the bid-ask differential specified

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the Commission written notice of its intent to file the proposed rule change at least five business days prior to the date of filing of the proposed rule change, or such shorter time as designated by the Commission. The Exchange has satisfied this requirement.

[16] 15 U.S.C. 78s(b)(2)(B).

[17] 17 CFR 200.30–3(a)(12).

[1] 15 U.S.C. 78s(b)(1).

[2] 15 U.S.C. 78a.

[3] 17 CFR 240.19b–4.

[4] The term "Exchange System" refers to the Exchange's electronic order delivery, execution and reporting system through which orders and quotes for listed options are consolidated for execution and/or display. *See* NYSE MKT Options Rule 900.2NY(48).

in Rule 925NY(b)(5) applicable at all times, including during an Auction.

Current Rule 925NY(b)(5) provides that options traded on the System during core trading hours may be quoted with a difference not to exceed $5 between the bid and offer regardless of the price of the bid ("standard-width quote"), except with respect to an Auction, in which case Rule 925NY(b)(4) governs bidding and offering quote differentials. Rule 925NY(b)(4)(A)–(E) set out Auction bid-ask differentials that vary depending on the price of the bid. Under Rule 925NY(b)(4)(A)–(E), the quote widths may not be more than: $0.25 if the bid is less than $2; $0.40 if the bid is at least $2 but does not exceed $5; $0.50 if the bid is more than $5 but does not exceed $10; $0.80 if the bid is more than $10 but does not exceed $20; and $1 if the bid is more than $20. The Exchange now proposes to replace the varying narrow-width bid-ask differentials that apply to Market Maker quotations during an Auction with the $5 quote differential that is in place at all other times.

The Exchange notes that the narrow-width bid-ask differentials applicable to Market Maker quotations during an Auction, which the current proposal would replace, were previously deleted from Rule 925NY in 2010,[5] and reinstituted in 2011.[6] The Exchange found that at times the absence of more narrow quotes during an Auction prevented series from opening promptly, and could unnecessarily delay the execution of orders. At that time, the Exchange believed that setting a narrower differential for Auction quotes would expedite the opening of all option series on the Exchange promptly after the opening of the underlying security.

The Exchange now believes, however, that the rationales[7] under which it first eliminated the narrow-width quoting obligations for Auctions in 2010 are once again evident to such an extent that the narrow-width quoting obligations are no longer necessary for Auctions, and thus the Exchange proposes to eliminate them again. The Exchange no longer has the concerns it had in 2011 regarding potential delays, both in the opening of series and in the execution of orders. In particular, the Exchange's 2012 amendment to Rule 952NY allows for series to open on the wider, standard-width quote when an Auction is not to take place,[8] which is currently the case in a majority of series openings on the Exchange.

Additionally, it is no longer necessary to require Market Makers to submit narrow, traditional bid-ask quotations to encourage a narrower Exchange market during the auction process, as was the original intent of the limitations on bid-ask differentials. Since the time of the original introduction of the System, the Exchange has instituted increased functionality to define price parameters during the auction process. The system will not conduct an Auction in a series until one of two conditions is met: (i) A Market Maker submits a narrow-width quote, or (ii) a narrow-width NBBO is received from OPRA. This is a systemic solution which renders the rules-based narrow bid-ask differential moot. Further, in light of the lowering of the Lead Market Maker quoting obligation to 90% in 2008,[9] there is no requirement for a Market Maker to submit a quotation for an Auction, and thus the Auction quote-width requirement imposes limits on a non-existent obligation.

Finally, the opening auction parameters described in Rule 952NY, under which an Auction will not be conducted unless the composite NYSE MKT bid-ask is within an acceptable range (identical to the bid-ask parameters pursuant to Rule 925NY(b)(4)(A)–(E)) would remain in effect under the Exchange's current proposal.

The Exchange thus believes that the current proposal is appropriate and further notes that the proposal would more closely align the Exchange's rules with the rules of other options exchanges that do not require narrow-width quotes during an opening auction. Neither BATS Exchange, Inc. ("BATS") nor NASDAQ Stock Market LLC ("NOM") imposes narrow-width quote requirements during an opening auction.[10]

2. Statutory Basis

The Exchange believes that the proposal is consistent with Section 6(b) of the Act,[11] in general, and furthers the objectives of Section 6(b)(5) of the Act,[12] in particular, because it is designed to prevent fraudulent and manipulative acts and practices, to promote just and equitable principles of trade, to foster cooperation and coordination with persons engaged in facilitating transactions in securities, and to remove impediments to, and perfect the mechanism of a free and open market and a national market system.

The proposed rule change is designed to remove impediments to, and perfect the mechanism of a free and open market and a national market system by setting price parameters for the opening Auction rather than relying on a restriction that does not have obligatory performance. The wider quote differential requirement for openings when an Auction is conducted will implement a less burdensome quoting obligation in a way that benefits market participants and enables them to safely execute their orders on the Exchange because the proposal maintains the price protection parameters established under Rule 952NY. This will reduce the likelihood of disadvantageous pricing for orders executed during an Auction, which also contributes to the protection of investors and the public interest generally. The Exchange believes that by maintaining these price protection parameters within the Auction process, rather than just as a requirement for submitted quotes, Customers and other market participants will continue to be afforded a level of price protection on executions that occur during an Auction. The proposed rule is also designed to promote just and equitable principles of trade because it would permit Market Makers to provide opening quotes more consistent with those provided by market makers on other options exchanges.[13]

[5] *See* Securities Exchange Act Release No. 62248 (June 9, 2010), 75 FR 34194 (June 16, 2010) (SR–NYSEAmex–2010–51).

[6] *See* Securities Exchange Act Release No. 63746 (January 20, 2011), 75 FR 4961 (Jan. 27, 2011) (SR–NYSEAmex–2011–05).

[7] The obligation for Market Makers to provide opening quotes at the widths described in Rule 925NY(b)(4)(A)–(E) had been adapted from the era when the Exchange conducted open outcry rotations, had only open outcry quotes available to respond to an order, and did not disseminate Firm Quotes. Further, an open outcry opening rotation only required a response from a single Market Maker. The opening market represented the firm quote for all Market Makers in a trading crowd, and any such Market Maker could be held to fill orders at the quoted market. The original intent of maintaining the obligation for Market Makers to submit narrow, traditional bid-ask quotations was to encourage a narrower aggregated Exchange market during the opening auction. This was especially necessary as NYSE MKT was often the first market to open a series, there was not necessarily an accurate National Best Bid/Offer ("NBBO") available, and the Exchange did not have a systemically enforced narrow-width bid-ask differential applicable to the auction process. Since the time of the original introduction of the System, however, NYSE MKT has instituted increased functionality to define price parameters during the auction process.

[8] *See* Securities Exchange Act Release No. 68383 (Dec. 7, 2012), 77 FR 74258 (Dec. 13, 2012) (SR–NYSEMKT–2012–72).

[9] *See* Securities Exchange Act Release No. 59472 (Feb. 27, 2009) 74 FR 9843 (Mar. 6, 2009) (SR–NYSEAltr–2008–14).

[10] *See* BATS Rule 22.5; NOM Rules Chapter VII, Sections 5–6.

[11] 15 U.S.C. 78f(b).

[12] 15 U.S.C. 78f(b)(5).

[13] *See* note 10, *supra*.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed rule change will impose any burden on competition not necessary or appropriate in furtherance of the purposes of the Act. To the contrary, the Exchange believes that the proposal will result in the Exchange operating in a more efficient way. The adoption of a less burdensome quoting obligation on NYSE MKT Market Makers during the auction process will allow them to compete more effectively with their counterparts on other options exchanges that are similarly not subject to a narrow-width bid-ask differential applicable during auctions. In addition, the proposed rule change is pro-competitive on both an inter-market and intra-market basis in that it is not only designed to help the Exchange compete more effectively with other options exchanges with similar rules, but could also lead to increased participation by a greater number of Market Makers on the Exchange during the auction process because of the more flexible quoting obligations it would impose.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

No written comments were solicited or received with respect to the proposed rule change.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

The Exchange has filed the proposed rule change pursuant to Section 19(b)(3)(A)(iii) of the Act [14] and Rule 19b–4(f)(6) thereunder.[15] Because the proposed rule change does not: (i) Significantly affect the protection of investors or the public interest; (ii) impose any significant burden on competition; and (iii) become operative prior to 30 days from the date on which it was filed, or such shorter time as the Commission may designate, if consistent with the protection of investors and the public interest, the proposed rule change has become effective pursuant to Section 19(b)(3)(A) of the Act and Rule 19b–4(f)(6)(iii) thereunder.

[14] 15 U.S.C. 78s(b)(3)(A)(iii).

[15] 17 CFR 240.19b–4(f)(6). In addition, Rule 19b–4(f)(6) requires a self-regulatory organization to give the Commission written notice of its intent to file the proposed rule change at least five business days prior to the date of filing of the proposed rule change, or such shorter time as designated by the Commission. The Exchange has satisfied this requirement.

At any time within 60 days of the filing of such proposed rule change, the Commission summarily may temporarily suspend such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act. If the Commission takes such action, the Commission shall institute proceedings under Section 19(b)(2)(B) [16] of the Act to determine whether the proposed rule change should be approved or disapproved.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet comment form (*http://www.sec.gov/rules/sro.shtml*); or
- Send an email to *rule-comments@sec.gov*. Please include File Number SR–NYSEMKT–2013–96 on the subject line.

Paper Comments

- Send paper comments in triplicate to Elizabeth M. Murphy, Secretary, Securities and Exchange Commission, 100 F Street NE., Washington, DC 20549–1090.

All submissions should refer to File Number SR–NYSEMKT–2013–96. This file number should be included on the subject line if email is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for Web site viewing and printing in the Commission's Public Reference Room, 100 F Street NE., Washington, DC 20549, on official business days between the hours of 10:00 a.m. and 3:00 p.m. Copies of the filing will also be available for inspection and copying at the NYSE's principal office and on its Internet Web site at *www.nyse.com*. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–NYSEMKT–2013–96 and should be submitted on or before December 31, 2013.

[16] 15 U.S.C. 78s(b)(2)(B).

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[17]

Kevin M. O'Neill,

Deputy Secretary.

[FR Doc. 2013–29381 Filed 12–9–13; 8:45 am]

BILLING CODE 8011–01–P

[17] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–70986; File No. SR–BATS–2013–051]

Self-Regulatory Organizations; BATS Exchange, Inc.; Order Granting Approval of Proposed Rule Change To List and Trade Shares of the iShares Liquidity Income Fund

December 4, 2013.

I. Introduction

On September 19, 2013, BATS Exchange, Inc. ("Exchange" or "BATS") filed with the Securities and Exchange Commission ("Commission"), pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 ("Act") [1] and Rule 19b–4 thereunder,[2] a proposed rule change to list and trade shares ("Shares") of the iShares Liquidity Income Fund ("Fund"). The proposed rule change was published for comment in the **Federal Register** on October 22, 2013.[3] The Commission received no comments on the proposal. This order grants approval of the proposed rule change.

II. Description of the Proposed Rule Change

The Exchange proposes to list and trade the Shares of the Fund pursuant to BATS Rule 14.11(i), which governs the listing and trading of Managed Fund Shares on the Exchange. The Shares will be offered by iShares U.S. ETF Trust ("Trust"), which was established as a Delaware statutory trust on June 21,

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] *See* Securities Exchange Act Release No. 70608 (October 3, 2013), 78 FR 62791 ("Notice").

2011.[4] BlackRock Fund Advisors is the investment adviser ("Adviser") to the Fund.[5] State Street Bank and Trust Company is the administrator, custodian, and transfer agent for the Trust. BlackRock Investments, LLC serves as the distributor for the Trust. The Exchange represents the Adviser is not a registered broker-dealer, but is affiliated with multiple broker-dealers, and has implemented fire walls with respect to those broker-dealers regarding access to information concerning the composition of or changes to the Fund's portfolio.[6]

Description of the Fund and the Shares

The Fund will seek to provide current income consistent with preservation of capital. To achieve its objective, the Fund will invest, under normal circumstances,[7] at least 80% of its net assets in a portfolio of U.S.-dollar-denominated, investment-grade, fixed- and floating-rate debt securities ("Fixed Income Securities"). The Fund will not be a money market fund and thus will not seek to maintain a stable net asset value of $1.00 per Share. In the absence of normal circumstances, the Fund may temporarily depart from its normal investment process, provided that such a departure is, in the opinion of the Adviser, consistent with the Fund's investment objective and in the best interest of the Fund. For example, the Fund may hold a higher-than-normal proportion of its assets in cash in response to adverse market, economic, or political conditions.

The Fund will hold Fixed Income Securities of at least 13 non-affiliated issuers. The Fund will not purchase the securities of issuers conducting their principal business activity in the same industry if, immediately after the purchase and as a result thereof, the value of the Fund's investments in that industry would equal or exceed 25% of the current value of the Fund's total assets, provided that this restriction does not limit the Fund's: (i) Investments in securities of other investment companies; (ii) investments in securities issued or guaranteed by the U.S. government or its agencies or instrumentalities; or (iii) investments in repurchase agreements collateralized by U.S. government securities. The Fund will not invest in non-U.S. equity securities.

According to the Exchange, the Fund intends to qualify each year as a regulated investment company ("RIC") under Subchapter M of the Internal Revenue Code of 1986, as amended.[8] According to the Exchange, the Fund will invest its assets, and will otherwise conduct its operations, in a manner that is intended to satisfy the qualifying income, diversification, and distribution requirements necessary to establish and maintain RIC qualification under Subchapter M.

Fixed Income Securities

According to the Exchange, the Fund intends to achieve its investment objective by investing, under normal circumstances, at least 80% of its net assets in a portfolio of U.S.-dollar-denominated, investment-grade Fixed Income Securities that are rated BBB- or higher by Standard & Poor's Financial Services LLC or Fitch Inc. ("Fitch"), rated Baa3 or higher by Moody's Investors Service, Inc. ("Moody's"), or, if unrated, determined by the Adviser to be of equivalent quality.[9] Under normal circumstances, the Fund will invest primarily in Fixed Income Securities maturing in three years or less. Under normal circumstances, short-term investments (generally, securities with original maturities of one year or less) held by the Fund will carry a rating in the highest two-rating categories of at least one nationally recognized statistical ratings organization (*e.g.*, A–2, P–2, or F2 or better by Standard & Poor's Ratings Services, Moody's, or Fitch, respectively) or will, if unrated, have been determined to be of comparable quality by the Adviser, at the time of investment.

According to the Exchange, Fixed Income Securities will include fixed- and floating-rate debt securities, such as corporate[10] and government bonds, agency securities,[11] instruments of non-U.S. issuers, privately-issued securities,[12] structured securities,[13] municipal bonds, money market securities,[14] and investment companies

[4] The Trust is registered as an open-end investment company under the Investment Company Act of 1940 ("1940 Act"). *See* Registration Statement on Form N–1A for the Trust, dated February 4, 2013 (File Nos. 333–179904 and 811–22649) ("Registration Statement"). The Commission has issued an order granting certain exemptive relief under the Investment Company Act of 1940 (15 U.S.C. 80a–1) ("1940 Act") ("Exemptive Order"). *See* Investment Company Act Release No. 29571 (January 24, 2011) (File No. 812–13601).

[5] BlackRock Fund Advisors is an indirect, wholly-owned subsidiary of BlackRock, Inc.

[6] *See* BATS Rule 14.11(i)(7). The Exchange represents further that, in the event (a) the Adviser becomes a broker-dealer or newly affiliated with a broker-dealer, or (b) any new adviser or sub-adviser is a broker-dealer or becomes affiliated with a broker-dealer, the Adviser will implement a fire wall with respect to its relevant personnel or its broker-dealer affiliate, as applicable, regarding access to information concerning the composition of or changes to the portfolio and will be subject to procedures designed to prevent the use and dissemination of material, non-public information regarding such portfolio.

[7] According to the Exchange, the term "under normal circumstances" includes, but is not limited to, the absence of adverse market, economic, political, or other conditions, including extreme volatility or trading halts in the fixed income markets or the financial markets generally; operational issues causing dissemination of inaccurate market information; or force majeure type events such as systems failure, natural or man-made disaster, act of God, armed conflict, act of terrorism, riot or labor disruption, or any similar intervening circumstance.

[8] 26 U.S.C. 851.

[9] The Adviser may determine that unrated Fixed Income Securities are of "equivalent quality" based on such credit quality factors as it deems appropriate, which may include among other things, performing an analysis similar, to the extent possible, to that performed by a nationally recognized statistical ratings organization when rating similar securities and issuers. In making such a determination, the Adviser may consider internal analyses and risk ratings, third party research and analysis, and other sources of information, as deemed appropriate by the Adviser.

[10] While the Fund is permitted to invest without restriction in corporate bonds, the Adviser expects that, under normal circumstances, the Fund will generally seek to invest in corporate bond issuances that have at least $100 million par amount outstanding in developed countries and at least $200 million par amount outstanding in emerging market countries.

[11] According to the Exchange, the term "agency securities" for these purposes generally includes securities issued by the following entities: Government National Mortgage Association (Ginnie Mae); Federal National Mortgage Association (Fannie Mae); Federal Home Loan Banks (FHLBanks); Federal Home Loan Mortgage Corporation (Freddie Mac); Farm Credit System (FCS) Farm Credit Banks (FCBanks); Student Loan Marketing Association (Sallie Mae); Resolution Funding Corporation (REFCORP); Financing Corporation (FICO); and the Farm Credit System (FCS) Financial Assistance Corporation (FAC). Agency securities can include, but are not limited to, mortgage-backed securities.

[12] According to the Exchange, "privately-issued securities" generally include Rule 144A securities and, in this context, may include both mortgage-backed and non-mortgage Rule 144A securities.

[13] According to the Exchange, "structured securities" generally include privately-issued and publicly-issued structured securities, including certain publicly-issued structured securities that are not agency securities. Examples include, but are not limited to: Asset-backed securities backed by assets such as consumer receivables, credit cards, student loans, and equipment leases; asset-backed commercial paper; credit linked notes; and secured funding notes.

[14] According to the Exchange, the Adviser expects that, under normal circumstances, the Fund intends to invest in money market securities (as described below) in a manner consistent with its investment objective in order to help manage cash flows in and out of the Fund, such as in connection with payment of dividends or expenses, and to satisfy margin requirements, to provide collateral, or to otherwise back investments in derivative instruments. For these purposes, money market securities include: Short-term, high-quality obligations issued or guaranteed by the U.S. Treasury or the agencies or instrumentalities of the U.S. government; short-term, high-quality securities issued or guaranteed by non-U.S. governments, agencies, and instrumentalities; repurchase agreements; money market mutual funds; commercial paper; and deposits and other obligations of U.S. and non-U.S. banks and financial institutions. All money market securities

Continued

(including investment companies advised by the Adviser or its affiliates) that invest in such Fixed Income Securities.[15] The Fund may invest up to 5% of its net assets in Fixed Income Securities and instruments of issuers that are domiciled in emerging market countries.

The Fund will invest in asset-backed and mortgage-backed Fixed Income Securities.[16] Asset-backed securities are fixed-income securities that are backed by a pool of assets, usually loans such as installment sale contracts or credit card receivables. Mortgage-backed securities are asset-backed securities based on a particular type of asset, a mortgage. According to the Exchange, there are a wide variety of mortgage-backed securities involving commercial or residential, fixed-rate or adjustable-rate mortgages, and mortgages issued by banks or government agencies.[17]

According to the Exchange, the Fund's investments will be consistent with the Fund's investment objective and will not be used to enhance leverage. The Exchange states that, under normal circumstances, the dollar-weighted average life of the Fund's portfolio is expected to be one year or less, as calculated by the Adviser,[18] and that the Fund will also seek to maintain a dollar-weighted average maturity that is less than 180 days.[19]

The Fund is an actively-managed fund that does not seek to replicate the performance of a specified index. The Exchange notes, however, that the Fund's portfolio will meet certain criteria for index-based, fixed income exchange-traded funds contained in Rule 14.11(c)(4)(B)(i).[20]

Other Portfolio Holdings

The Fund may, to a limited extent (under normal circumstances, less than 20% of the Fund's net assets), engage in transactions in futures contracts, options, and swaps.[21]

The Fund may hold up to an aggregate amount of 15% of its net assets in illiquid securities (calculated at the time of investment), including Rule 144A securities deemed illiquid by the Adviser[22] under the 1940 Act. The Fund will monitor its portfolio liquidity on an ongoing basis to determine whether, in light of current circumstances, an adequate level of liquidity is being maintained, and will consider taking appropriate steps in order to maintain adequate liquidity if, through a change in values, net assets, or other circumstances, more than 15% of the Fund's net assets are held in illiquid securities. According to the Exchange, illiquid securities include securities subject to contractual or other restrictions on resale and other instruments that lack readily available markets as determined in accordance with Commission staff guidance.

Additional information regarding the Shares and the Fund, including investment strategies, risks, creation and redemption procedures, fees and expenses, portfolio holdings disclosure policies, calculation of net asset value ("NAV"), distributions, taxes, and reports to be distributed to beneficial owners of the Shares can be found in the Notice and Registration Statement, as applicable.[23]

III. Discussion and Commission's Findings

The Commission has carefully reviewed the proposed rule change and finds that it is consistent with the requirements of Section 6 of the Act[24] and the rules and regulations thereunder applicable to a national securities exchange.[25] In particular, the Commission finds that the proposal is consistent with Section 6(b)(5) of the Act,[26] which requires, among other things, that the Exchange's rules be designed to prevent fraudulent and manipulative acts and practices, to promote just and equitable principles of trade, to foster cooperation and

acquired by the Fund will be rated investment grade. The Fund does not intend to invest in any unrated money market securities. However, the Exchange states that the Fund may do so to a limited extent—for example, when a rated money market security becomes unrated, if that money market security is determined by the Adviser to be of comparable quality to investment grade money market securities. The Adviser may determine that unrated securities are of comparable quality to investment grade securities based on such credit quality factors as it deems appropriate, which may include, among other things, performing an analysis similar, to the extent possible, to that performed by a nationally recognized statistical rating organization rating similar securities and issuers.

[15] According to the Exchange, the Fund currently anticipates investing in only registered open-end investment companies, including mutual funds and the open-end investment company funds described in BATS Rule 14.11, but the Exchange notes that the Exemptive Order allows the Fund to invest in "shares of other ETFs, shares of money market mutual funds, or other investment companies."

[16] The Fund has not established a fixed limit to the amount of asset-backed and mortgage-backed debt securities in which it will invest, but the Exchange represents that, as noted above, at least 80% of the Fund's net assets will be, under normal circumstances, invested in investment-grade Fixed Income Securities; that neither high-yield, asset-backed securities nor high-yield mortgage-backed securities are included in the Fund's principal investment strategies; and that the Fund's portfolio will meet certain criteria of the Exchange's generic listing standards for index-based, fixed-income exchange-traded funds. *See, infra,* note 20. The exchange states that the liquidity of a security, especially in the case of asset-backed and mortgage-backed debt securities, is a substantial factor in the Fund's security selection process, and the Commission notes that the Fund may not invest more than 15% of its net assets in illiquid securities.

[17] *See supra* note 11.

[18] Dollar-weighted average life is the weighted average of the times when principal is to be repaid.

[19] According to the Exchange, dollar-weighted average maturity is calculated by taking the average length of time to maturity (fixed-rate) or the next interest rate reset (floating-rate) for each underlying instrument held by the Fund, weighted according to the relative holdings per instrument.

[20] *See* BATS Rule 14.11(c)(4)(B)(i) governing fixed income based Index Fund Shares. The Fund's portfolio will meet the following requirements of Rule 14.11(c)(4)(B)(i): (i) The index or portfolio must consist of Fixed Income Securities (Rule 14.11(c)(4)(B)(i)(a)); (ii) a component may be a convertible security, however, once the convertible security component converts to an underlying equity security, the component is removed from the index or portfolio (Rule 14.11(c)(4)(B)(i)(c)); (iii) no component fixed-income security (excluding Treasury Securities) will represent more than 30% of the weight of the index or portfolio, and the five highest weighted component fixed-income securities do not in the aggregate account for more than 65% of the weight of the index or portfolio (Rule 14.11(c)(4)(B)(i)(d)); (iv) an underlying index or portfolio (excluding exempted securities) must include securities from a minimum of 13 non-affiliated issuers (Rule 14.11(c)(4)(B)(i)(e)); and (v) component securities that in aggregate account for at least 90% of the weight of the index or portfolio must be either: (1) From issuers that are required to file reports pursuant to Sections 13 and 15(d) of the Act; (2) from issuers that have a worldwide market value of its outstanding common equity held by non-affiliates of $700 million or more; (3) from issuers that have outstanding securities that are notes, bonds, debentures, or evidence of indebtedness having a total remaining principal amount of at least $1 billion; (4) exempted securities as defined in Section 3(a)(12) of the Act; or (5) from issuers that are a government of a foreign country or a political subdivision of a foreign country (Rule 14.11(c)(4)(B)(i)(f)).

[21] Derivatives might be included in the Fund's investments to serve the investment objectives of the Fund. According to the Exchange, examples include, but are not limited to, treasury futures to hedge against rising interest rates, currency futures to hedge against foreign exchange rates, interest rate swaps, credit default swaps, total return swaps, and equity index options. The derivatives will be exchange traded or centrally cleared, and they will be collateralized. Derivatives are not a principal investment strategy of the Fund.

[22] In reaching liquidity decisions, the Adviser may consider factors including: The frequency of trades and quotes for the security; the number of dealers wishing to purchase or sell the security and the number of other potential purchasers; dealer undertakings to make a market in the security; the nature of the security and the nature of the marketplace trades (*e.g.*, the time needed to dispose of the security, the method of soliciting offers, and the mechanics of transfer); any legal or contractual restrictions on the ability to transfer the security or asset; significant developments involving the issuer or counterparty specifically (*e.g.*, default, bankruptcy, etc.) or the securities markets generally; and settlement practices, registration procedures, limitations on currency conversion or repatriation, and transfer limitations (for foreign securities or other assets).

[23] *See supra* notes 3 and 4, respectively.

[24] 15 U.S.C. 78f.

[25] In approving this proposed rule change, the Commission has considered the proposed rule's impact on efficiency, competition, and capital formation. *See* 15 U.S.C. 78c(f).

[26] 15 U.S.C. 78f(b)(5).

coordination with persons engaged in facilitating transactions in securities, to remove impediments to and perfect the mechanism of a free and open market and a national market system, and, in general, to protect investors and the public interest. The Commission notes that the Fund and the Shares must comply with the requirements of proposed BATS Rule 14.11(i) to be listed and traded on the Exchange.

The Commission finds that the proposal is also consistent with Section 11A(a)(1)(C)(iii) of the Act,[27] which sets forth Congress' finding that it is in the public interest and appropriate for the protection of investors and the maintenance of fair and orderly markets to assure the availability to brokers, dealers, and investors of information with respect to quotations for, and transactions in, securities. Quotation and last-sale information for the Shares will be available on the facilities of the Consolidated Tape Association ("CTA"). The Intraday Indicative Value ("IIV"), which will reflect an estimated intraday value of the Fund's portfolio and be based upon the current value for the components of the Disclosed Portfolio (as defined below), will be updated and widely disseminated by one or more major market data vendors at least every 15 seconds during the Exchange's Regular Trading Hours.[28] On each business day, before commencement of trading in Shares during Regular Trading Hours [29] on the Exchange, the Fund will disclose on its Web site the identities and quantities of the portfolio of securities and other assets ("Disclosed Portfolio") held by the Fund that will form the basis for the Fund's calculation of NAV at the end of the business day.[30] The NAV of the Fund's Shares generally will be calculated once daily Monday through Friday as of the close of regular trading on the New York Stock Exchange, generally 4:00 p.m. Eastern Time. Additionally, information regarding market price and volume of the Shares will be continually available on a real-time basis throughout the day on brokers' computer screens and other electronic services. The previous day's closing price and trading volume information for the Shares will also be published daily in the financial section of newspapers. Intraday, executable price quotations on Fixed Income Securities and other assets are available from major broker-dealer firms and—for exchange-traded assets, including investment companies, futures, and options—intraday price and volume information is available directly from the applicable listing exchange. Intraday price and volume information is also available through subscription services, such as Bloomberg, Thomson Reuters, and International Data Corporation, which can be accessed by authorized participants and other investors. The Web site for the Fund will include a form of the prospectus for the Fund, additional data relating to NAV, and other applicable quantitative information.

The Commission further believes that the proposal to list and trade the Shares is reasonably designed to promote fair disclosure of information that may be necessary to price the Shares appropriately and to prevent trading when a reasonable degree of transparency cannot be assured. The Commission notes that the Exchange will obtain a representation from the issuer of the Shares that the NAV per Share will be calculated daily and that the NAV and the Disclosed Portfolio will be made available to all market participants at the same time.[31] Trading in the Shares also will be subject to BATS Rule 14.11(i)(4)(B)(iv), which sets forth circumstances under which Shares of the Fund may be halted.[32] The Exchange may halt trading in the Shares if trading is not occurring in the securities or the financial instruments constituting the Disclosed Portfolio of the Fund, or if other unusual conditions or circumstances detrimental to the maintenance of a fair and orderly market are present.[33] Further, the Commission notes that the Reporting Authority that provides the Disclosed Portfolio must implement and maintain, or be subject to, procedures designed to prevent the use and dissemination of material, non-public information regarding the actual components of the portfolio.[34] The Exchange states that it prohibits the distribution of material, non-public information by its employees. The Exchange also states that the Adviser is affiliated with multiple broker-dealers, and the Adviser has implemented fire walls with respect to those broker-dealers regarding access to information concerning the composition of or changes to the Fund's portfolio.[35] Moreover, the Exchange represents that it is able to obtain information via the Intermarket Surveillance Group ("ISG") from other exchanges that are members of ISG or with which the Exchange has in place a comprehensive surveillance sharing agreement.

The Exchange further represents that the Shares are deemed to be equity securities, thus rendering trading in the Shares subject to the Exchange's existing rules governing the trading of equity securities. In support of this proposal, the Exchange has made representations, including:

(1) The Shares will be subject to BATS Rule 14.11(i), which sets forth the initial and continued listing criteria applicable to Managed Fund Shares.

(2) The Exchange has appropriate rules to facilitate transactions in the Shares during all trading sessions.

(3) The Exchange's surveillance procedures applicable to derivative products, which include Managed Fund Shares, are adequate to properly monitor the trading of the Shares on the Exchange during all trading sessions and to deter and detect violations of

[27] 15 U.S.C. 78k–1(a)(1)(C)(iii).

[28] According to the Exchange, several major market data vendors display or make widely available IIVs published via the CTA or other data feeds. Quotations of certain of the Fund's holdings may not be updated during U.S. trading hours if those holdings do not trade in the United States or if updated prices cannot be ascertained.

[29] Regular Trading Hours are 9:30 a.m. to 4:00 p.m. Eastern Time.

[30] The Disclosed Portfolio will include, as applicable, the names, quantity, percentage weighting, and market value of Fixed Income Securities and other assets held by the Fund, and the characteristics of such assets. The Web site and information will be publicly available at no charge.

[31] *See* BATS Rule 14.11(i)(4)(A)(ii).

[32] *See* BATS Rule 14.11(i)(4)(B)(iv).

[33] *See* BATS Rule 14.11(i)(4)(B)(iii) (providing additional considerations for the suspension of trading in or removal from listing of Managed Fund Shares on the Exchange). With respect to trading halts, the Exchange may consider all relevant factors in exercising its discretion to halt or suspend trading in the Shares of the Fund. The Exchange will halt trading in the Shares under the conditions specified in BATS Rule 11.18. Trading also may be halted because of market conditions or for reasons that, in the view of the Exchange, make trading in the Shares inadvisable.

[34] *See* BATS Rule 14.11(i)(4)(B)(ii)(B).

[35] *See supra* note 6 and accompanying text. An investment adviser to an open-end fund is required to be registered under the Investment Advisers Act of 1940 ("Advisers Act"). As a result, the Adviser and its related personnel are subject to the provisions of Rule 204A–1 under the Advisers Act relating to codes of ethics. This Rule requires investment advisers to adopt a code of ethics that reflects the fiduciary nature of the relationship to clients as well as compliance with other applicable securities laws. Accordingly, procedures designed to prevent the communication and misuse of non-public information by an investment adviser must be consistent with Rule 204A–1 under the Advisers Act. In addition, Rule 206(4)–7 under the Advisers Act makes it unlawful for an investment adviser to provide investment advice to clients unless such investment adviser has (i) adopted and implemented written policies and procedures reasonably designed to prevent violation, by the investment adviser and its supervised persons, of the Advisers Act and the Commission rules adopted thereunder; (ii) implemented, at a minimum, an annual review regarding the adequacy of the policies and procedures established pursuant to subparagraph (i) above and the effectiveness of their implementation; and (iii) designated an individual (who is a supervised person) responsible for administering the policies and procedures adopted under subparagraph (i) above.

Exchange rules and applicable federal securities laws.

(4) The Exchange may obtain information regarding trading in the Shares and the underlying shares in investment companies, futures, and options via the ISG, from other exchanges who are members or affiliates of the ISG or with which the Exchange has entered into a comprehensive surveillance sharing agreement.[36]

(5) Prior to the commencement of trading, the Exchange will inform its members in an Information Circular ("Circular") of the special characteristics and risks associated with trading the Shares. Specifically, the Circular will discuss the following: (a) The procedures for purchases and redemptions of Shares in Creation Units (and that Shares are not individually redeemable); (b) BATS Rule 3.7, which imposes suitability obligations on Exchange members with respect to recommending transactions in the Shares to customers; (c) how information regarding the IIV is disseminated; (d) the risks involved in trading the Shares during the Pre-Opening[37] and After Hours Trading Sessions[38] when an updated IIV will not be calculated or publicly disseminated; (e) the requirement that members deliver a prospectus to investors purchasing newly issued Shares prior to or concurrently with the confirmation of a transaction; and (f) trading information.

(6) For initial and continued listing, the Fund must be in compliance with Rule 10A–3 under the Act.[39]

(7) The Fund may hold up to an aggregate amount of 15% of its net assets in illiquid securities (calculated at the time of investment), including Rule 144A securities deemed illiquid by the Adviser under the 1940 Act. The Fund will monitor its portfolio liquidity on an ongoing basis to determine whether, in light of current circumstances, an adequate level of liquidity is being maintained, and will consider taking appropriate steps in order to maintain adequate liquidity if, through a change in values, net assets, or other circumstances, more than 15% of the Fund's net assets are held in illiquid securities.

(8) The Fund may engage in derivatives transactions, including transactions in futures contracts, options, and swaps, to a limited extent (under normal circumstances, less than 20% of the Fund's net assets). The derivatives will be exchange-traded or centrally cleared, and they will be collateralized.

(9) The Fund's investments will be consistent with the Fund's investment objective and will not be used to enhance leverage.

(10) The Fund's portfolio will meet certain criteria for index-based, fixed income exchange-traded funds contained in Rule 14.11(c)(4)(B)(i).[40]

(11) The Fund will not invest in non-U.S. equity securities.

(12) A minimum of 100,000 Shares will be outstanding at the commencement of trading on the Exchange.

This approval order is based on all of the Exchange's representations and description of the Fund, including those set forth above and in the Notice.

For the foregoing reasons, the Commission finds that the proposed rule change is consistent with Section 6(b)(5) of the Act[41] and the rules and regulations thereunder applicable to a national securities exchange.

IV. Conclusion

It is therefore ordered, pursuant to Section 19(b)(2) of the Act,[42] that the proposed rule change (SR–BATS–2013–051) be, and it hereby is, approved.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[43]

Kevin M. O'Neill,

Deputy Secretary.

[FR Doc. 2013–29386 Filed 12–9–13; 8:45 am]

BILLING CODE 8011–01–P

SECURITIES AND EXCHANGE COMMISSION

[File No. 500–1]

Guar Global Ltd.; Order of Suspension of Trading

December 6, 2013.

It appears to the Securities and Exchange Commission that the public interest and the protection of investors require a suspension of trading in the securities of Guar Global Ltd. ("Guar Global") because of concerns regarding the accuracy and adequacy of information in the marketplace and potentially manipulative transactions in Guar Global's common stock. Guar Global is a Nevada corporation based in McKinney, Texas. It is quoted on OTC Link under the symbol GGBL.

The Commission is of the opinion that the public interest and the protection of investors require a suspension of trading in the securities of the above-listed company.

Therefore, it is ordered, pursuant to Section 12(k) of the Securities Exchange Act of 1934, that trading in the securities of the above-listed company is suspended for the period from 9:30 a.m. EST on December 6, 2013 through 11:59 p.m. EST on December 19, 2013.

By the Commission.

Elizabeth M. Murphy,

Secretary.

[FR Doc. 2013–29529 Filed 12–6–13; 4:15 pm]

BILLING CODE 8011–01–P

SECURITIES AND EXCHANGE COMMISSION

[File No. 500–1]

Aden Solutions, Inc.; Order of Suspension of Trading

December 6, 2013.

It appears to the Securities and Exchange Commission that there is a lack of current and accurate information concerning the securities of Aden Solutions, Inc. The company has not filed any periodic reports since the period ended September 30, 2011 and there are questions regarding the accuracy of publicly available information about the company.

The Commission is of the opinion that the public interest and the protection of investors require a suspension of trading in the securities of the above-listed company.

Therefore, it is ordered, pursuant to Section 12(k) of the Securities Exchange Act of 1934, that trading in the securities of the above-listed company is suspended for the period from 9:30 a.m. EST on December 6, 2013, through 11:59 p.m. EST on December 19, 2013.

By the Commission.

Jill M. Peterson,

Assistant Secretary.

[FR Doc. 2013–29528 Filed 12–6–13; 4:15 pm]

BILLING CODE 8011–01–P

SMALL BUSINESS ADMINISTRATION

Reporting and Recordkeeping Requirements Under OMB Review

AGENCY: Small Business Administration.

[36] The Exchange represents that all of the investment company securities, futures, and options will trade on markets that are members of ISG or with which the Exchange has in place a comprehensive surveillance sharing agreement.

[37] The Pre-Opening Session is from 8:00 a.m. to 9:30 a.m. Eastern Time.

[38] The After Hours Trading Session is from 4:00 p.m. to 5:00 p.m. Eastern Time.

[39] *See* 17 CFR 240.10A–3.

[40] *See supra* note 20 and accompanying text.

[41] 15 U.S.C. 78f(b)(5).

[42] 15 U.S.C. 78s(b)(2).

[43] 17 CFR 200.30–3(a)(12).

ACTION: Notice of 30 day Reporting Requirements Submitted for OMB Review.

SUMMARY: Under the provisions of the Paperwork Reduction Act (44 U.S.C. Chapter 35), agencies are required to submit proposed reporting and recordkeeping requirements to OMB for review and approval, and to publish a notice in the **Federal Register** notifying the public that the agency has made such a submission.

DATES: Submit comments on or before January 9, 2014. If you intend to comment but cannot prepare comments promptly, please advise the OMB Reviewer and the Agency Clearance Officer before the deadline.

Copies: Request for clearance (OMB 83–1), supporting statement, and other documents submitted to OMB for review may be obtained from the Agency Clearance Officer.

ADDRESSES: Address all comments concerning this notice to: *Agency Clearance Officer,* Curtis Rich, Small Business Administration, 409 3rd Street, SW., 5th Floor, Washington, DC 20416; and *OMB Reviewer,* Office of Information and Regulatory Affairs, Office of Management and Budget, New Executive Office Building, Washington, DC 20503,

FOR FURTHER INFORMATION CONTACT: Curtis Rich, Agency Clearance Officer, (202) 205–7030 *curtis.rich@sba.gov.*

Abstract: SBA Direct is an optional feature of SBA.gov that helps customized, relevant SBA.gov information directly to the user which will help site visitors, including small business owners, the ability to quickly and efficiently locate content on SBA.gov. SBA Community is also an optional feature of SBA.gov which allows users to contribute to SBA.gov by posting success stories, comments, or questions in a forum interface. The community will allow site visitors, including small businesses the ability to ask questions regarding starting and managing a business.

SUPPLEMENTARY INFORMATION:

Title: SBA Direct and SBA Online Community.

Frequency: On Occasion.

SBA Form Number: N/A.

Description of Respondents: Entrepreneurs, lenders, small business owners, and among others.

Responses: 413,000.

Annual Burden: 4,325.

Curtis Rich,

Management Analyst.

[FR Doc. 2013–29371 Filed 12–9–13; 8:45 am]

BILLING CODE P

SMALL BUSINESS ADMINISTRATION

Reporting and Recordkeeping Requirements Under OMB Review

AGENCY: Small Business Administration.

ACTION: 30-Day Notice.

SUMMARY: The Small Business Administration (SBA) is publishing this notice to comply with requirements of the Paperwork Reduction Act (PRA) (44 U.S.C. Chapter 35), which requires agencies to submit proposed reporting and recordkeeping requirements to OMB for review and approval, and to publish a notice in the **Federal Register** notifying the public that the agency has made such a submission. This notice also allows an additional 30 days for public comments.

DATES: Submit comments on or before January 9, 2014.

ADDRESSES: Comments should refer to the information collection by name and/or OMB Control Number and should be sent to: *Agency Clearance Officer,* Curtis Rich, Small Business Administration, 409 3rd Street SW., 5th Floor, Washington, DC 20416; and *SBA Desk Officer,* Office of Information and Regulatory Affairs, Office of Management and Budget, New Executive Office Building, Washington, DC 20503.

FOR FURTHER INFORMATION CONTACT: Curtis Rich, Agency Clearance Officer, (202) 205–7030 *curtis.rich@sba.gov.*

Copies: A copy of the Form OMB 83–1, supporting statement, and other documents submitted to OMB for review may be obtained from the Agency Clearance Officer.

SUPPLEMENTARY INFORMATION: The Small Business Investment Act authorizes SBA to guarantee a debenture issued by a Certified Development Company (CDC) participating in SBA's 504 Loan Program. The proceeds from each debenture are used to fund loans ("504 loans") to eligible small business concerns (SBCs). 15 U.S.C. 697(a). The first information collection described below, SBA Form 1244 (OMB Control Number 3245–0071), is the Application for Section 504 Loans. The second information collection, the CDC Annual Report Guide, SBA Form 1253 (OMB Control Number 3245–0074) relates to the annual report required from each CDC as stated in 13 CFR 120.830. Prior notice of proposed changes to these information collections was published in the **Federal Register** on August 30, 2013, at 78 FR 53816. The changes are necessary to conform the forms to recent updates in the Lender and Development Company Loan Programs standard operating procedures, designated as SOP 50 10 5 (F). The changes include revisions to the exhibits required to be attached to the 504 loan application such as a clarification of who is required to submit credit reports, and addition of a requirement to submit a Credit Alert Verification Reporting System (CAIVRS) report to document that an applicant, guarantors or affiliates have no prior loss to the government or delinquent Federal debt. Changes to the CDC Annual Report Guide include a clarification of the consequences for failure to file the report in a timely manner, and clarification of the requirement to submit financial statements that have been reviewed by an independent CPA.

SBA notes that these changes resulting from updates to the SOP are in addition to the changes that the Agency proposed in the February 25, 2013, publication of *504 and 7(a) Loan Program Updates* notice of proposed rulemaking. (78 FR 12633). That rulemaking is still pending final review and approval. As soon as SBA receives that approval it will make any additional and necessary changes to Forms 1244 and 1253 to conform to the final rule.

Solicitation of Public Comments

Comments may be submitted on (a) whether the collection of information is necessary for the agency to properly perform its functions; (b) whether the burden estimates are accurate; (c) whether there are ways to minimize the burden, including through the use of automated techniques or other forms of information technology; and (d) whether there are ways to enhance the quality, utility, and clarity of the information.

Summary of Information Collections

(1) *Title:* Application for Section 504 Loan.

Description of Respondents: Small Business Concerns applying for a Section 504 loan and Certified Development Companies.

Form Number: SBA Form 1244 collects information that is used to determine the creditworthiness and repayment ability of the small business concern and its eligibility for SBA financial assistance; as well as the terms and conditions of the 504 loan. Form 1244 is also used by CDCs to request SBA's guarantee on the debenture.

Estimated Annual Respondents: 7,000.

Estimated Annual Responses: 7,000.

Estimated Annual Hour Burden: 14,613.

(2) *Title:* Certified Development Company (CDC) Annual Report Guide.

Description of Respondents: Certified Development Companies.

Form Number: SBA Form 1253 outlines the information (financial statements, economic development activities, and other operational and management information) that the CDC must submit to comply with the annual reporting requirement.

Estimated Annual Respondents: 260.

Estimated Annual Responses: 260.

Estimated Annual Hour Burden: 7,280.

Curtis B. Rich,

Management Analyst.

[FR Doc. 2013–29372 Filed 12–9–13; 8:45 am]

BILLING CODE 8025–01–P

DEPARTMENT OF STATE

[Public Notice 8545]

Imposition of Additional Sanctions on Syria Under the Chemical and Biological Weapons Control and Warfare Elimination Act of 1991

AGENCY: Bureau of International Security and Nonproliferation, Department of State.

ACTION: Notice.

SUMMARY: On August 2, 2013, a determination was made that the Government of Syria used chemical weapons in violation of international law or lethal chemical weapons against its own nationals. Notice of this determination was published on September 10, 2013, in the **Federal Register,** under Public Notice 8460. That determination resulted in sanctions against the Government of Syria. Section 307(b) of the Chemical and Biological Weapons Control and Warfare Elimination Act of 1991, 22 U.S.C. 5604(a) and 5605(a), requires a decision within three months of the August 2, 2013 determination regarding the imposition of additional sanctions. The United States Government decided on November 1, 2013, to impose such additional sanctions on the Government of Syria. In addition, the United States Government determined that it is essential to the national security interests of the United States to partially waive the application of these additional sanctions with respect to activities in furtherance of United States policies regarding the Syrian conflict.

The following is notice of the additional sanctions to be imposed pursuant to Section 307(b)(2) of the Act (22 U.S.C. 5605(b)), subject to the waiver described above.

DATES: *Effective Date:* Upon publication in the **Federal Register.**

FOR FURTHER INFORMATION CONTACT: Pamela K. Durham, Office of Missile, Biological, and Chemical Nonproliferation, Bureau of International Security and Nonproliferation, Department of State, Telephone (202) 647–4930.

SUPPLEMENTARY INFORMATION: Pursuant to Section 307(b) of the Chemical and Biological Weapons Control and Warfare Elimination Act of 1991, as amended (22 U.S.C. 5604(a) and 5605(a)), on November 1, 2013, the Under Secretary of State for Arms Control and International Security, Rose Gottemoeller, decided to impose additional sanctions on the Government of Syria. As a result, the following additional sanctions are hereby imposed, subject to partial waivers as noted below:

1. Bank Loans—The United States Government shall prohibit any United States bank from making any loan or providing any credit to the Government of Syria, except for loans or credits for the purpose of purchasing food or other agricultural commodities or products.

2. Further Export Restrictions—The authorities of section 6 of the Export Administration Act of 1979 shall be used to prohibit exports to Syria of all other goods and technology (excluding food and other agricultural commodities and products).

3. Presidential Action Regarding Aviation—The Executive Branch is authorized to notify the Government of Syria of its intention to suspend the authority of foreign air carriers owned or controlled by Syria to engage in foreign air transportation to or from the United States.

The application of these additional sanctions is partially waived with respect to activities in furtherance of United States policies regarding the Syrian conflict. Determinations as to whether activities are in furtherance of U.S. policies regarding the Syrian conflict will be made on a case-by-case basis with the involvement of the Department of State, using existing interagency procedures to the maximum extent possible. These measures shall be implemented by the responsible departments and agencies of the United States Government and will remain in place for at least one year or until further notice.

Dated: December 4, 2013.

Vann H. Van Diepen,

Acting Assistant Secretary of State for International Security and Nonproliferation.

[FR Doc. 2013–29441 Filed 12–9–13; 8:45 am]

BILLING CODE 4710–02–P

DEPARTMENT OF TRANSPORTATION

Federal Highway Administration

[Docket No. FHWA–2013–0057]

Agency Information Collection Activities: Request for Comments for a New Information Collection

AGENCY: Federal Highway Administration (FHWA), DOT.

ACTION: Notice and request for comments.

SUMMARY: In compliance with the Paperwork Reduction Act (PRA) of 1995 (44 U.S.C. 3501–3521), this notice announces that FHWA will submit the collection of information described below to the Office of Management and Budget (OMB) for review and comment. The **Federal Register** Notice with a 60-day comment period soliciting comments on the following collection of information was published on June 25, 2013. The PRA submission describes the nature of the information collection and its expected cost and burden.

DATES: Please submit comments by January 9, 2014.

ADDRESSES: You may submit comments identified by DOT Docket ID 2013–0057 by any of the following methods:

Web site: For access to the docket to read background documents or comments received go to the Federal eRulemaking Portal: Go to *http://www.regulations.gov.* Follow the online instructions for submitting comments.

Fax: 1–202–493–2251.

Mail: Docket Management Facility, U.S. Department of Transportation, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE., Washington, DC 20590–0001.

Hand Delivery or Courier: U.S. Department of Transportation, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE., Washington, DC 20590, between 9 a.m. and 5 p.m. ET, Monday through Friday, except Federal holidays.

FOR FURTHER INFORMATION CONTACT: Tom Kearney, 518–431–8890, Office of Freight Management & Operations (HOFM–1), Office of Operations, Federal Highway Administration, Department of Transportation, Leo O'Brien Federal Building, Room 715, Albany, NY 12207. Office hours are from 7:30 a.m. to 4:00 p.m., Monday through Friday, except Federal holidays.

SUPPLEMENTARY INFORMATION:

Title: Survey and Comparative Assessment of Truck Parking Facilities.

Background: Section 1401(c) of the Moving Ahead for Progress in the 21st Century Act (MAP–21) requires the U.S.

Department of Transportation (USDOT) to complete a survey and comparative assessment of truck parking facilities in each State. Specifically, the study is required to: (1) Evaluate the capability of the State to provide adequate parking and rest facilities for commercial motor vehicles engaged in interstate transportation; (2) assess the volume of commercial motor vehicle traffic in the State; and (3) develop a system of metrics to measure the adequacy of commercial motor vehicle parking facilities in the State. It also requires the results of the survey to be made available to the public on a USDOT accessible Web site.

Respondents: The respondents to the survey include State transportation and enforcement officials, private sector facility owners or operators, State trucking association representatives, and truck drivers. The target groups of respondents are individuals who are responsible for providing or overseeing the operation of truck parking facilities and the stakeholders who depend on truck parking facilities to safely conduct their business. The target group identified in the legislation is "State commercial vehicle safety personnel." The Federal Highway Administration (FHWA) has interpreted that term to include the State Department of Transportation (DOT) personnel involved in commercial vehicle safety programs and activities, State enforcement personnel directly involved in enforcing highway safety laws and regulations, and personnel involved in highway incident and accident response. FHWA believes the survey should not be limited to publicly owned facilities and seeks input from private sector facility owners or operators. In addition, FHWA also believes that input from trucking company representatives involved in logistics, driver scheduling, and truck drivers themselves, are key stakeholders most likely to know where more truck parking is needed.

Section 1401(c)(1)(C) of MAP–21 requires the development of a system of metrics to measure the adequacy of commercial vehicle parking facilities. Therefore, FHWA intends to invite key stakeholders to participate in a focus group, which will assist in the identification and development of those metrics. The key stakeholders that will be invited to serve on the focus group will include representatives of the national stakeholder organizations listed above.

Types of Survey Questions: FHWA intends to survey State DOT personnel about the location, number of spaces, availability of those spaces, and demand for truck parking in their State. Truck parking spaces found at rest facilities will be included in the survey. FHWA seeks to identify impediments to adequate truck parking capacity including, but not limited to: Legislative, regulatory, or financial issues; zoning; public and private impacts, approval, and participation; availability of land; insurance requirements; and other issues. In addition, FHWA intends to survey private truck stop operators in each state about the location, number of truck parking spaces, availability of those spaces, and demand for the spaces at their facilities. Public safety officials in each state will be surveyed about their records and observations concerning truck parking use and patterns, including the location and frequency of trucks parked adjacent to roadways, and on exit and entrance ramps to roadway facilities. FHWA intends to survey trucking companies and truck drivers about: The location of parking facilities; the frequency that an insufficient amount of truck parking is encountered; capacity at rest facilities; future truck parking needs and locations; availability of information on truck parking capacity; and other impediments to truck parking. Other questions may be included based on input from the focus groups, stakeholder outreach, FHWA's discretion, or as follow-up to the survey.

Estimate:

State Departments of Transportation = 50 (1 hour each) + [up to 10 individuals × up to 5 hours of meeting and travel] = up to 100 hours;

State Enforcement Personnel = 50 (1 hour each) + [up to 10 individuals × up to 5 hours of meeting and travel] = up to 100 hours;

Private Facility Owners/Operators = 229 (30 minutes each) + [up to 10 individuals × up to 5 hours of meeting and travel] = up to 165 hours;

Trucking Association Representatives = 50 (1 hour each) + [up to 10 individuals × up to 5 hours of meeting and travel] = up to 100 hours;

Commercial Motor Vehicle Drivers = 400 (30 minutes each) + [up to 10 individuals × up to 5 hours of meeting and travel] = up to 250 hours;

Total number of respondents = 779 for the survey, and up to an additional 50 for focus groups (there is potential for overlap of individuals responding to the survey and participating on a voluntary basis in the focus group).

Total burden hours = at least 629 hours and no more than 929 hours (as allocated above).

Estimated Total Annual Burden: This survey will be updated periodically; the estimated total burden for each survey cycle for all respondents is no less than 629 hours.

Public Comment: Between June 25 and August 26, 2013, FHWA invited comments on the approach proposed for conducting the Survey, the contents of the Survey Instrument, and the burden that would occur in the operation of the Survey [see Docket No. FHWA–2013–0017]. Five comments were received during this time period:

- A message supporting the proposed data collection process was received from Missouri DOT.
- A comment from the Texas DOT recommending that the survey include an inquiry about expenditures made by the States on "upkeep and maintenance of truck parking facilities including damage caused by truckers." This question has been incorporated into the Survey instrument.
- The Virginia DOT submitted comments including an offer to coordinate with them on the Statewide Truck Parking Survey they are embarking on. A preliminary discussion has been conducted with VA DOT to share the steps, goals and objectives of this effort, the status and goals of the VA DOT Study, and the identification of areas where the efforts could be synchronized. The Virginia DOT also pointed out the benefits of aerial mapping tools in identifying truck parking locations. FHWA intends to employ a mapping effort under this project.
- Comments were received from the National Association of Truck Stop Operators (NATSO) laying out several points for FHWA's consideration:
  - Data collection recommendations on number of spaces, sensitivity to time of day and day of week in determining demand (demand is dynamic temporally), enumerating the number of trucks parked in less than ideal locations (highway shoulders, access and egress ramp shoulders, etc.) are all included in the scope of FHWA's Survey;
  - NATSO pointed out that FMCSA's new "Hours-of-Service" regulations will affect truck parking demand and it must be considered in the Survey. This consideration is included in the operation of the Survey FHWA intends to conduct;
  - Reminder that developing "Truck VMT by State" will include trucks that don't have parking needs. FHWA is aware and sensitive to this situation and intends to address this consideration in the

project;

- Reminder that changes in the trucking industry "business model" are underway where the "hub-spoke" model that the industry is transitioning to requires less parking opportunities being required. FHWA will address this factor under the project;
- Request that the question of "why" is considered when areas that suffer a shortage in truck parking opportunities are identified. FHWA will address this point in the operation of the project;

- The Owner-Operator, Independent Drivers Association (OOIDA) submitted a number of comments for FHWA's consideration:
  - The number of drivers that FHWA suggested would be surveyed (150 in the **Federal Register** Notice) was seen as inadequate. FHWA reached out to OOIDA for information on the appropriate number of drivers to be surveyed, the number of 400 drivers was offered by OOIDA and the outreach to drivers by FHWA will now include 400 drivers;
  - OOIDA reminded FHWA that the survey of privately owned and operated facilities should not solely include national, multi-state enterprises. OOIDA pointed out those smaller scale facility owners should be included in the Survey. USDOT intends, working with NATSO, to include small, medium and large scale facility owners and operators in the Survey;
  - OOIDA expressed interest in participating in the Metrics Workshop that will be conducted under this project. FHWA intends to include OOIDA representatives as invitees to this event.

FHWA appreciates the comments that were submitted and has, overall, incorporated the suggestions offered into the Survey and other work activities being developed under this Project.

Authority: The Paperwork Reduction Act of 1995; 44 U.S.C. Chapter 35, as amended; and 49 CFR 1.48.

Issued On: December 4, 2013.

Michael Howell,

Information Collection Officer.

[FR Doc. 2013–29428 Filed 12–9–13; 8:45 am]

BILLING CODE P

DEPARTMENT OF TRANSPORTATION

Federal Highway Administration

[Docket No. FHWA–2013–0056]

Agency Information Collection Activities: Request for Comments for a New Information Collection

AGENCY: Federal Highway Administration (FHWA), DOT.

ACTION: Notice and request for comments.

SUMMARY: In compliance with the Paperwork Reduction Act (PRA) of 1995 (44 U.S.C. 3501–3521), this notice announces that FHWA will submit the collection of information described below to the Office of Management and Budget (OMB) for review and comment. The **Federal Register** Notice with a 60-day comment period soliciting comments on the following collection of information was published on May 20, 2013. The PRA submission describes the nature of the information collection and its expected cost and burden.

DATES: Please submit comments by January 9, 2014.

ADDRESSES: You may submit comments identified by DOT Docket ID 2013–0056 by any of the following methods:

Web site: For access to the docket to read background documents or comments received go to the Federal eRulemaking Portal: Go to *http://www.regulations.gov*. Follow the online instructions for submitting comments.

Fax: 1–202–493–2251.

Mail: Docket Management Facility, U.S. Department of Transportation, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE., Washington, DC 20590–0001.

Hand Delivery or Courier: U.S. Department of Transportation, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE., Washington, DC 20590, between 9 a.m. and 5 p.m. ET, Monday through Friday, except Federal holidays.

Crystal Jones, 202–366–2976, Office of Freight Management & Operations (HOFM–1), Office of Operations, Federal Highway Administration, 1200 New Jersey Ave, Room E84–313, Washington, DC 20509. Office hours are from 8:30 a.m. to 5:00 p.m., Monday through Friday, except Federal holidays.

SUPPLEMENTARY INFORMATION:

Title: USDOT Survey on Projects of National and Regional Significance (PNRS).

Background: This information collection will facilitate compliance with the requirements of Moving Ahead for Progress in the 21st Century Act (MAP–21) as stated in Section 1120 (l)—Project of National and Regional Significance (PNRS). The information collection is not a solicitation for a grant application. Response to the information collection is voluntary; and responding or not responding will not help, harm or directly influence the USDOT's evaluation for any future funding or solicitation for projects.

The information collected will be used by USDOT in submitting the required report to Congress regarding PNRS, in accordance with MAP–21 Section 1120. The analysis to support the development of the content of the report will include; a review of project eligibility and the supporting information submitted by the respondents. As a minimum, all respondents will be asked to provide information that demonstrates how the project of national or regional significance meets the requirements outlined in the law.

Section 1301 of the Safe, Accountable, Flexible, Efficient Transportation Equity Act: A Legacy for Users (SAFETEA–LU) (Pub. L. 109–59; 119 Stat. 1144) established a program to provide grants to States for PNRS to improve the safe, secure, and efficient movement of people and goods throughout the United States and to improve the health and welfare of the national economy. The PNRS program was amended under Section 1120 of the Moving Ahead for Progress in the 21st Century Act, (MAP–21), Public Law 112–141 as follows:

- Expands eligible applicants to include a tribal government or consortium of tribal governments, a transit agency; or a multi-State or multi-jurisdictional group in addition to State DOTs.
- Reduces the floor on total project costs to $500m or 50% of the state's apportionment (previously 75%).
- Adds evaluation criteria to consider if a project improves roadways vital to national energy security and removes criteria related to technology.
- Requires United States Department of Transportation (USDOT) to develop a Report to Congress regarding PNRS. The purpose of the report is to identify projects of national and regional significance that:
  - Will significantly improve the performance of the Federal-aid highway system, nationally or regionally;
  - Generate national economic benefits that reasonably exceed the costs of the projects, including increased access to jobs, labor, and other critical economic inputs;
  - Reduce long-term congestion, including impacts in the State, region, and the United States, and increase

speed, reliability, and accessibility of the movement of people or freight; and

○ Improve transportation safety, including reducing transportation accidents, and serious injuries and fatalities; and

○ Can be supported by an acceptable degree of non-Federal financial commitments.

Respondents: The target groups of respondents are eligible applicants for the PRNS program, this includes:

(A) A State department of transportation or a group of State departments of transportation;

(B) A tribal government or consortium of tribal governments;

(C) A transit agency; or

(D) A multi-State or multi-jurisdictional group of the agencies described in (A) through (C) above.

The target groups identified in the MAP–21 are "State departments of transportation" (SDOTs). The FHWA interprets SDOTs to be the minimum target group of respondents and believes it is necessary to survey all eligible applicants groups, in order to compile the comprehensive list of projects required by the law.

Estimate:

State Departments of Transportation = 52
Transit Agencies = 50
Tribal Governments = 10
Multi-state or multi-jurisdictional groups = 10

Burden hours:

80 hours/State Department of Transportation = 4160 hours
40 hours/Transit Agency = 2000 hours
10 hours/Tribal Government = 100
20 hours/Multi-state or multi-jurisdictional groups = 200
Total burden hours = 6460 (as allocated above).

Estimated Average Burden per Response: The estimated average reporting burden per response is 80 hours per State Department of Transportation, 40 hours per large transit agency, 10 hours per tribal government and 20 hours per Multi-state or multi-jurisdictional groups. The estimated average burden for SDOTs is greater than other respondents, this is in part because the FHWA expects that SDOTs, in developing their PNRS project lists, will gather input from project developers, such metropolitan planning organizations, seaports, railroads, economic development organizations, and entities which have responsibility for planning and/or implementing transportation infrastructure projects.

Estimated Total Annual Burden: This information collection is a one-time requirement.

Authority: The Paperwork Reduction Act of 1995; 44 U.S.C. Chapter 35, as amended; and 49 CFR 1.48.

Issued On: December 4, 2013.

Michael Howell,

Information Collection Officer.

[FR Doc. 2013–29427 Filed 12–9–13; 8:45 am]

BILLING CODE P

DEPARTMENT OF TRANSPORTATION

Federal Motor Carrier Safety Administration

[Docket No. FMCSA–2013–0349]

Agency Information Collection Activities; Revision of a Currently-Approved Information Collection Request: Hazardous Materials Safety Permits

AGENCY: FMCSA, DOT.

ACTION: Notice and request for comments.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995, FMCSA announces its plan to submit the Information Collection Request (ICR) described below to the Office of Management and Budget (OMB) for its review and approval and invites public comment. The FMCSA requests approval to revise and extend an ICR entitled, "Hazardous Materials Safety Permits." This ICR requires companies holding permits to develop communications plans that allow for the periodic tracking of the shipments. A record of the communications that includes the time of the call and location of the shipment may be kept by either the driver (e.g., recorded in the log book) or the company. These records must be kept, either physically or electronically, for at least six months at the company's principal place of business or readily available to the employees at the company's principal place of business.

DATES: We must receive your comments on or before February 10, 2014.

ADDRESSES: You may submit comments identified by Federal Docket Management System (FDMS) Docket Number FMCSA–2013–0349 using any of the following methods:

- *Federal eRulemaking Portal: http://www.regulations.gov.* Follow the online instructions for submitting comments.
- *Fax:* 1–202–493–2251.
- *Mail:* Docket Management Facility; U.S. Department of Transportation, 1200 New Jersey Avenue SE., West Building, Ground Floor, Room W12–140, 20590–0001.
- *Hand Delivery or Courier:* West Building, Ground Floor, Room W12–140, 1200 New Jersey Avenue SE., Washington, DC, between 9 a.m. and 5 p.m. e.t., Monday through Friday, except Federal holidays.

Instructions: All submissions must include the Agency name and docket number. For detailed instructions on submitting comments and additional information on the exemption process, see the Public Participation heading below. Note that all comments received will be posted without change to *http://www.regulations.gov,* including any personal information provided. Please see the Privacy Act heading below.

Docket: For access to the docket to read background documents or comments received, go to *http://www.regulations.gov,* and follow the online instructions for accessing the dockets, or go to the street address listed above.

Privacy Act: Anyone is able to search the electronic form of all comments received into any of our dockets by the name of the individual submitting the comment (or signing the comment, if submitted on behalf of an association, business, labor union, etc.). You may review DOT's complete Privacy Act Statement for the Federal Docket Management System published in the **Federal Register** on January 17, 2008 (73 FR 3316), or you may visit *http://edocket.access.gpo.gov/2008/pdfE8–794.pdf.*

Public Participation: The Federal eRulemaking Portal is available 24 hours each day, 365 days each year. You can obtain electronic submission and retrieval help and guidelines under the "help" section of the Federal eRulemaking Portal Web site. If you want us to notify you that we received your comments, please include a self-addressed, stamped envelope or postcard, or print the acknowledgement page that appears after submitting comments online. Comments received after the comment closing date will be included in the docket and will be considered to the extent practicable.

FOR FURTHER INFORMATION CONTACT: Mr. Paul Bomgardner, Hazardous Materials Division, Department of Transportation, Federal Motor Carrier Safety Administration, West Building 6th Floor, 1200 New Jersey Avenue SE., Washington, DC 20590. Telephone: 202–493–0027; email *paul.bomgardner@dot.gov.*

SUPPLEMENTARY INFORMATION:

Background: The Secretary of Transportation (Secretary) is responsible for implementing regulations to issue safety permits for transporting certain HM in accordance with 49 U.S.C. 5101

et seq. The Hazardous Materials (HM) Safety Permit regulations (49 CFR part 385, Subpart E) require carriers to complete a "Combined Motor Carrier Identification Report and HM Permit Application" (Form MCS–150B). The HM Safety Permit regulations also require carriers to have a security program. As part of the HM Safety Permit regulations, carriers are required to develop and maintain route plans so that law enforcement officials can verify the correct location of the HM shipment. The FMCSA requires companies holding permits to develop a communications plan that allows for the periodic tracking of the shipment. This information covers the record of communications that includes the time of the call and location of the shipment. The records may be kept by either the driver (e.g., recorded in the log book) or the company. These records must be kept, either physically or electronically, for at least six months at the company's principal place of business or be readily available to employees at the company's principal place of business.

Title: Hazardous Materials Safety Permits.

OMB Control Number: 2126–0030.

Type of Request: Revision of a currently-approved information collection.

Respondents: Motor carriers subject to the Hazardous Materials Safety Permit requirements in 49 CFR part 385, Subpart E.

Estimated Number of Respondents: 1,382.

Estimated Time per Response: 5 minutes. The communication between motor carriers and their drivers must take place at least two times per day. It is estimated that it will take 5 minutes to maintain a daily communication record for each driver.

Expiration Date: May 31, 2014

Frequency of Response: On occasion.

Estimated Total Annual Burden: 967,000 hours [11.6 million trips × 5 minutes/60 minutes per record = 966,666.66 rounded to 967,000].

Public Comments Invited: You are asked to comment on any aspect of this information collection, including: (1) Whether the proposed collection is necessary for the performance of FMCSA's functions; (2) the accuracy of the estimated burden; (3) ways for FMCSA to enhance the quality, usefulness, and clarity of the collected information; and (4) ways that the burden could be minimized without reducing the quality of the collected information. The agency will summarize or include your comments in the request for OMB's clearance of this information collection.

Issued under the authority of 49 CFR 1.87 on: November 19, 2013.

G. Kelly Leone,

Associate Administrator, Office of Research and Information Technology and Chief Information Officer.

[FR Doc. 2013–29425 Filed 12–9–13; 8:45 am]

BILLING CODE 4910–EX–P

DEPARTMENT OF TRANSPORTATION

Federal Motor Carrier Safety Administration

[Docket No. FMCSA–2013–0451]

Hours of Service of Drivers: Oregon Trucking Associations; Application for Exemption

AGENCY: Federal Motor Carrier Safety Administration (FMCSA), DOT.

ACTION: Notice of application for exemption; request for comments.

SUMMARY: FMCSA announces that the Oregon Trucking Associations (OTA) has applied for a limited exemption from the 30-minute rest-break requirement of the Agency's hours-of-service regulations [49 CFR 395.3(a)(3)(ii)]. It seeks the exemption for motor carriers and their commercial motor vehicle (CMV) drivers who transport timber from Oregon forestlands during periods in which fire safety restrictions limit their hours of operation. FMCSA requests public comment on the application for exemption.

DATES: Comments must be received on or before January 9, 2014.

ADDRESSES: You may submit comments identified by Federal Docket Management System Number FMCSA–2013–0451 by any of the following methods:

- *Federal eRulemaking Portal: www.regulations.gov.* Follow the online instructions for submitting comments.
- *Fax:* 1–202–493–2251.
- *Mail:* Docket Management Facility, U.S. Department of Transportation, 1200 New Jersey Avenue SE., West Building, Ground Floor, Room W12–140, Washington, DC 20590–0001.
- *Hand Delivery or Courier:* West Building, Ground Floor, Room W12–140, 1200 New Jersey Avenue SE., between 9 a.m. and 5 p.m. ET, Monday through Friday, except Federal holidays.

Instructions: All submissions must include the Agency name and docket number. For detailed instructions on submitting comments and additional information on the exemption process, see the *Public Participation* heading below. Note that all comments received will be posted without change to *www.regulations.gov,* including any personal information provided. Please see the *Privacy Act* heading below.

Privacy Act: Anyone is able to search the electronic form of all comments received into any of our dockets by the name of the individual submitting the comment (or signing the comment, if submitted on behalf of an association, business, labor union, etc.). You may review a Privacy Act notice regarding our public dockets in the January 17, 2008, issue of the **Federal Register** (73 FR 3316).

Public Participation: The Federal eRulemaking Portal is available 24 hours each day, 365 days each year. You can get electronic submission and retrieval help and guidelines under the "help" section of the Federal eRulemaking Portal Web site. If you want us to notify you that we received your comments, please include a self-addressed, stamped envelope or postcard, or print the acknowledgement page that appears after submitting comments online.

Submitting Comments: You may submit your comments and material online or by fax, mail, or hand delivery, but please use only one of these means. To submit your comment online, go to *www.regulations.gov* and in the search box insert the docket number "FMCSA–2013–0451" and click the SEARCH button. When the new screen appears, click on the blue "Comment Now!" button on the right hand side of the page. On the new page, enter information required including the specific section of this document to which each comment applies, and provide a reason for each suggestion or recommendation. If you submit your comments by mail or hand delivery, submit them in an unbound format, no larger than 8½ by 11 inches, suitable for copying and electronic filing. If you submit comments by mail and would like to know that they reached the facility, please enclose a stamped, self-addressed postcard or envelope.

Viewing Comments and Documents: To view comments, as well as any documents mentioned in this notice, go to *www.regulations.gov* and in the search box insert the docket number "FMCSA–2013–0451" and click "Search." Next, click "Open Docket Folder" and you will find all documents and comments related to the proposed rulemaking.

FOR FURTHER INFORMATION CONTACT: Mr. Thomas Yager, Chief, FMCSA Driver and Carrier Operations Division; Office of Carrier, Driver, and Vehicle Safety Standards; Telephone: 202–366–4325. Email: *MCPSD@dot.gov.*

SUPPLEMENTARY INFORMATION:

Background

FMCSA has authority under 49 U.S.C. 31136(e) and 31315 to grant exemptions from certain parts of the Federal Motor Carrier Safety Regulations. FMCSA must publish a notice of each exemption request in the **Federal Register** (49 CFR 381.315(a)). The Agency must provide the public an opportunity to inspect the information relevant to the application, including any safety analyses that have been conducted. The Agency must also provide an opportunity for public comment on the request.

The Agency reviews safety analyses and public comments submitted, and determines whether granting the exemption would likely achieve a level of safety equivalent to, or greater than, the level that would be achieved by the current regulation (49 CFR 381.305). The Agency may grant an exemption subject to specified terms and conditions. The decision of the Agency must be published in the **Federal Register** (49 CFR 381.315(b)) with the reasons for denying or granting the application and, if granted, the name of the person or class of persons receiving the exemption, and the regulatory provision from which the exemption is granted. The notice must also specify the effective period and explain the terms and conditions of the exemption. The exemption may be renewed (49 CFR 381.300(b)).

On December 27, 2011, FMCSA published a final rule establishing mandatory rest breaks for CMV drivers (76 FR 81133). Effective July 1, 2013, drivers may not operate a CMV if 8 hours or more have elapsed since the end of the driver's last off-duty or sleeper-berth period of at least 30 minutes [49 CFR 395.3(a)(3)(ii)]. FMCSA did not specify when drivers must take the 30-minute break. Drivers who already take shorter breaks during the duty day could comply with the rule by extending one of these breaks to 30 minutes.

Exemption Request of Oregon Trucking Associations

OTA applies for exemption on behalf of motor carriers and drivers who operate CMVs on Oregon forestlands to transport logs to lumber mills for processing. OTA states that lumber mills depend on a regular volume of logs for their economic viability, and that environmental restrictions limit the amount of timber that can be harvested from Oregon forestlands. In addition, when the risk of fire increases, the Oregon Department of Forestry (ODF) further limits logging operations. For example, OTA states that at the time of its application (August 26, 2013), a Level III fire safety restriction barred CMVs from Oregon forestlands at 1:00 p.m. daily. OTA asserts that fire-safety restrictions are often in place from July to late October each year. If logging operators have to leave the forest lands by 1:00 p.m. during fire restrictions, they need all available time prior to 1:00 p.m. as on-duty time, without a rest break.

OTA asserts that the new 30-minute break requirement makes it impossible for log trucks to provide a sufficient volume of logs to the mills when operations are time-limited by fire restrictions. OTA seeks relief from this requirement when operating CMVs on Oregon forestland when that land is restricted by fire safety rules. OTA states that its members engaged in these operations are willing to restrict their duty day when operating under the exemption to a maximum of 12 hours in lieu of the 14-hour limit of the HOS rules. OTA states that during these periods of limited operations, its members would achieve the same level of safety with this exemption in place as they would achieve if required to observe the rest-break requirement.

Request for Comments

In accordance with 49 U.S.C. 31136(e) and 31315(b)(4), FMCSA requests public comment on OTA's application for an exemption from the rest-break requirement of 49 CFR 395.3(a)(3)(ii). The Agency will consider all comments received by close of business on January 9, 2014. Comments will be available for examination in the docket at the location listed under the **ADDRESSES** section of this notice. The Agency will consider to the extent practicable comments received in the public docket after the closing date of the comment period.

Issued on: December 2, 2013.

Larry W. Minor,

Associate Administrator for Policy.

[FR Doc. 2013–29413 Filed 12–9–13; 8:45 am]

BILLING CODE 4910–EX–P

DEPARTMENT OF TRANSPORTATION

Federal Motor Carrier Safety Administration

[Docket No. FMCSA–2011–0298]

Qualification of Drivers; Exemption Applications; Vision

AGENCY: Federal Motor Carrier Safety Administration (FMCSA), DOT.

ACTION: Notice of renewal of exemptions; request for comments.

SUMMARY: FMCSA announces its decision to renew the exemptions from the vision requirement in the Federal Motor Carrier Safety Regulations for 3 individuals. FMCSA has statutory authority to exempt individuals from the vision requirement if the exemptions granted will not compromise safety. The Agency has concluded that granting these exemption renewals will provide a level of safety that is equivalent to or greater than the level of safety maintained without the exemptions for these commercial motor vehicle (CMV) drivers.

DATES: This decision is effective January 5, 2014. Comments must be received on or before January 9, 2014.

ADDRESSES: You may submit comments bearing the Federal Docket Management System (FDMS) numbers: Docket No. [Docket No. FMCSA–2011–0298], using any of the following methods:

- *Federal eRulemaking Portal:* Go to *http://www.regulations.gov*. Follow the on-line instructions for submitting comments.
- *Mail:* Docket Management Facility; U.S. Department of Transportation, 1200 New Jersey Avenue SE., West Building Ground Floor, Room W12–140, Washington, DC 20590–0001.
- *Hand Delivery or Courier:* West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE., Washington, DC, between 9 a.m. and 5 p.m., Monday through Friday, except Federal Holidays.
- *Fax:* 1–202–493–2251.

Instructions: Each submission must include the Agency name and the docket number for this notice. Note that DOT posts all comments received without change to *http://www.regulations.gov*, including any personal information included in a comment. Please see the Privacy Act heading below.

Docket: For access to the docket to read background documents or comments, go to *http://www.regulations.gov* at any time or Room W12–140 on the ground level of the West Building, 1200 New Jersey Avenue SE., Washington, DC, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The Federal Docket Management System (FDMS) is available 24 hours each day, 365 days each year. If you want acknowledgment that we received your comments, please include a self-addressed, stamped envelope or postcard or print the acknowledgement

page that appears after submitting comments on-line.

Privacy Act: Anyone may search the electronic form of all comments received into any of our dockets by the name of the individual submitting the comment (or of the person signing the comment, if submitted on behalf of an association, business, labor union, etc.). You may review DOT's Privacy Act Statement for the Federal Docket Management System (FDMS) published in the **Federal Register** on January 17, 2008 (73 FR 3316).

FOR FURTHER INFORMATION CONTACT: Elaine M. Papp, Chief, Medical Programs Division, 202–366–4001, *fmcsamedical@dot.gov*, FMCSA, Department of Transportation, 1200 New Jersey Avenue SE., Room W64–224, Washington, DC 20590–0001. Office hours are from 8:30 a.m. to 5 p.m. Monday through Friday, except Federal holidays.

SUPPLEMENTARY INFORMATION:

Background

Under 49 U.S.C. 31136(e) and 31315, FMCSA may renew an exemption from the vision requirements in 49 CFR 391.41(b)(10), which applies to drivers of CMVs in interstate commerce, for a two-year period if it finds "such exemption would likely achieve a level of safety that is equivalent to or greater than the level that would be achieved absent such exemption." The procedures for requesting an exemption (including renewals) are set out in 49 CFR part 381.

Exemption Decision

This notice addresses 3 individuals who have requested renewal of their exemptions in accordance with FMCSA procedures. FMCSA has evaluated these 3 applications for renewal on their merits and decided to extend each exemption for a renewable two-year period. They are:

Michael P. Eisenreich (MN)
John T. Thor (MN)
George G. Ulferts, Jr. (IA)

The exemptions are extended subject to the following conditions: (1) That each individual has a physical examination every year (a) by an ophthalmologist or optometrist who attests that the vision in the better eye continues to meet the requirements in 49 CFR 391.41(b)(10), and (b) by a medical examiner who attests that the individual is otherwise physically qualified under 49 CFR 391.41; (2) that each individual provides a copy of the ophthalmologist's or optometrist's report to the medical examiner at the time of the annual medical examination; and (3) that each individual provide a copy of the annual medical certification to the employer for retention in the driver's qualification file and retains a copy of the certification on his/her person while driving for presentation to a duly authorized Federal, State, or local enforcement official. Each exemption will be valid for two years unless rescinded earlier by FMCSA. The exemption will be rescinded if: (1) The person fails to comply with the terms and conditions of the exemption; (2) the exemption has resulted in a lower level of safety than was maintained before it was granted; or (3) continuation of the exemption would not be consistent with the goals and objectives of 49 U.S.C. 31136(e) and 31315.

Basis for Renewing Exemptions

Under 49 U.S.C. 31315(b)(1), an exemption may be granted for no longer than two years from its approval date and may be renewed upon application for additional two year periods. In accordance with 49 U.S.C. 31136(e) and 31315, each of the 3 applicants has satisfied the entry conditions for obtaining an exemption from the vision requirements (76 FR 70213; 77 FR 541). Each of these 3 applicants has requested renewal of the exemption and has submitted evidence showing that the vision in the better eye continues to meet the requirement specified at 49 CFR 391.41(b)(10) and that the vision impairment is stable. In addition, a review of each record of safety while driving with the respective vision deficiencies over the past two years indicates each applicant continues to meet the vision exemption requirements.

These factors provide an adequate basis for predicting each driver's ability to continue to drive safely in interstate commerce. Therefore, FMCSA concludes that extending the exemption for each renewal applicant for a period of two years is likely to achieve a level of safety equal to that existing without the exemption.

Request for Comments

FMCSA will review comments received at any time concerning a particular driver's safety record and determine if the continuation of the exemption is consistent with the requirements at 49 U.S.C. 31136(e) and 31315. However, FMCSA requests that interested parties with specific data concerning the safety records of these drivers submit comments by January 9, 2014.

FMCSA believes that the requirements for a renewal of an exemption under 49 U.S.C. 31136(e) and 31315 can be satisfied by initially granting the renewal and then requesting and evaluating, if needed, subsequent comments submitted by interested parties. As indicated above, the Agency previously published notices of final disposition announcing its decision to exempt these 3 individuals from the vision requirement in 49 CFR 391.41(b)(10). The final decision to grant an exemption to each of these individuals was made on the merits of each case and made only after careful consideration of the comments received to its notices of applications. The notices of applications stated in detail the qualifications, experience, and medical condition of each applicant for an exemption from the vision requirements. That information is available by consulting the above cited **Federal Register** publications.

Interested parties or organizations possessing information that would otherwise show that any, or all, of these drivers are not currently achieving the statutory level of safety should immediately notify FMCSA. The Agency will evaluate any adverse evidence submitted and, if safety is being compromised or if continuation of the exemption would not be consistent with the goals and objectives of 49 U.S.C. 31136(e) and 31315, FMCSA will take immediate steps to revoke the exemption of a driver.

Submitting Comments

You may submit your comments and material online or by fax, mail, or hand delivery, but please use only one of these means. FMCSA recommends that you include your name and a mailing address, an email address, or a phone number in the body of your document so that FMCSA can contact you if there are questions regarding your submission.

To submit your comment online, go to *http://www.regulations.gov* and in the search box insert the docket numbers FMCSA–2011–0298 and click the search button. When the new screen appears, click on the blue "Comment Now!" button on the right hand side of the page. On the new page, enter information required including the specific section of this document to which each comment applies, and provide a reason for each suggestion or recommendation. If you submit your comments by mail or hand delivery, submit them in an unbound format, no larger than 8½ by 11 inches, suitable for copying and electronic filing. If you submit comments by mail and would like to know that they reached the facility, please enclose a stamped, self-addressed postcard or envelope.

We will consider all comments and material received during the comment period and may change this proposed rule based on your comments. FMCSA may issue a final rule at any time after the close of the comment period.

Viewing Comments and Documents

To view comments, as well as any documents mentioned in this preamble, to submit your comment online, go to *http://www.regulations.gov* and in the search box insert the docket number FMCSA–2011–0298 and click "Search." Next, click "Open Docket Folder" and you will find all documents and comments related to the proposed rulemaking.

Issued on: December 3, 2013.

Larry W. Minor,

Associate Administrator for Policy.

[FR Doc. 2013–29419 Filed 12–9–13; 8:45 am]

BILLING CODE 4910–EX–P

DEPARTMENT OF TRANSPORTATION

National Highway Traffic Safety Administration

[Docket No. NHTSA–2013–0136]

Decision That Certain Nonconforming Motor Vehicles Are Eligible for Importation

AGENCY: National Highway Traffic Safety Administration, DOT.

ACTION: Grant of Petitions.

SUMMARY: This document announces decisions by NHTSA that certain motor vehicles not originally manufactured to comply with all applicable Federal Motor Vehicle Safety Standards (FMVSS) are eligible for importation into the United States because they are substantially similar to vehicles originally manufactured for sale in the United States and certified by their manufacturers as complying with the safety standards, and they are capable of being readily altered to conform to the standards or because they have safety features that comply with, or are capable of being altered to comply with, all applicable FMVSS.

DATES: These decisions became effective on the dates specified in Annex A.

ADDRESSES: For further information contact Mr. Coleman Sachs, Office of Vehicle Safety Compliance, NHTSA (202–366–3151).

SUPPLEMENTARY INFORMATION:

Background

Under 49 U.S.C. 30141(a)(1)(A), a motor vehicle that was not originally manufactured to conform to all applicable FMVSS shall be refused admission into the United States unless NHTSA has decided that the motor vehicle is substantially similar to a motor vehicle originally manufactured for importation into and/or sale in the United States, certified under 49 U.S.C. 30115, and of the same model year as the model of the motor vehicle to be compared, and is capable of being readily altered to conform to all applicable FMVSS.

Where there is no substantially similar U.S.-certified motor vehicle, 49 U.S.C. 30141(a)(1)(B) permits a nonconforming motor vehicle to be admitted into the United States if its safety features comply with, or are capable of being altered to comply with, all applicable FMVSS based on destructive test data or such other evidence as NHTSA decides to be adequate.

Petitions for eligibility decisions may be submitted by either manufacturers or importers who have registered with NHTSA pursuant to 49 CFR part 592. As specified in 49 CFR 593.7, NHTSA publishes notice in the **Federal Register** of each petition that it receives, and affords interested persons an opportunity to comment on the petition. At the close of the comment period, NHTSA decides, on the basis of the petition and any comments that it has received, whether the vehicle is eligible for importation. The agency then publishes this decision in the **Federal Register**.

NHTSA received petitions from registered importers to decide whether the vehicles listed in Annex A to this notice are eligible for importation into the United States. To afford an opportunity for public comment, NHTSA published notice of these petitions as specified in Annex A. The reader is referred to those notices for a thorough description of the petitions.

Comments: No substantive comments were received in response to the petitions identified in Appendix A.

NHTSA Decision: Accordingly, on the basis of the foregoing, NHTSA hereby decides that each motor vehicle listed in Annex A to this notice, which was not originally manufactured to comply with all applicable FMVSS, is either substantially similar to a motor vehicle manufactured for importation into and/or sale in the United States, and certified under 49 U.S.C. 30115, as specified in Annex A, and is capable of being readily altered to conform to all applicable FMVSS or has safety features that comply with, or are capable of being altered to comply with, all applicable Federal Motor Vehicle Safety Standards.

Vehicle Eligibility Number for Subject Vehicles: The importer of a vehicle admissible under any final decision must indicate on the form HS–7 accompanying entry the appropriate vehicle eligibility number indicating that the vehicle is eligible for entry. Vehicle eligibility numbers assigned to vehicles admissible under this decision are specified in Annex A.

Authority: 49 U.S.C. 30141(a)(1)(A), (a)(1)(B) and (b)(1); 49 CFR 593.7; delegations of authority at 49 CFR 1.50 and 501.7.

Issued on: December 4, 2013.

Claude H. Harris,

Director, Office of Vehicle Safety Compliance.

Annex A—Nonconforming Motor Vehicles Decided To Be Eligible for Importation

1. Docket No. NHTSA–2013–0033

Nonconforming Vehicles: 1996 Chevrolet Impala Passenger Cars
Substantially Similar U.S. Certified Vehicles: 1996 Chevrolet Impala Passenger Cars
Notice of Petition Published at: 78 FR 45997 (July 30, 2013)
Vehicle Eligibility Number: VSP–561 (effective date September 12, 2013)

2. Docket No. NHTSA–2013–0020

Nonconforming Vehicles: 2005 Jaguar XKR Passenger Cars
Substantially Similar U.S. Certified Vehicles: 2005 Jaguar XKR Passenger Cars
Notice of Petition Published at: 78 FR 45999 (July 30, 2013)
Vehicle Eligibility Number: VSP–560 (effective date September 12, 2013)

3. Docket No. NHTSA–2013–0034

Nonconforming Vehicles: 2004 BMW 760i Passenger Cars
Substantially Similar U.S. Certified Vehicles: 2004 BMW 760i Passenger Cars
Notice of Petition Published at: 78 FR 44621 (July 24, 2013)
Vehicle Eligibility Number: VSP–559 (effective date September 6, 2013)

4. Docket No. NHTSA–2013–0059, NHTSA–2013–0032

Nonconforming Vehicles: 2005, 2006 Mercedes-Benz SLR Passenger Cars (Manufactured Prior to September 1, 2006)
Substantially Similar U.S. Certified Vehicles: 2005, 2006 Mercedes-Benz SLR Passenger Cars (Manufactured Prior to September 1, 2006)
Notice of Petition Published at: 78 FR 38442 (June 26, 2013)
Vehicle Eligibility Number: VSP–558 (effective date August 2, 2013)

5. Docket No. NHTSA–2013–0062

Nonconforming Vehicles: 2002 BMW R1100 S Motorcycles

Substantially Similar U.S. Certified Vehicles: 2002 BMW R1100 S Motorcycles

Notice of Petition Published at: 78 FR 29811 (May 21, 2013)

Vehicle Eligibility Number: VSP–557 (effective date July 26, 2013)

6. Docket No. NHTSA–2013–0061

Nonconforming Vehicles: 2003 BMW K1200 GT Motorcycles

Substantially Similar U.S. Certified Vehicles: 2003 BMW K1200 GT Motorcycles

Notice of Petition Published at: 78 FR 29810 (May 21, 2013)

Vehicle Eligibility Number: VSP–556 (effective date July 26, 2013)

7. Docket No. NHTSA–2013–0037, NHTSA–2013–0032

Nonconforming Vehicles: 2005, 2006, 2007 Alpine B5 Series Passenger Cars (Manufactured Prior to September 1, 2006)

Because there are no substantially similar U.S.—certified version 2005, 2006, 2007 Alpine B5 Series Passenger Cars (Manufactured Prior to September 1, 2006) the petitioner sought import eligibility under 49 U.S.C. 30141(a)(1)(B).

Notice of Petition Published at: 78 FR 30961 (May 23, 2013)

Vehicle Eligibility Number: VCP–53 (effective date July 26, 2013)

8. Docket No. NHTSA–2013–0064

Nonconforming Vehicles: 1988–1996 Alpine B10 Series Passenger Cars

Because there are no substantially similar U.S.—certified version 1988–1996 Alpine B10 Series Passenger Cars the petitioner sought import eligibility under 49 U.S.C. 30141(a)(1)(B).

Notice of Petition Published at: 78 FR 59092 (September 25, 2013)

Vehicle Eligibility Number: VCP–54 (effective date November 14, 2013)

[FR Doc. 2013–29406 Filed 12–9–13; 8:45 am]

BILLING CODE 4910–59–P

DEPARTMENT OF TRANSPORTATION

National Highway Traffic Safety Administration

[Docket No. NHTSA–2013–0125; Notice 1]

Hankook Tire America Corp, Receipt of Petition for Decision of Inconsequential Noncompliance

AGENCY: National Highway Traffic Safety Administration (NHTSA), Department of Transportation (DOT).

ACTION: Receipt of petition.

SUMMARY: Hankook Tire America Corp, (Hankook) has determined that certain model year Hankook Roadhandler Sport (H432) tires manufactured between June 21, 2013 and August 29, 2013, do not fully comply with paragraph S5.5(f) of Federal Motor Vehicle Safety Standard (FMVSS) No. 139, *New Pneumatic Radial Tires for Light Vehicles*. Hankook has filed an appropriate report dated October 4, 2013, pursuant to 49 CFR part 573, *Defect and Noncompliance Responsibility and Reports*.

DATES: The closing date for comments on the petition is January 9, 2014.

ADDRESSES: Interested persons are invited to submit written data, views, and arguments on this petition. Comments must refer to the docket and notice number cited at the beginning of this notice and be submitted by any of the following methods:

- *Mail:* Send comments by mail addressed to: U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE., Washington, DC 20590.
- *Hand Deliver:* Deliver comments by hand to: U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE., Washington, DC 20590. The Docket Section is open on weekdays from 10 a.m. to 5 p.m. except Federal Holidays.
- *Electronically:* Submit comments electronically by: Logging onto the Federal Docket Management System (FDMS) Web site at *http://www.regulations.gov/*. Follow the online instructions for submitting comments. Comments may also be faxed to (202) 493–2251.

Comments must be written in the English language, and be no greater than 15 pages in length, although there is no limit to the length of necessary attachments to the comments. If comments are submitted in hard copy form, please ensure that two copies are provided. If you wish to receive confirmation that your comments were received, please enclose a stamped, self-addressed postcard with the comments. Note that all comments received will be posted without change to *http://www.regulations.gov*, including any personal information provided.

Documents submitted to a docket may be viewed by anyone at the address and times given above. The documents may also be viewed on the Internet at *http://www.regulations.gov* by following the online instructions for accessing the dockets. DOT's complete Privacy Act Statement is available for review in the **Federal Register** published on April 11, 2000, (65 FR 19477–78).

The petition, supporting materials, and all comments received before the close of business on the closing date indicated below will be filed and will be considered. All comments and supporting materials received after the closing date will also be filed and will be considered to the extent possible. When the petition is granted or denied, notice of the decision will be published in the **Federal Register** pursuant to the authority indicated below.

SUPPLEMENTARY INFORMATION:

I. Hankook's Petition: Pursuant to 49 U.S.C. 30118(d) and 30120(h) (see implementing rule at 49 CFR part 556), Hankook submitted a petition for an exemption from the notification and remedy requirements of 49 U.S.C. Chapter 301 on the basis that this noncompliance is inconsequential to motor vehicle safety.

This notice of receipt of Hankook's petition is published under 49 U.S.C. 30118 and 30120 and does not represent any agency decision or other exercise of judgment concerning the merits of the petition.

II. Tires Involved: Affected are approximately 6,257 Roadhandler Sport (H432), size 215/45R17 91W XL, Hankook tires manufactured between June 21, 2013 and August 29, 2013.

III. Noncompliance: Hankook explains that the noncompliance is that, due to a mold labeling error, the sidewall marking on the side of the tires incorrectly describes the actual number of plies in the tread area of the tires as required by paragraph S5.5(f) of 49 CFR 571.139. Specifically, the tires in question were inadvertently manufactured with "Ply Tread 2 steel + 1 Polyester + 2 Nylon, Sidewall 1 Polyester." The correct labeling and stamping to match the tire construction should have been "Ply Tread 2 steel + 1 Polyester + 1 Nylon, Sidewall 1 Polyester."

IV. Rule Text: Paragraph S5.5(f) of FMVSS No. 139 requires in pertinent part:

S5.5 Tire Markings. Except as specified in paragraphs (a) through (i) of S5.5, each tire must be marked on each sidewall with the information specified in S5.5(a) through (d) and on one side-wall with the information specified in S5.5(e) through (i) according to the phase-in schedule specified in S7 of this standard. The markings must be placed between the maximum section width and the bead on at least one sidewall, unless the maximum section width of the tire is located in an area that is not more than one-fourth of the distance from the bead to the shoulder of the tire. If the maximum section width that falls within that area, those markings must appear between the bead and a point one-half the distance from the bead to the shoulder of the tire, on at least one sidewall. The markings must be in letters and numerals not less than 0.078 inches high and raised above or sunk below the tire surface not less than 0.015 inches . . .

(f) The actual number of plies in the sidewall, and the actual number of plies in the tread area, if different.

V. Summary of Hankook's Analyses: Hankook stated its belief that the subject noncompliance is inconsequential to motor vehicle safety for the following reasons:

1. The affected subject tires meet or exceed all applicable FMVSS performance standards.

2. The subject tires will not be affected based on performance, durability, or safety they are designed and build for.

Hankook has additionally informed NHTSA that it has corrected the noncompliance so that all future production of these Roadhandler Sport (H432) tires will comply with FMVSS No. 139.

In summation, Hankook believes that the described noncompliance of the subject tires is inconsequential to motor vehicle safety, and that its petition, to exempt from providing recall notification of noncompliance as required by 49 U.S.C. 30118 and remedying the recall noncompliance as required by 49 U.S.C. 30120 should be granted.

NHTSA notes that the statutory provisions (49 U.S.C. 30118(d) and 30120(h)) that permit manufacturers to file petitions for a determination of inconsequentiality allow NHTSA to exempt manufacturers only from the duties found in sections 30118 and 30120, respectively, to notify owners, purchasers, and dealers of a defect or noncompliance and to remedy the defect or noncompliance. Therefore, any decision on this petition only applies to the subject tires that Hankook no longer controlled at the time it determined that the noncompliance existed. However, any decision on this petition does not relieve tire distributors and dealers of the prohibitions on the sale, offer for sale, or introduction or delivery for introduction into interstate commerce of the noncompliant tires under their control after Hankook notified them that the subject noncompliance existed.

Authority: (49 U.S.C. 30118, 30120: delegations of authority at 49 CFR 1.95 and 501.8)

Issued on: December 4, 2013.

Claude H. Harris,

Director, Office of Vehicle Safety Compliance.

[FR Doc. 2013–29405 Filed 12–9–13; 8:45 am]

BILLING CODE 4910–59–P

DEPARTMENT OF TRANSPORTATION

Surface Transportation Board

[Docket No. AB 55 (Sub-No. 718X)] [Docket No. AB 507 (Sub-No. 1X)]

CSX Transportation, Inc.—Abandonment Exemption—in Alachua County, Fla. and Florida Northern Railroad Company, Inc.—Discontinuance of Service Exemption—in Alachua County, Fla.

CSX Transportation, Inc. (CSXT), and Florida Northern Railroad Company, Inc. (FNOR), jointly filed a verified notice of exemption under 49 CFR part 1152 subpart F—*Exempt Abandonments and Discontinuances of Service* for CSXT to abandon approximately 11.62 miles of rail line on CSXT's Southern Region, Jacksonville Division, West Coast Subdivision, between milepost AR 716.88, at High Springs, and milepost AR 726.69, at Newberry, and milepost ARB 717.11, at High Springs, and milepost ARB 718.92, at High Springs, in Alachua County, Fla. (the Line); and (2) FNOR to discontinue service over approximately 9.81 miles of rail between milepost AR 716.88, at High Springs, and milepost AR 726.69, at Newberry (the FNOR Line).[1] The Line traverses United States Postal Service Zip Codes 32643 and 32669.

CSXT and FNOR have certified that: (1) No local traffic has moved over the Line for at least two years; (2) no overhead traffic has moved over the Line for at least two years and overhead traffic, if there were any, can be rerouted over other lines; (3) no formal complaint filed by a user of rail service on the Line (or by a state or local government entity acting on behalf of such user) regarding cessation of service over the Line either is pending before the Surface Transportation Board or before any U.S. District Court or has been decided in favor of the complainant within the two-year period; and (4) the requirements at 49 CFR 1105.7(c) (environmental reports), 49 CFR 1105.11 (transmittal letter), 49 CFR 1105.12 (newspaper publication), and 49 CFR 1152.50(d)(1) (notice to governmental agencies) have been met.[2]

As a condition to this exemption, any employee adversely affected by the abandonment or discontinuance shall be protected under *Oregon Short Line Railroad—Abandonment Portion Goshen Branch Between Firth & Ammon, in Bingham & Bonneville Counties, Idaho,* 360 I.C.C. 91 (1979). To address whether this condition adequately protects affected employees, a petition for partial revocation under 49 U.S.C. 10502(d) must be filed.

Provided no formal expression of intent to file an offer of financial assistance (OFA) has been received, this exemption will be effective on January 9, 2014, unless stayed pending reconsideration. Petitions to stay that do not involve environmental issues,[3] formal expressions of intent to file an OFA under 49 CFR 1152.27(c)(2),[4] and trail use/rail banking requests under 49 CFR 1152.29 must be filed by December 20, 2013. Petitions to reopen or requests for public use conditions under 49 CFR 1152.28 must be filed by December 30, 2013, with the Surface Transportation Board, 395 E Street SW., Washington, DC 20423–0001.

A copy of any petition filed with the Board should be sent to CSXT's representative: Louis E. Gitomer, Law Offices of Louis E. Gitomer, 600 Baltimore Avenue, Suite 301, Towson, MD 21204. A copy of any petition filed with the Board also should be sent to FNOR's representative: Thomas J. Litwiler, Fletcher & Sippel, LLC, 29 North Wacker Drive, Suite 920, Chicago, IL 60606–2832.

[1] The FNOR Line is a portion of the Line. CSXT leased the FNOR Line to FNOR in 2005 as part of the transaction in *Florida Northern Railroad—Lease Exemption—Line of CSX Transportation, Inc.*, FD 34689 (STB served June 15, 2005). Since that time, FNOR also has operated the CSXT trackage between milepost ARB 717.11, and milepost ARB 718.92, the remainder of the Line, as exempt industry track.

[2] The Line has been embargoed due to track condition since July 22, 2011. Prime Conduit, the only shipper on the FNOR Line, receives service via transloading at Jacksonville, Fla., or other nearby transloading locations.

[3] The Board will grant a stay if an informed decision on environmental issues (whether raised by a party or by the Board's Office of Environmental Analysis (OEA) in its independent investigation) cannot be made before the exemption's effective date. *See Exemption of Out-of-Serv. Rail Lines,* 5 I.C.C. 2d 377 (1989). Any request for a stay should be filed as soon as possible so that the Board may take appropriate action before the exemption's effective date.

[4] Each OFA must be accompanied by the filing fee, which is currently set at $1600. *See* 49 CFR 1002.2(f)(25).

If the verified notice contains false or misleading information, the exemption is void *ab initio.*

Applicants have filed environmental and historic reports that address the effects, if any, of the abandonment and discontinuance on the environment and historic resources. OEA will issue an environmental assessment (EA) by December 13, 2013. Interested persons may obtain a copy of the EA by writing to OEA (Room 1100, Surface Transportation Board, Washington, DC 20423–0001) or by calling OEA, at (202) 245–0305. Assistance for the hearing impaired is available through the Federal Information Relay Service (FIRS) at 1–800–877–8339. Comments on environmental and historic preservation matters must be filed with 15 days after the EA becomes available to the public.

Environmental, historic preservation, public use, or trail use/rail banking conditions will be imposed, where appropriate, in a subsequent decision.

Pursuant to the provisions of 49 CFR 1152.29(e)(2), CSXT shall file a notice of consummation with the Board to signify that it has exercised the authority granted and fully abandoned the Line. If consummation has not been effected by CSXT's filing of a notice of consummation by December 10, 2014, and there are no legal or regulatory barriers to consummation, the authority to abandon will automatically expire.

Board decisions and notices are available on our Web site at "*www.stb.dot.gov.*"

Decided: December 5, 2013.

By the Board, Rachel D. Campbell, Director, Office of Proceedings.

Raina S. White,

Clearance Clerk.

[FR Doc. 2013–29429 Filed 12–9–13; 8:45 am]

BILLING CODE 4915–01–P

FEDERAL REGISTER

Vol. 78 Tuesday,
No. 237 December 10, 2013

Part II

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Parts 405, 410, 411, et al.
Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 405, 410, 411, 414, 423, and 425

[CMS–1600–FC]

RIN 0938–AR56

Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014

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

ACTION: Final rule with comment period.

SUMMARY: This major final rule with comment period addresses changes to the physician fee schedule, clinical laboratory fee schedule, and other Medicare Part B payment policies to ensure that our payment systems are updated to reflect changes in medical practice and the relative value of services. This final rule with comment period also includes a discussion in the Supplementary Information regarding various programs. (See the Table of Contents for a listing of the specific issues addressed in the final rule with comment period.)

DATES: *Effective date:* The provisions of this final rule with comment period are effective on January 1, 2014, except for the amendments to §§ 405.350, 405.355, 405.405.2413, 405.2415, 405.2452, 410.19, 410.26, 410.37, 410.71, 410.74, 410.75, 410.76, 410.77, and 414.511, which are effective January 27, 2014, and the amendments to §§ 405.201, § 405.203, § 405.205, § 405.207, § 405.209, § 405.211, § 405.212, § 405.213, § 411.15, and 423.160, which are effective on January 1, 2015.

The incorporation by reference of certain publications listed in the rule is approved by the Director of the Federal Register as of January 1, 2014.

Applicability dates: Additionally, the policies specified in under the following preamble sections are applicable January 27, 2014:

- Physician Compare Web site (section III.G.);
- Physician Self-Referral Prohibition: Annual Update to the List of CPT/HCPCS Codes. (section III.N.)

Comment date: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on January 27, 2014. (See the **SUPLEMENTARY INFORMATION** section of this final rule with comment period for a list of the provisions open for comment.)

ADDRESSES: In commenting, please refer to file code CMS–1600–FC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *www.regulations.gov*. Follow the instructions for "submitting a comment."

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1600–FC, P.O. Box 8013, Baltimore, MD 21244–8013.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1600–FC, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments before the close of the comment period to either of the following addresses:

a. For delivery in Washington, DC—Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC 20201.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD—Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–7195 in advance to schedule your arrival with one of our staff members.

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

FOR FURTHER INFORMATION CONTACT:

Elliott Isaac, (410) 786–4735 or *Elliott.Isaac@cms.hhs.gov*, for any physician payment issues not identified below.

Chava Sheffield, (410) 786–2298 or *Chava.Sheffield@cms.hhs.gov*, for issues related to practice expense methodology, impacts, the sustainable growth rate, or conversion factors.

Ryan Howe, (410) 786–3355 or *Ryan.Howe@cms.hhs.gov*, for issues related to direct practice expense inputs or interim final direct PE inputs.

Kathy Kersell, (410) 786–2033 or *Kathleen.Kersell@cms.hhs.gov*, for issues related to misvalued services.

Jessica Bruton, (410) 786–5991 or *Jessica.Bruton@cms.hhs.gov*, for issues related to work or malpractice RVUs.

Heidi Oumarou, (410) 786–7942 or *Heidi.Oumarou@cms.hhs.gov*, for issues related to the revision of Medicare Economic Index (MEI).

Gail Addis, (410) 786–4552 or *Gail.Addis@cms.hhs.gov*, for issues related to the refinement panel.

Craig Dobyski, (410) 786–4584 or *Craig.Dobyski@cms.hhs.gov*, for issues related to geographic practice cost indices.

Ken Marsalek, (410) 786–4502 or *Kenneth.Marsalek@cms.hhs.gov*, for issues related to telehealth services.

Simone Dennis, (410) 786–8409 or *Simone.Dennis@cms.hhs.gov*, for issues related to therapy caps.

Darlene Fleischmann, (410) 786–2357 or *Darlene.Fleischmann@cms.hhs.gov*, for issues related to "incident to" services or complex chronic care management services.

Corinne Axelrod, (410) 786–5620 or *Corrine.Axelrod@cms.hhs.gov*, for issues related to "incident to" services in Rural Health Clinics or Federally Qualified Health Centers.

Roberta Epps, (410) 786–4503 or *Roberta.Epps@cms.hhs.gov*, for issues related to chiropractors billing for evaluation and management services.

Rosemarie Hakim, (410) 786–3934 or *Rosemarie.Hakim@cms.hhs.gov*, for issues related to coverage of items and services furnished in FDA-approved investigational device exemption clinical trials.

Jamie Hermansen, (410) 786–2064 or *Jamie.Hermansen@cms.hhs.gov* or Jyme Schafer, (410) 786–4643 or *Jyme.Schafer@cms.hhs.gov*, for issues related to ultrasound screening for abdominal aortic aneurysms or colorectal cancer screening.

Anne Tayloe-Hauswald, (410) 786–4546 or *Anne-E-Tayloe.Hauswald@*

cms.hhs.gov, for issues related to ambulance fee schedule and clinical lab fee schedule.

Ronke Fabayo, (410) 786–4460 or *Ronke.Fabayo@cms.hhs.gov* or Jay Blake, (410) 786–9371 or *Jay.Blake@cms.hhs.gov*, for issues related to individual liability for payments made to providers and suppliers and handling of incorrect payments.

Rashaan Byers, (410) 786–2305 or *Rashaan.Byers@cms.hhs.gov*, for issues related to physician compare.

Christine Estella, (410) 786–0485 or *Christine.Estella@cms.hhs.gov*, for issues related to the physician quality reporting system and EHR incentive program.

Sandra Adams, (410) 786–8084 or *Sandra.Adams@cms.hhs.gov*, for issues related to Medicare Shared Savings Program.

Michael Wrobleswki, (410) 786–4465 or *Michael.Wrobleswki@cms.hhs.gov*, for issues related to value-based modifier and improvements to physician feedback.

Andrew Morgan, (410) 786–2543 or *Andrew.Morgan@cms.hhs.gov*, for issues related to e-prescribing under Medicare Part D.

Pauline Lapin, (410)786–6883 or *Pauline.Lapin@cms.hhs.gov*, for issues related to the chiropractic services demonstration budget neutrality issue.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: *http://www.regulations.gov*. Follow the search instructions on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

Table of Contents

Acronyms

In addition, because of the many organizations and terms to which we refer by acronym in this final rule with comment period, we are listing these acronyms and their corresponding terms in alphabetical order below:

ASC Ambulatory surgical center
ATRA American Taxpayer Relief Act (Pub. L. 112–240)
AWV Annual wellness visit
BBA Balanced Budget Act of 1997 (Pub. L. 105–33)
BBRA [Medicare, Medicaid and State Child Health Insurance Program] Balanced Budget Refinement Act of 1999 (Pub. L. 106–113)
BEA Bureau of Economic Analysis
CAH Critical access hospital
CBSA Core-Based Statistical Area
CCM Chronic Care Management
CED Coverage with evidence development
CEHRT Certified EHR technology
CF Conversion factor
CLFS Clinical Laboratory Fee Schedule
CMD Contractor medical director
CMHC Community mental health center
CMT Chiropractic manipulative treatment
CORF Comprehensive outpatient rehabilitation facility
CPC Comprehensive Primary Care
CPEP Clinical Practice Expert Panel
CPI–U Consumer Price Index for Urban Areas
CPS Current Population Survey
CPT [Physicians] Current Procedural Terminology (*CPT codes, descriptions and other data only are copyright 2013 American Medical Association. All rights reserved.*)
CQM Clinical quality measure
CT Computed tomography
CTA Computed tomographic angiography
CY Calendar year
DFAR Defense Federal Acquisition Regulations
DHS Designated health services
DRA Deficit Reduction Act of 2005 (Pub. L. 109–171)
DSMT Diabetes self-management training
ECEC Employer Costs for Employee Compensation
ECI Employment Cost Index
eCQM Electronic clinical quality measures
EHR Electronic health record
EMTALA Emergency Medical Treatment and Labor Act
eRx Electronic prescribing
ESRD End-stage renal disease
FAR Federal Acquisition Regulations
FFS Fee-for-service
FOBT Fecal occult blood test
FQHC Federally qualified health center
FR Federal Register
GAF Geographic adjustment factor
GAO Government Accountability Office
GPCI Geographic practice cost index
GPRO Group practice reporting option
HCPCS Healthcare Common Procedure Coding System
HHS [Department of] Health and Human Services
HOPD Hospital outpatient department
HPSA Health professional shortage area
IDE Investigational device exemption
IDTF Independent diagnostic testing facility
IOM Institute of Medicine
IPPE Initial Preventive Physical Examination
IPPS Inpatient Prospective Payment System
IQR Inpatient Quality Reporting
IWPUT Intensity of work per unit of time
KDE Kidney disease education
AAA Abdominal aortic aneurysms
ACA Affordable Care Act (Pub. L. 111–148)
ACO Accountable care organization
AHE Average hourly earnings
AMA American Medical Association
AMA RUC AMA [Specialty Society] Relative (Value) Update Committee

LCD Local coverage determination
LDT Laboratory-developed test
MA Medicare Advantage
MAC Medicare Administrative Contractor
MAPCP Multi-payer Advanced Primary Care Practice
MCTRJCA Middle Class Tax Relief and Job Creation Act of 2012 (Pub. L. 112–96)
MDC Major diagnostic category
MedPAC Medicare Payment Advisory Commission
MEI Medicare Economic Index
MFP Multi-Factor Productivity
MGMA Medical Group Management Association
MIEA–TRHCA The Medicare Improvements and Extension Act, Division B of the Tax Relief and Health Care Act (Pub. L. 109–432)
MIPPA Medicare Improvements for Patients and Providers Act (Pub. L. 110–275)
MMEA Medicare and Medicaid Extenders Act (Pub. L. 111–309)
MMSEA Medicare, Medicaid, and State Children's Health Insurance Program Extension Act (Pub. L. 110–73)
MP Malpractice
MPPR Multiple procedure payment reduction
MRA Magnetic resonance angiography
MRI Magnetic resonance imaging
MSA Metropolitan Statistical Areas
MSPB Medicare Spending per Beneficiary
MSSP Medicare Shared Savings Program
MU Meaningful use
NCD National coverage determination
NCQDIS National Coalition of Quality Diagnostic Imaging Services
NP Nurse practitioner
NPI National Provider Identifier
NPP Nonphysician practitioner
OACT CMS's Office of the Actuary
OBRA '89 Omnibus Budget Reconciliation Act of 1989
OBRA '90 Omnibus Budget Reconciliation Act of 1990
OES Occupational Employment Statistics
OMB Office of Management and Budget
OPPS Outpatient prospective payment system
PC Professional component
PCIP Primary Care Incentive Payment
PDP Prescription Drug Plan
PE Practice expense
PE/HR Practice expense per hour
PEAC Practice Expense Advisory Committee
PECOS Provider Enrollment, Chain, and Ownership System
PFS Physician Fee Schedule
PLI Professional Liability Insurance
PMA Premarket approval
POS Place of Service
PQRS Physician Quality Reporting System
PPIS Physician Practice Expense Information Survey
QRUR Quality and Resources Use Report
RBRVS Resource-based relative value scale
RFA Regulatory Flexibility Act
RHC Rural health clinic
RIA Regulatory impact analysis
RoPR Registry of Patient Registries
RUCA Rural Urban Commuting Area
RVU Relative value unit
SBA Small Business Administration
SGR Sustainable growth rate
SMS Socioeconomic Monitoring System
SNF Skilled nursing facility
SOI Statistics of Income
TAP Technical Advisory Panel
TC Technical component
TIN Tax identification number
TPTCCA Temporary Payroll Tax Cut Continuation Act (Pub. L. 112–78)
UAF Update adjustment factor
USPSTF United States Preventive Services Task Force
VBP Value-based purchasing
VBM Value-Based Modifier

Addenda Available Only Through the Internet on the CMS Web site

The PFS Addenda along with other supporting documents and tables referenced in this final rule with comment period are available through the Internet on the CMS Web site at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html.* Click on the link on the left side of the screen titled, "PFS Federal Regulations Notices" for a chronological list of PFS **Federal Register** and other related documents. For the CY 2014 PFS final rule with comment period, refer to item CMS–1600–FC. Readers who experience any problems accessing any of the Addenda or other documents referenced in this final rule with comment period and posted on the CMS Web site identified above should contact *Elliot.Isaac@cms.hhs.gov.*

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I. Executive Summary and Background

A. Executive Summary

1. Purpose

This major final rule with comment period revises payment polices under the Medicare Physician Fee Schedule (PFS) and makes other policy changes related to Medicare Part B payment. Unless otherwise noted, these changes are applicable to services furnished in CY 2014.

2. Summary of the Major Provisions

The Social Security Act (Act) requires us to establish payments under the PFS based on national uniform relative value units (RVUs) that account for the relative resources used in furnishing a service. The Act requires that RVUs be established for three categories of resources: work, practice expense (PE); and malpractice (MP) expense; and that we establish by regulation each year payment amounts for all physicians' services, incorporating geographic adjustments to reflect the variations in the costs of furnishing services in different geographic areas. In this major final rule with comment period, we establish RVUs for CY 2014 for the PFS, and other Medicare Part B payment policies, to ensure that our payment systems are updated to reflect changes in medical practice and the relative value of services as well as changes in the statute. In addition, this final rule with comment period includes discussions and/or policy changes regarding:

- Misvalued PFS Codes.
- Telehealth Services.
- Applying Therapy Caps to Outpatient Therapy Services Furnished by CAHs.
- Requiring Compliance with State law as a Condition of Payment for Services Furnished Incident to Physicians' (and Other Practitioners') Services.
- Revising the MEI based on MEI TAP Recommendations.
- Updating the Ambulance Fee Schedule regulations.
- Adjusting the Clinical Laboratory Fee Schedule based on technological changes
- Updating the—

++ Physician Compare Web site.
++ Physician Quality Reporting System.
++ Electronic Prescribing (eRx) Incentive Program.
++ Medicare Shared Savings Program.
++ Electronic Health Record (EHR) Incentive Program.

- Budget Neutrality for the Chiropractic Services Demonstration.
- Physician Value-Based Payment Modifier and the Physician Feedback Reporting Program.

3. Summary of Costs and Benefits

We have determined that this final rule with comment period is economically significant. For a detailed discussion of the economic impacts, see section VII. of this final rule with comment period.

B. Background

Since January 1, 1992, Medicare has paid for physicians' services under section 1848 of the Act, "Payment for

Physicians' Services." The system relies on national relative values that are established for work, PE, and MP, which are then adjusted for geographic cost variations. These values are multiplied by a conversion factor (CF) to convert the RVUs into payment rates. The concepts and methodology underlying the PFS were enacted as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89) (Pub. L. 101–239, enacted on December 19, 1989), and the Omnibus Budget Reconciliation Act of 1990 (OBRA '90 (Pub. L. 101–508, enacted on November 5, 1990). The final rule published on November 25, 1991 (56 FR 59502) set forth the first fee schedule used for payment for physicians' services.

We note that throughout this final rule with comment period, unless otherwise noted, the term "practitioner" is used to describe both physicians and nonphysician practitioners who are permitted to bill Medicare under the PFS for services furnished to Medicare beneficiaries.

1. Development of the Relative Values

a. Work RVUs

The physician work RVUs established for the implementation of the fee schedule in January 1992 were developed with extensive input from the physician community. A research team at the Harvard School of Public Health developed the original physician work RVUs for most codes under a cooperative agreement with the Department of Health and Human Services (HHS). In constructing the code-specific vignettes used in determining the original physician work RVUs, Harvard worked with panels of experts, both inside and outside the federal government, and obtained input from numerous physician specialty groups.

We establish work RVUs for new and revised codes based, in part, on our review of recommendations received from the American Medical Association/Specialty Society Relative Value Update Committee (AMA RUC).

b. Practice Expense RVUs

Initially, only the work RVUs were resource-based, and the PE and MP RVUs were based on average allowable charges. Section 121 of the Social Security Act Amendments of 1994 (Pub. L. 103–432, enacted on October 31, 1994), amended section 1848(c)(2)(C)(ii) of the Act and required us to develop resource-based PE RVUs for each physicians' service beginning in 1998. We were required to consider general categories of expenses (such as office rent and wages of personnel, but excluding malpractice expenses) comprising PEs. Originally, this method was to be used beginning in 1998, but section 4505(a) of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33, enacted on August 5, 1997) delayed implementation of the resource-based PE RVU system until January 1, 1999. In addition, section 4505(b) of the BBA provided for a 4-year transition period from the charge-based PE RVUs to the resource-based PE RVUs.

We established the resource-based PE RVUs for each physicians' service in a final rule, published November 2, 1998 (63 FR 58814), effective for services furnished in CY 1999. Based on the requirement to transition to a resource-based system for PE over a 4-year period, payment rates were not fully based upon resource-based PE RVUs until CY 2002. This resource-based system was based on two significant sources of actual PE data: The Clinical Practice Expert Panel (CPEP) data and the AMA's Socioeconomic Monitoring System (SMS) data. (These data sources are described in greater detail in the CY 2012 final rule with comment period (76 FR 73033).)

Separate PE RVUs are established for services furnished in facility settings, such as a hospital outpatient department (HOPD) or an ambulatory surgical center (ASC), and in non-facility settings, such as a physician's office. The nonfacility RVUs reflect all of the direct and indirect PEs involved in furnishing a service described by a particular HCPCS code. The difference, if any, in these PE RVUs generally results in a higher payment in the nonfacility setting because in the facility settings some costs are borne by the facility. Medicare's payment to the facility (such as the outpatient prospective payment system (OPPS) payment to the HOPD) would reflect costs typically incurred by the facility. Thus, payment associated with those facility resources is not made under the PFS.

Section 212 of the Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106–113, enacted on November 29, 1999) directed the Secretary of Health and Human Services (the Secretary) to establish a process under which we accept and use, to the maximum extent practicable and consistent with sound data practices, data collected or developed by entities and organizations to supplement the data we normally collect in determining the PE component. On May 3, 2000, we published the interim final rule (65 FR 25664) that set forth the criteria for the submission of these supplemental PE survey data. The criteria were modified in response to comments received, and published in the **Federal Register** (65 FR 65376) as part of a November 1, 2000 final rule. The PFS final rules published in 2001 and 2003, respectively, (66 FR 55246 and 68 FR 63196) extended the period during which we would accept these supplemental data through March 1, 2005.

In the CY 2007 PFS final rule with comment period (71 FR 69624), we revised the methodology for calculating direct PE RVUs from the top-down to the bottom-up methodology beginning in CY 2007. We adopted a 4-year transition to the new PE RVUs. This transition was completed for CY 2010. In the CY 2010 PFS final rule with comment period, we updated the practice expense per hour (PE/HR) data that are used in the calculation of PE RVUs for most specialties (74 FR 61749). In CY 2010, we began a 4-year transition to the new PE RVUs using the updated PE/HR data, which was completed for CY 2013.

c. Malpractice RVUs

Section 4505(f) of the BBA amended section 1848(c) of the Act to require that we implement resource-based MP RVUs for services furnished on or after CY 2000. The resource-based MP RVUs were implemented in the PFS final rule with comment period published November 2, 1999 (64 FR 59380). The MP RVUs are based on malpractice insurance premium data collected from commercial and physician-owned insurers from all the states, the District of Columbia, and Puerto Rico.

d. Refinements to the RVUs

Section 1848(c)(2)(B)(i) of the Act requires that we review RVUs no less often than every 5 years. Prior to CY 2013, we conducted periodic reviews of work RVUs and PE RVUs independently. We completed Five-Year Reviews of Work RVUs that were effective for calendar years 1997, 2002, 2007, and 2012.

While refinements to the direct PE inputs initially relied heavily on input from the AMA RUC Practice Expense Advisory Committee (PEAC), the shifts to the bottom-up PE methodology in CY 2007 and to the use of the updated PE/HR data in CY 2010 have resulted in significant refinements to the PE RVUs in recent years.

In the CY 2012 PFS final rule with comment period (76 FR 73057), we finalized a proposal to consolidate reviews of work and PE RVUs under section 1848(c)(2)(B) of the Act and reviews of potentially misvalued codes

under section 1848(c)(2)(K) of the Act into one annual process.

With regard to MP RVUs, we completed Five-Year Reviews of MP that were effective in CY 2005 and CY 2010.

In addition to the Five-Year Reviews, beginning for CY 2009, CMS and the AMA RUC have identified and reviewed a number of potentially misvalued codes on an annual basis based on various identification screens. This annual review of work and PE RVUs for potentially misvalued codes was supplemented by the amendments to section 1848 of the Act, as enacted by section 3134 of the Affordable Care Act, which requires the agency to periodically identify, review and adjust values for potentially misvalued codes with an emphasis on seven specific categories (see section II.C.2. of this final rule with comment period).

e. Application of Budget Neutrality to Adjustments of RVUs

As described in section VII.C.1. of this final rule with comment period, in accordance with section 1848(c)(2)(B)(ii)(II) of the Act, if revisions to the RVUs would cause expenditures for the year to change by more than $20 million, we make adjustments to ensure that expenditures do not increase or decrease by more than $20 million.

2. Calculation of Payments Based on RVUs

To calculate the payment for each physicians' service, the components of the fee schedule (work, PE, and MP RVUs) are adjusted by geographic practice cost indices (GPCIs) to reflect the variations in the costs of furnishing the services. The GPCIs reflect the relative costs of physician work, PE, and MP in an area compared to the national average costs for each component. (See section II.F.2 of this final rule with comment period for more information about GPCIs.)

RVUs are converted to dollar amounts through the application of a CF, which is calculated based on a statutory formula by CMS's Office of the Actuary (OACT). The CF for a given year is calculated using (a) the productivity-adjusted increase in the Medicare Economic Index (MEI) and (b) the Update Adjustment Factor (UAF), which is calculated by taking into account the Medicare Sustainable Growth Rate (SGR), an annual growth rate intended to control growth in aggregate Medicare expenditures for physicians' services, and the allowed and actual expenditures for physicians' services. For a more detailed discussion of the calculation of the CF, the SGR, and the MEI, we refer readers to section II.G. of this final rule with comment period.

The formula for calculating the Medicare fee schedule payment amount for a given service and fee schedule area can be expressed as:

Payment = [(RVU work × GPCI work) + (RVU PE × GPCI PE) + (RVU MP × GPCI MP)] × CF.

3. Separate Fee Schedule Methodology for Anesthesia Services

Section 1848(b)(2)(B) of the Act specifies that the fee schedule amounts for anesthesia services are to be based on a uniform relative value guide, with appropriate adjustment of an anesthesia conversion factor, in a manner to assure that fee schedule amounts for anesthesia services are consistent with those for other services of comparable value. Therefore, there is a separate fee schedule methodology for anesthesia services. Specifically, we establish a separate conversion factor for anesthesia services and we utilize the uniform relative value guide, or base units, as well as time units, to calculate the fee schedule amounts for anesthesia services. Since anesthesia services are not valued using RVUs, a separate methodology for locality adjustments is also necessary. This involves an adjustment to the national anesthesia CF for each payment locality.

4. Most Recent Changes to the Fee Schedule

The CY 2013 PFS final rule with comment period (77 FR 68892) implemented changes to the PFS and other Medicare Part B payment policies. It also finalized many of the CY 2012 interim final RVUs and established interim final RVUs for new and revised codes for CY 2013 to ensure that our payment system is updated to reflect changes in medical practice, coding changes, and the relative values of services. It also implemented certain statutory provisions including provisions of the Affordable Care Act (Pub. L. 111–148) and the Middle Class Tax Relief and Jobs Creation Act (MCTRJCA) (Pub. L. 112–96), including claims-based data reporting requirements for therapy services.

In the CY 2013 PFS final rule with comment period, we announced the following for CY 2013: the total PFS update of −26.5 percent; the initial estimate for the SGR of −19.7 percent; and the CY 2013 CF of $25.0008. These figures were calculated based on the statutory provisions in effect on November 1, 2012, when the CY 2013 PFS final rule with comment period was issued.

On January 2, 2013, the American Taxpayer Relief Act (ATRA) of 2012 (Pub. L. 112–240) was signed into law. Section 601(a) of the ATRA specified a zero percent update to the PFS CF for CY 2013. As a result, the CY 2013 PFS conversion factor was revised to $34.0320. In addition, the ATRA extended and added several provisions affecting Medicare services furnished in CY 2013, including:

- Section 602—extending the 1.0 floor on the work geographic practice cost index through CY 2013;
- Section 603—extending the exceptions process for outpatient therapy caps through CY 2013, extending the application of the cap and manual medical review threshold to services furnished in the HOPD through CY 2013, and requiring the counting of a proxy amount for therapy services furnished in a Critical Access Hospital (CAH) toward the cap and threshold during CY 2013.

In addition to the changes effective for CY 2013, section 635 of ATRA revised the equipment utilization rate assumption for advanced imaging services furnished on or after January 1, 2014.

A correction document (78 FR 48996) was issued to correct several technical and typographical errors that occurred in the CY 2013 PFS final rule with comment period.

II. Provisions of the Final Rule With Comment Period for PFS

A. Resource-Based Practice Expense (PE) Relative Value Units (RVUs)

1. Overview

Practice expense (PE) is the portion of the resources used in furnishing a service that reflects the general categories of physician and practitioner expenses, such as office rent and personnel wages, but excluding malpractice expenses, as specified in section 1848(c)(1)(B) of the Act. Section 121 of the Social Security Amendments of 1994 (Pub. L. 103–432), enacted on October 31, 1994, amended section 1848(c)(2)(C)(ii) of the Act to require us to develop a methodology for a resource-based system for determining PE RVUs for each physician's service. We develop PE RVUs by looking at the direct and indirect practice resources involved in furnishing each service. Direct expense categories include clinical labor, medical supplies, and medical equipment. Indirect expenses include administrative labor, office expense, and all other expenses. The sections that follow provide more

detailed information about the methodology for translating the resources involved in furnishing each service into service-specific PE RVUs. We refer readers to the CY 2010 PFS final rule with comment period (74 FR 61743 through 61748) for a more detailed explanation of the PE methodology.

In addition, we note that section 1848(c)(2)(B)(ii)(II) of the Act provides that adjustments in RVUs for a year may not cause total PFS payments to differ by more than $20 million from what they would have otherwise been if the adjustments were not made. Therefore, if revisions to the RVUs cause expenditures to change by more than $20 million, we make adjustments to ensure that expenditures do not increase or decrease by more than $20 million.

2. Practice Expense Methodology

a. Direct Practice Expense

We determine the direct PE for a specific service by adding the costs of the direct resources (that is, the clinical staff, equipment, and supplies) typically involved with furnishing that service. The costs of the resources are calculated using the refined direct PE inputs assigned to each CPT code in our PE database, which are based on our review of recommendations received from the AMA RUC and those provided in response to public comment periods. For a detailed explanation of the direct PE methodology, including examples, we refer readers to the Five-Year Review of Work Relative Value Units Under the PFS and Proposed Changes to the Practice Expense Methodology proposed notice (71 FR 37242) and the CY 2007 PFS final rule with comment period (71 FR 69629).

b. Indirect Practice Expense per Hour Data

We use survey data on indirect PEs incurred per hour worked in developing the indirect portion of the PE RVUs. Prior to CY 2010, we primarily used the practice expense per hour (PE/HR) by specialty that was obtained from the AMA's Socioeconomic Monitoring Surveys (SMS). The AMA administered a new survey in CY 2007 and CY 2008, the Physician Practice Expense Information Survey (PPIS). The PPIS is a multispecialty, nationally representative, PE survey of both physicians and nonphysician practitioners (NPPs) paid under the PFS using a survey instrument and methods highly consistent with those used for the SMS and the supplemental surveys. The PPIS gathered information from 3,656 respondents across 51 physician specialty and health care professional groups. We believe the PPIS is the most comprehensive source of PE survey information available. We used the PPIS data to update the PE/HR data for the CY 2010 PFS for almost all of the Medicare-recognized specialties that participated in the survey.

When we began using the PPIS data in CY 2010, we did not change the PE RVU methodology itself or the manner in which the PE/HR data are used in that methodology. We only updated the PE/HR data based on the new survey. Furthermore, as we explained in the CY 2010 PFS final rule with comment period (74 FR 61751), because of the magnitude of payment reductions for some specialties resulting from the use of the PPIS data, we transitioned its use over a 4-year period (75 percent old/25 percent new for CY 2010, 50 percent old/50 percent new for CY 2011, 25 percent old/75 percent new for CY 2012, and 100 percent new for CY 2013) from the previous PE RVUs to the PE RVUs developed using the new PPIS data. As provided in the CY 2010 PFS final rule with comment period (74 FR 61751), the transition to the PPIS data was complete for CY 2013. Therefore, the CY 2013 and CY 2014 PE RVUs are developed based entirely on the PPIS data, except as noted in this section.

Section 1848(c)(2)(H)(i) of the Act requires us to use the medical oncology supplemental survey data submitted in 2003 for oncology drug administration services. Therefore, the PE/HR for medical oncology, hematology, and hematology/oncology reflects the continued use of these supplemental survey data.

Supplemental survey data on independent labs from the College of American Pathologists were implemented for payments beginning in CY 2005. Supplemental survey data from the National Coalition of Quality Diagnostic Imaging Services (NCQDIS), representing independent diagnostic testing facilities (IDTFs), were blended with supplementary survey data from the American College of Radiology (ACR) and implemented for payments beginning in CY 2007. Neither IDTFs, nor independent labs, participated in the PPIS. Therefore, we continue to use the PE/HR that was developed from their supplemental survey data.

Consistent with our past practice, the previous indirect PE/HR values from the supplemental surveys for these specialties were updated to CY 2006 using the MEI to put them on a comparable basis with the PPIS data.

We also do not use the PPIS data for reproductive endocrinology and spine surgery since these specialties currently are not separately recognized by Medicare, nor do we have a method to blend the PPIS data with Medicare-recognized specialty data.

We do not use the PPIS data for sleep medicine since there is not a full year of Medicare utilization data for that specialty given the specialty code was only available beginning in October 1, 2012. We anticipate using the PPIS data to create PE/HR for sleep medicine for CY 2015 when we will have a full year of data to make the calculations.

Previously, we established PE/HR values for various specialties without SMS or supplemental survey data by crosswalking them to other similar specialties to estimate a proxy PE/HR. For specialties that were part of the PPIS for which we previously used a crosswalked PE/HR, we instead used the PPIS-based PE/HR. We continue previous crosswalks for specialties that did not participate in the PPIS. However, beginning in CY 2010 we changed the PE/HR crosswalk for portable x-ray suppliers from radiology to IDTF, a more appropriate crosswalk because these specialties are more similar to each other with respect to physician time.

For registered dietician services, the resource-based PE RVUs have been calculated in accordance with the final policy that crosswalks the specialty to the "All Physicians" PE/HR data, as adopted in the CY 2010 PFS final rule with comment period (74 FR 61752) and discussed in more detail in the CY 2011 PFS final rule with comment period (75 FR 73183).

c. Allocation of PE to Services

To establish PE RVUs for specific services, it is necessary to establish the direct and indirect PE associated with each service.

(1) Direct Costs

The relative relationship between the direct cost portions of the PE RVUs for any two services is determined by the relative relationship between the sum of the direct cost resources (that is, the clinical staff, equipment, and supplies) typically involved with furnishing each of the services. The costs of these resources are calculated from the refined direct PE inputs in our PE database. For example, if one service has a direct cost sum of $400 from our PE database and another service has a direct cost sum of $200, the direct portion of the PE RVUs of the first service would be twice as much as the direct portion of the PE RVUs for the second service.

(2) Indirect Costs

Section II.B.2.b. of this final rule with comment period describes the current data sources for specialty-specific indirect costs used in our PE calculations. We allocated the indirect costs to the code level on the basis of the direct costs specifically associated with a code and the greater of either the clinical labor costs or the physician work RVUs. We also incorporated the survey data described earlier in the PE/HR discussion. The general approach to developing the indirect portion of the PE RVUs is described as follows:

- For a given service, we use the direct portion of the PE RVUs calculated as previously described and the average percentage that direct costs represent of total costs (based on survey data) across the specialties that furnish the service to determine an initial indirect allocator. In other words, the initial indirect allocator is calculated so that the direct costs equal the average percentage of direct costs of those specialties furnishing the service. For example, if the direct portion of the PE RVUs for a given service is 2.00 and direct costs, on average, represented 25 percent of total costs for the specialties that furnished the service, the initial indirect allocator would be calculated so that it equals 75 percent of the total PE RVUs. Thus, in this example the initial indirect allocator would equal 6.00, resulting in a total PE RVUs of 8.00 (2.00 is 25 percent of 8.00 and 6.00 is 75 percent of 8.00).
- Next, we add the greater of the work RVUs or clinical labor portion of the direct portion of the PE RVUs to this initial indirect allocator. In our example, if this service had work RVUs of 4.00 and the clinical labor portion of the direct PE RVUs was 1.50, we would add 4.00 (since the 4.00 work RVUs are greater than the 1.50 clinical labor portion) to the initial indirect allocator of 6.00 to get an indirect allocator of 10.00. In the absence of any further use of the survey data, the relative relationship between the indirect cost portions of the PE RVUs for any two services would be determined by the relative relationship between these indirect cost allocators. For example, if one service had an indirect cost allocator of 10.00 and another service had an indirect cost allocator of 5.00, the indirect portion of the PE RVUs of the first service would be twice as great as the indirect portion of the PE RVUs for the second service.
- Next, we incorporate the specialty-specific indirect PE/HR data into the calculation. In our example, if based on the survey data, the average indirect cost of the specialties furnishing the first service with an allocator of 10.00 was half of the average indirect cost of the specialties furnishing the second service with an indirect allocator of 5.00, the indirect portion of the PE RVUs of the first service would be equal to that of the second service.

d. Facility and Nonfacility Costs

For procedures that can be furnished in a physician's office, as well as in a hospital or facility setting, we establish two PE RVUs: Facility and nonfacility. The methodology for calculating PE RVUs is the same for both the facility and nonfacility RVUs, but is applied independently to yield two separate PE RVUs. Because in calculating the PE RVUs for services furnished in a facility, we do not include resources that would generally not be provided by physicians when furnishing the service in a facility, the facility PE RVUs are generally lower than the nonfacility PE RVUs. Medicare makes a separate payment to the facility for its costs of furnishing a service.

e. Services With Technical Components (TCs) and Professional Components (PCs)

Diagnostic services are generally comprised of two components: A professional component (PC); and a technical component (TC). The PC and TC may be furnished independently or by different providers, or they may be furnished together as a "global" service. When services have separately billable PC and TC components, the payment for the global service equals the sum of the payment for the TC and PC. To achieve this we use a weighted average of the ratio of indirect to direct costs across all the specialties that furnish the global service, TCs, and PCs; that is, we apply the same weighted average indirect percentage factor to allocate indirect expenses to the global service, PCs, and TCs for a service. (The direct PE RVUs for the TC and PC sum to the global under the bottom-up methodology.)

f. PE RVU Methodology

For a more detailed description of the PE RVU methodology, we refer readers to the CY 2010 PFS final rule with comment period (74 FR 61745 through 61746).

(1) Setup File

First, we create a setup file for the PE methodology. The setup file contains the direct cost inputs, the utilization for each procedure code at the specialty and facility/nonfacility place of service level, and the specialty-specific PE/HR data calculated from the surveys.

(2) Calculate the Direct Cost PE RVUs

Sum the costs of each direct input.

Step 1: Sum the direct costs of the inputs for each service. Apply a scaling adjustment to the direct inputs.

Step 2: Calculate the aggregate pool of direct PE costs for the current year. This is the product of the current aggregate PE (direct and indirect) RVUs, the CF, and the average direct PE percentage from the survey data used for calculating the PE/HR by specialty.

Step 3: Calculate the aggregate pool of direct PE costs for use in ratesetting. This is the product of the aggregated direct costs for all services from Step 1 and the utilization data for that service. For CY 2014, we adjusted the aggregate pool of direct PE costs in proportion to the change in the PE share in the revised MEI, as discussed in section II.D. of this final rule with comment period.

Step 4: Using the results of Step 2 and Step 3, calculate a direct PE scaling adjustment to ensure that the aggregate pool of direct PE costs calculated in Step 3 does not vary from the aggregate pool of direct PE costs for the current year. Apply the scaling factor to the direct costs for each service (as calculated in Step 1).

Step 5: Convert the results of Step 4 to an RVU scale for each service. To do this, divide the results of Step 4 by the CF. Note that the actual value of the CF used in this calculation does not influence the final direct cost PE RVUs, as long as the same CF is used in Step 2 and Step 5. Different CFs will result in different direct PE scaling factors, but this has no effect on the final direct cost PE RVUs since changes in the CFs and changes in the associated direct scaling factors offset one another.

(3) Create the Indirect Cost PE RVUs

Create indirect allocators.

Step 6: Based on the survey data, calculate direct and indirect PE percentages for each physician specialty.

Step 7: Calculate direct and indirect PE percentages at the service level by taking a weighted average of the results of Step 6 for the specialties that furnish the service. Note that for services with TCs and PCs, the direct and indirect percentages for a given service do not vary by the PC, TC, and global service.

Step 8: Calculate the service level allocators for the indirect PEs based on the percentages calculated in Step 7. The indirect PEs are allocated based on the three components: the direct PE RVUs; the clinical PE RVUs; and the work RVUs.

For most services the indirect allocator is: Indirect PE percentage *

(direct PE RVUs/direct percentage) + work RVUs.

There are two situations where this formula is modified:

- If the service is a global service (that is, a service with global, professional, and technical components), then the indirect PE allocator is: indirect percentage (direct PE RVUs/direct percentage) + clinical PE RVUs + work RVUs.
- If the clinical labor PE RVUs exceed the work RVUs (and the service is not a global service), then the indirect allocator is: indirect PE percentage (direct PE RVUs/direct percentage) + clinical PE RVUs.

(**Note:** For global services, the indirect PE allocator is based on both the work RVUs and the clinical labor PE RVUs. We do this to recognize that, for the PC service, indirect PEs will be allocated using the work RVUs, and for the TC service, indirect PEs will be allocated using the direct PE RVUs and the clinical labor PE RVUs. This also allows the global component RVUs to equal the sum of the PC and TC RVUs.)

For presentation purposes in the examples in Table 1, the formulas were divided into two parts for each service.

- The first part does not vary by service and is the indirect percentage (direct PE RVUs/direct percentage).
- The second part is either the work RVU, clinical labor PE RVU, or both depending on whether the service is a global service and whether the clinical PE RVUs exceed the work RVUs (as described earlier in this step).

Apply a scaling adjustment to the indirect allocators.

Step 9: Calculate the current aggregate pool of indirect PE RVUs by multiplying the current aggregate pool of PE RVUs by the average indirect PE percentage from the survey data.

Step 10: Calculate an aggregate pool of indirect PE RVUs for all PFS services by adding the product of the indirect PE allocators for a service from Step 8 and the utilization data for that service. For CY 2014, we adjusted the indirect cost pool in proportion to the change in the PE share in the revised MEI, as discussed in section II.D. of this final rule with comment period.

Step 11: Using the results of Step 9 and Step 10, calculate an indirect PE adjustment so that the aggregate indirect allocation does not exceed the available aggregate indirect PE RVUs and apply it to indirect allocators calculated in Step 8.

Calculate the indirect practice cost index.

Step 12: Using the results of Step 11, calculate aggregate pools of specialty-specific adjusted indirect PE allocators for all PFS services for a specialty by adding the product of the adjusted indirect PE allocator for each service and the utilization data for that service.

Step 13: Using the specialty-specific indirect PE/HR data, calculate specialty-specific aggregate pools of indirect PE for all PFS services for that specialty by adding the product of the indirect PE/HR for the specialty, the physician time for the service, and the specialty's utilization for the service across all services furnished by the specialty.

Step 14: Using the results of Step 12 and Step 13, calculate the specialty-specific indirect PE scaling factors.

Step 15: Using the results of Step 14, calculate an indirect practice cost index at the specialty level by dividing each specialty-specific indirect scaling factor by the average indirect scaling factor for the entire PFS.

Step 16: Calculate the indirect practice cost index at the service level to ensure the capture of all indirect costs. Calculate a weighted average of the practice cost index values for the specialties that furnish the service. (*Note:* For services with TCs and PCs, we calculate the indirect practice cost index across the global service, PCs, and TCs. Under this method, the indirect practice cost index for a given service (for example, echocardiogram) does not vary by the PC, TC, and global service.)

Step 17: Apply the service level indirect practice cost index calculated in Step 16 to the service level adjusted indirect allocators calculated in Step 11 to get the indirect PE RVUs.

(4) Calculate the Final PE RVUs

Step 18: Add the direct PE RVUs from Step 6 to the indirect PE RVUs from Step 17 and apply the final PE budget neutrality (BN) adjustment and the MEI revision adjustment.

The final PE BN adjustment is calculated by comparing the results of Step 18 to the current pool of PE RVUs (prior to the adjustments corresponding with the MEI revision described in section II.D. of this final rule with comment period). This final BN adjustment is required to redistribute RVUs from step 18 to all PE RVUs in the PFS, and because certain specialties are excluded from the PE RVU calculation for ratesetting purposes, but we note that all specialties are included for purposes of calculating the final BN adjustment. (See "Specialties excluded from ratesetting calculation" later in this section.)

(5) Setup File Information

- *Specialties excluded from ratesetting calculation:* For the purposes of calculating the PE RVUs, we exclude certain specialties, such as certain nonphysician practitioners paid at a percentage of the PFS and low-volume specialties, from the calculation. These specialties are included for the purposes of calculating the BN adjustment. They are displayed in Table 1.

TABLE 1—SPECIALTIES EXCLUDED FROM RATESETTING CALCULATION

Specialty code	Specialty description
49	Ambulatory surgical center.
50	Nurse practitioner.
51	Medical supply company with certified orthotist.
52	Medical supply company with certified prosthetist.
53	Medical supply company with certified prosthetist-orthotist.
54	Medical supply company not included in 51, 52, or 53.
55	Individual certified orthotist.
56	Individual certified prosthestist.
57	Individual certified prosthetist-orthotist.
58	Individuals not included in 55, 56, or 57.
59	Ambulance service supplier, e.g., private ambulance companies, funeral homes, etc.
60	Public health or welfare agencies.
61	Voluntary health or charitable agencies.
73	Mass immunization roster biller.
74	Radiation therapy centers.
87	All other suppliers (e.g., drug and department stores).
88	Unknown supplier/provider specialty.
89	Certified clinical nurse specialist.
95	Competitive Acquisition Program (CAP) Vendor.
96	Optician.
97	Physician assistant.
A0	Hospital.
A1	SNF.
A2	Intermediate care nursing facility.
A3	Nursing facility, other.
A4	HHA.
A5	Pharmacy.
A6	Medical supply company with respiratory therapist.
A7	Department store.
1	Supplier of oxygen and/or oxygen related equipment.
2	Pedorthic personnel.
3	Medical supply company with pedorthic personnel.

- *Crosswalk certain low volume physician specialties:* Crosswalk the utilization of certain specialties with relatively low PFS utilization to the associated specialties.
- *Physical therapy utilization:* Crosswalk the utilization associated with all physical therapy services to the specialty of physical therapy.
- *Identify professional and technical services not identified under the usual*

TC and 26 modifiers: Flag the services that are PC and TC services, but do not use TC and 26 modifiers (for example, electrocardiograms). This flag associates the PC and TC with the associated global code for use in creating the indirect PE RVUs. For example, the professional service, CPT code 93010 (Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only), is associated with the global service, CPT code 93000 (Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report).

- *Payment modifiers:* Payment modifiers are accounted for in the creation of the file consistent with current payment policy as implemented in claims processing. For example, services billed with the assistant at surgery modifier are paid 16 percent of the PFS amount for that service; therefore, the utilization file is modified to only account for 16 percent of any service that contains the assistant at surgery modifier. Similarly, for those services to which volume adjustments are made to account for the payment modifiers, time adjustments are applied as well. For time adjustments to surgical services, the intraoperative portion in the physician time file is used; where it is not present, the intraoperative percentage from the payment files used by contractors to process Medicare claims is used instead. Where neither is available, we use the payment adjustment ratio to adjust the time accordingly. Table 2 details the manner in which the modifiers are applied.

TABLE 2—APPLICATION OF PAYMENT MODIFIERS TO UTILIZATION FILES

Modifier	Description	Volume adjustment	Time adjustment
80,81,82	Assistant at Surgery	16%	Intraoperative portion.
AS	Assistant at Surgery—Physician Assistant	14% (85% * 16%)	Intraoperative portion.
50 or LT and RT	Bilateral Surgery	150%	150% of physician time.
51	Multiple Procedure	50%	Intraoperative portion.
52	Reduced Services	50%	50%.
53	Discontinued Procedure	50%	50%.
54	Intraoperative Care only	Preoperative + Intraoperative Percentages on the payment files used by Medicare contractors to process Medicare claims.	Preoperative + Intraoperative portion.
55	Postoperative Care only	Postoperative Percentage on the payment files used by Medicare contractors to process Medicare claims.	Postoperative portion.
62	Co-Surgeons	62.5%	50%.
66	Team Surgeons	33%	33%.

We also make adjustments to volume and time that correspond to other payment rules, including special multiple procedure endoscopy rules and multiple procedure payment reductions (MPPR). We note that section 1848(c)(2)(B)(v) of the Act exempts certain reduced payments for multiple imaging procedures and multiple therapy services from the BN calculation under section 1848(c)(2)(B)(ii)(II) of the Act. These MPPRs are not included in the development of the RVUs.

For anesthesia services, we do not apply adjustments to volume since the average allowed charge is used when simulating RVUs, and therefore, includes all adjustments. A time adjustment of 33 percent is made only for medical direction of two to four cases since that is the only situation where time units are duplicative.

- *Work RVUs:* The setup file contains the work RVUs from this final rule with comment period.

(6) Equipment Cost per Minute

The equipment cost per minute is calculated as:

*(1/(minutes per year * usage)) * price * ((interest rate/(1 − (1/((1 + interest rate)^ life of equipment)))) + maintenance)*

Where:

minutes per year = maximum minutes per year if usage were continuous (that is, usage = 1); generally 150,000 minutes.
usage = variable, see discussion below.
price = price of the particular piece of equipment.
life of equipment = useful life of the particular piece of equipment.
maintenance = factor for maintenance; 0.05.
interest rate = variable, see discussion below.

Usage: We currently use an equipment utilization rate assumption of 50 percent for most equipment, with the exception of expensive diagnostic imaging equipment. For CY 2013, expensive diagnostic imaging equipment, which is equipment priced at over $1 million (for example, computed tomography (CT) and magnetic resonance imaging (MRI) scanners), we use an equipment utilization rate assumption of 75 percent. Section 1848(b)(4)(C) of the Act, as modified by section 635 of the ATRA), requires that for fee schedules established for CY 2014 and subsequent years, in the methodology for determining PE RVUs for expensive diagnostic imaging equipment, the Secretary shall use a 90 percent assumption. The provision also requires that the reduced expenditures attributable to this change in the utilization rate for CY 2014 and subsequent years shall not be taken into account when applying the BN limitation on annual adjustments described in section 1848(c)(2)(B)(ii)(II) of the Act. We are applying the 90 percent utilization rate assumption in CY 2014 to all of the services to which the 75 percent equipment utilization rate assumption applied in CY 2013. These services are listed in a file called "CY 2014 CPT Codes Subject to 90 Percent Usage Rate," available on the CMS Web site under downloads for the CY 2014 PFS final rule with comment period at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html.* These codes are also displayed in Table 3.

TABLE 3—CPT CODES SUBJECT TO 90 PERCENT EQUIPMENT UTILIZATION RATE ASSUMPTION

CPT code	Short descriptor
70336 ..	Mri, temporomandibular joint(s).
70450 ..	Ct head/brain w/o dye.
70460 ..	Ct head/brain w/dye.
70470 ..	Ct head/brain w/o & w/dye.
70480 ..	Ct orbit/ear/fossa w/o dye.
70481 ..	Ct orbit/ear/fossa w/dye.
70482 ..	Ct orbit/ear/fossa w/o & w/dye.
70486 ..	Ct maxillofacial w/o dye.
70487 ..	Ct maxillofacial w/dye.
70488 ..	Ct maxillofacial w/o & w/dye.
70490 ..	Ct soft tissue neck w/o dye.
70491 ..	Ct soft tissue neck w/dye.
70492 ..	Ct soft tissue neck w/o & w/dye.
70496 ..	Ct angiography, head.
70498 ..	Ct angiography, neck.
70540 ..	Mri orbit/face/neck w/o dye.
70542 ..	Mri orbit/face/neck w/dye.
70543 ..	Mri orbit/face/neck w/o & w/dye.
70544 ..	Mr angiography head w/o dye.
70545 ..	Mr angiography head w/dye.
70546 ..	Mr angiography head w/o & w/dye.
70547 ..	Mr angiography neck w/o dye.
70548 ..	Mr angiography neck w/dye.
70549 ..	Mr angiography neck w/o & w/dye.
70551 ..	Mri brain w/o dye.
70552 ..	Mri brain w/dye.
70553 ..	Mri brain w/o & w/dye.
70554 ..	Fmri brain by tech.
71250 ..	Ct thorax w/o dye.
71260 ..	Ct thorax w/dye.
71270 ..	Ct thorax w/o & w/dye.
71275 ..	Ct angiography, chest.
71550 ..	Mri chest w/o dye.
71551 ..	Mri chest w/dye.
71552 ..	Mri chest w/o & w/dye.
71555 ..	Mri angio chest w/ or w/o dye.
72125 ..	CT neck spine w/o dye.
72126 ..	Ct neck spine w/dye.
72127 ..	Ct neck spine w/o & w/dye.
72128 ..	Ct chest spine w/o dye.
72129 ..	Ct chest spine w/dye.
72130 ..	Ct chest spine w/o & w/dye.
72131 ..	Ct lumbar spine w/o dye.
72132 ..	Ct lumbar spine w/dye.
72133 ..	Ct lumbar spine w/o & w/dye.
72141 ..	Mri neck spine w/o dye.
72142 ..	Mri neck spine w/dye.
72146 ..	Mri chest spine w/o dye.
72147 ..	Mri chest spine w/dye.
72148 ..	Mri lumbar spine w/o dye.
72149 ..	Mri lumbar spine w/dye.
72156 ..	Mri neck spine w/o & w/dye.
72157 ..	Mri chest spine w/o & w/dye.
72158 ..	Mri lumbar spine w/o & w/dye.

TABLE 3—CPT CODES SUBJECT TO 90 PERCENT EQUIPMENT UTILIZATION RATE ASSUMPTION—Continued

CPT code	Short descriptor
72159 ..	Mr angio spine w/o & w/dye.
72191 ..	Ct angiography, pelv w/o & w/dye.
72192 ..	Ct pelvis w/o dye.
72193 ..	Ct pelvis w/dye.
72194 ..	Ct pelvis w/o & w/dye.
72195 ..	Mri pelvis w/o dye.
72196 ..	Mri pelvis w/dye.
72197 ..	Mri pelvis w/o & w/dye.
72198 ..	Mri angio pelvis w/or w/o dye.
73200 ..	Ct upper extremity w/o dye.
73201 ..	Ct upper extremity w/dye.
73202 ..	Ct upper extremity w/o & w/dye.
73206 ..	Ct angio upper extr w/o & w/dye.
73218 ..	Mri upper extr w/o dye.
73219 ..	Mri upper extr w/dye.
73220 ..	Mri upper extremity w/o & w/dye.
73221 ..	Mri joint upper extr w/o dye.
73222 ..	Mri joint upper extr w/dye.
73223 ..	Mri joint upper extr w/o & w/dye.
73225 ..	Mr angio upr extr w/o & w/dye.
73700 ..	Ct lower extremity w/o dye.
73701 ..	Ct lower extremity w/dye.
73702 ..	Ct lower extremity w/o & w/dye.
73706 ..	Ct angio lower ext w/o & w/dye.
73718 ..	Mri lower extremity w/o dye.
73719 ..	Mri lower extremity w/dye.
73720 ..	Mri lower ext w/& w/o dye.
73721 ..	Mri joint of lwr extre w/o dye.
73722 ..	Mri joint of lwr extr w/dye.
73723 ..	Mri joint of lwr extr w/o & w/dye.
73725 ..	Mr angio lower ext w or w/o dye.
74150 ..	Ct abdomen w/o dye.
74160 ..	Ct abdomen w/dye.
74170 ..	Ct abdomen w/o & w/dye.
74174 ..	Ct angiography, abdomen and pelvis w/o & w/dye.
74175 ..	Ct angiography, abdom w/o & w/ dye.
74176 ..	Ct abdomen and pelvis w/o dye.
74177 ..	Ct abdomen and pelvis w/dye.
74178 ..	Ct abdomen and pelvis w/ and w/o dye.
74181 ..	Mri abdomen w/o dye.
74182 ..	Mri abdomen w/dye.
74183 ..	Mri abdomen w/o and w/dye.
74185 ..	Mri angio, abdom w/or w/o dye.
74261 ..	Ct colonography, w/o dye.
74262 ..	Ct colonography, w/dye.
75557 ..	Cardiac mri for morph.
75559 ..	Cardiac mri w/stress img.
75561 ..	Cardiac mri for morph w/dye.
75563 ..	Cardiac mri w/stress img & dye.
75565 ..	Card mri vel flw map add-on.

TABLE 3—CPT CODES SUBJECT TO 90 PERCENT EQUIPMENT UTILIZATION RATE ASSUMPTION—Continued

CPT code	Short descriptor
75571 ..	Ct hrt w/o dye w/ca test.
75572 ..	Ct hrt w/3d image.
75573 ..	Ct hrt w/3d image, congen.
75574 ..	Ct angio hrt w/3d image.
75635 ..	Ct angio abdominal arteries.
76380 ..	CAT scan follow up study.
77058 ..	Mri, one breast.
77059 ..	Mri, broth breasts.
77078 ..	Ct bone density, axial.
77084 ..	Magnetic image, bone marrow.

Comment: Several commenters objected to the statutorily-mandated change in equipment utilization rate assumptions, but none provided evidence that CMS has authority to use a different equipment utilization assumption for these services.

Response: As mandated by statute, we are finalizing our proposed change in the equipment utilization rate for these services.

Interest Rate: In the CY 2013 final rule with comment period (77 FR 68902), we updated the interest rates used in developing an equipment cost per minute calculation. The interest rate was based on the Small Business Administration (SBA) maximum interest rates for different categories of loan size (equipment cost) and maturity (useful life). The interest rates are listed in Table 4. (See 77 FR 68902 for a thorough discussion of this issue.)

TABLE 4—SBA MAXIMUM INTEREST RATES

Price	Useful life	Interest rate (percent)
<$25K	<7 Years	7.50
$25K to $50K	<7 Years	6.50
>$50K	<7 Years	5.50
<$25K	7+ Years	8.00
$25K to $50K	7+ Years	7.00
>$50K	7+ Years	6.00

See 77 FR 68902 for a thorough discussion of this issue.

TABLE 5—CALCULATION OF PE RVUS UNDER METHODOLOGY FOR SELECTED CODES

	Step	Source	Formula	99213 Office visit, est Non-facility	33533 CABG, arterial, single Facility	71020 Chest x-ray Non-facility	71020–TC Chest x-ray, Non-facility	71020–26 Chest x-ray, Non-facility	93000 ECG, complete, Non-facility	93005 ECG, tracing Non-facility	93010 ECG, report Non-facility
(1) Labor cost (Lab)	Step 1	AMA		13.32	77.52	5.74	5.74	0.00	5.10	5.10	0.00
(2) Supply cost (Sup)	Step 1	AMA		2.98	7.34	3.39	3.39	0.00	1.19	1.19	0.00
(3) Equipment cost (Eqp)	Step 1	AMA		0.17	0.58	7.24	7.24	0.00	0.09	0.09	0.00
(4) Direct cost (Dir)	Step 1		=(1)+(2)+(3)	16.48	85.45	16.38	16.38	0.00	6.38	6.38	0.00
(5) Direct adjustment (Dir. Adj.).	Steps 2–4	See footnote *		0.5511	0.5511	0.5511	0.5511	0.5511	0.5511	0.5511	0.5511
(6) Adjusted Labor	Steps 2–4	=Lab * Dir Adj	=(1)*(5)	7.34	42.72	3.16	3.16	0.00	2.81	2.81	0.00
(7) Adjusted Supplies	Steps 2–4	=Eqp * Dir Adj	=(2)*(5)	1.64	4.05	1.87	1.87	0.00	0.66	0.66	0.00
(8) Adjusted Equipment	Steps 2–4	=Sup * Dir Adj	=(3)*(5)	0.10	0.32	3.99	3.99	0.00	0.05	0.05	0.00
(9) Adjusted Direct	Steps 2–4		=(6)+(7)+(8)	9.08	47.09	9.03	9.03	0.00	3.52	3.52	0.00
(10) Conversion Factor (CF)	Step 5	PFS		34.0230	34.0230	34.0230	34.0230	34.0230	34.0230	34.0230	34.0230
(11) Adj. labor cost converted.	Step 5	=(Lab * Dir Adj)/CF	=(6)/(10)	0.22	1.26	0.09	0.09	0.00	0.08	0.08	0.00
(12) Adj. supply cost converted.	Step 5	=(Sup * Dir Adj)/CF	=(7)/(10)	0.05	0.12	0.05	0.05	0.00	0.02	0.02	0.00
(13) Adj. equipment cost converted.	Step 5	=(Eqp * Dir Adj)/CF	=(8)/(10)	0.00	0.01	0.12	0.12	0.00	0.00	0.00	0.00
(14) Adj. direct cost converted.	Step 5		=(11)+(12)+(13)	0.27	1.38	0.27	0.27	0.00	0.10	0.10	0.00
(15) Work RVU	Setup File	PFS		0.97	33.75	0.22	0.00	0.22	0.17	0.00	0.17
(16) Dir_pct	Steps 6,7	Surveys		0.31	0.18	0.31	0.31	0.31	0.31	0.31	0.31
(17) Ind_pct	Steps 6,7	Surveys		0.69	0.82	0.69	0.69	0.69	0.69	0.69	0.69
(18) Ind. Alloc. Formula (1st part).	Step 8	See Step 8		((14)/(16))*(17)	((14)/(16))*(17)	((14)/(16))*(17)	((14)/(16))*(17)	((14)/(16))*(17)	((14)/(16))*(17)	((14)/(16))*(17)	((14)/(16))*(17)
(19) Ind. Alloc.(1st part)	Step 8		See 18	0.81	6.51	0.65	0.65	0	0.26	0.26	0
(20) Ind. Alloc. Formula (2nd part).	Step 8	See Step 8		(15)	(15)	(15+11)	(11)	(15)	(15+11)	(11)	(15)
(21) Ind. Alloc.(2nd part)	Step 8		See 20	0.97	33.75	0.31	0.09	0.22	0.25	0.08	0.17
(22) Indirect Allocator (1st + 2nd).	Step 8		=(19)+(21)	1.78	40.26	0.96	0.74	0.22	0.51	0.34	0.17
(23) Indirect Adjustment (Ind. Adj.).	Steps 9–11	See Footnote **		0.3848	0.3848	0.3848	0.3848	0.3848	0.3848	0.3848	0.3848
(24) Adjusted Indirect Allocator.	Steps 9–11	=Ind Alloc * Ind Adj		0.68	15.49	0.37	0.29	0.08	0.20	0.13	0.07
(25) Ind. Practice Cost Index (IPCI).	Steps 12–16			1.07	0.76	0.95	0.95	0.95	0.91	0.91	0.91
(26) Adjusted Indirect	Step 17	= Adj.Ind Alloc * PCI	=(24)*(25)	0.73	11.74	0.35	0.27	0.08	0.18	0.12	0.06
(27) PE RVU	Step 18	=(Adj Dir + Adj Ind) * Other Adj.	=((14)+(26)) * Other Adj)	1.00	13.08	0.63	0.55	0.08	0.28	0.22	0.06

Note: PE RVUs in Table 5, row 27, may not match Addendum B due to rounding.

* The direct adj = [current pe rvus * CF * avg dir pct]/[sum direct inputs] = [step2]/[step3]

** The indirect adj = [current pe rvus * avg ind pct]/[sum of ind allocators] = [step9]/[step10]

Note: The use of any particular conversion factor (CF) in Table 5 to illustrate the PE Calculation has no effect on the resulting RVUs.

Note: The Other Adjustment includes an adjustment for the equipment utilization change.

3. Adjusting RVUs To Match PE Share of the Medicare Economic Index (MEI)

For CY 2014, as explained in detail in section II.D of this final rule with comment period, we are finalizing revisions to the MEI based on the recommendations of the MEI Technical Advisory Panel (TAP). The MEI is an index that measures the price change of the inputs used to furnish physician services. This measure was authorized by statute and is developed by the CMS Office of the Actuary. We believe that the MEI is the best measure available of the relative weights of the three components in payments under the PFS—work, PE and malpractice. Accordingly, we believe that to assure that the PFS payments reflect the resources in each of these components as required by section 1848(c)(3) of the Act, the RVUs used in developing rates should reflect the same weights in each component as the MEI. We proposed to accomplish this by holding the work RVUs constant and adjusting the PE RVUs, the MP RVUs and the CF to produce the appropriate balance in RVUs among components and payments. In the proposed rule and above, we detailed the steps necessary to accomplish this result (see steps 3, 10, and 18).

This proposed adjustment is consistent with our longstanding practice to make adjustments to match the RVUs for the PFS components with the MEI cost share weights for the components, including the adjustments described in the CY 1999 PFS Final Rule (63 FR 58829), CY 2004 PFS Final Rule 68 FR 63246–63247, and CY 2011 PFS Final Rule (75 FR 73275). We note that the revisions to the MEI finalized in section II.D of this final rule are made to the MEI as rebased for CY 2011, and that the RVUs we proposed for CY 2014 reflect the weights of the MEI as rebased for CY 2011 and revised for CY 2014. As such, the relationships among the work, PE, and malpractice RVUs under the PFS are aligned with those under the revised 2006-based MEI.

Comment: Several commenters requested explanation regarding the relationship between the proposed MEI revision and the proposed RVUs. One commenter suggested that it would be better to scale the work RVUs upward instead of scaling the PE RVUs downward to achieve the weighting adjustment.

Response: The change in the relationship among work, PE, and malpractice RVUs could be accomplished by applying adjustments directly to the work, PE, and malpractice RVUs or by holding the RVUs constant for one component, scaling the other two components and applying a budget neutrality adjustment to the conversion factor. We proposed to make the adjustment by holding work RVUs constant consistent with prior adjustments and in response to many public comments made during previous rulemaking (see, for example, 75 FR 73275) indicating a strong preference and persuasive arguments in favor of keeping the work RVUs stable over.time since work RVUs generally only change based on reviews of particular services. In contrast, PE RVUs are developed annually, irrespective of changes in the direct PE inputs for particular services, so that scaling of PE RVUs is less disruptive to the public review of values that determine PFS payment rates. We took this approach for the CY 2014 adjustment because we believe the methodology and reasons for making the adjustment in this way are settled and remain valid. For these reasons, we are finalizing the proposed rebasing of the relationship among RVU components by holding the work RVUs constant, decreasing the PE RVUs and the MP RVUs, and applying a budget neutrality adjustment to the CF.

Comment: Several commenters argued that the RVU components should not be weighted consistent with the revised MEI as it was it was entirely appropriate to include nurse practitioner and physician assistant wages in the physician practice expense calculation because physicians often employ nurse practitioners, physician assistants and other non-physicians.

Response: We refer commenters to section II.D. of the final rule with comment period regarding the appropriate classification of wages in the MEI. Regarding classification of labor inputs in the RVU components, the decision as to whether something should be considered a practice expense or work under the PFS does not depend on the employment status of the health care professional furnishing the service. Resource inputs are classified based on whether they relate to the "work" or "practice expense" portion of a service. The clinical labor portion of the direct PE input database includes the portion of services provided by practitioners who do not bill Medicare directly, such as registered nurses and other clinical labor. We do not include in this category the costs of nurse practitioners and others who can bill Medicare directly. Under the PFS, the work component of a service is valued based on the work involved in furnishing the typical service. The value is the same whether the service is billed by a physician or another practitioner (such as a nurse practitioner or physician assistant) who is permitted to bill Medicare directly for the service. We acknowledge that these practitioners may perform a variety of services in a physician office—some of which would be included in the work portion and others that would be included in the PE portion as clinical labor. Similarly, it is not unusual for physicians to hire other physicians to work in their practices, but we likewise do not consider those costs to be part of the clinical labor that is included as a practice expense. Since values for services under the PFS are based upon the typical case rather than the type of practitioner that performs the service in a particular situation, we continue to believe it is appropriate to include the work performed by professionals eligible to bill Medicare directly in the work component of PFS payments, even in cases when they are employed by physicians.

Additionally, we note that none of the commenters who questioned the appropriate accounting for the work of these nonphysician practitioners addressed how it would be appropriate to treat the costs for these nonphysician practitioners differently for purposes of calculating RVUs and the MEI. The labor of nonphysician practitioners who can bill independently for their services under the PFS is considered as work under the physician fee schedule since these services are also furnished by physicians and the RVUs for these PFS services do not vary based on whether furnished by a physician or nonphysician. As such, we believe that the change in the MEI to shift these costs from the PE to the work category as described in section II.D. of this final rule with comment period is entirely consistent with the PFS in this regard.

We would also note that the change in the MEI was recommended by the MEI TAP that identified a discrepancy between how the work of non-physician practitioners is captured in the RVUs, how billing works under the PFS, and how costs are accounted for in the MEI. With the change in the MEI being finalized in this final rule with comment period, we continue to believe that the MEI weights are the best reflection of the PFS component weights, and we believe it is appropriate to finalize this adjustment in the RVUs as well.

Comment: Several commenters strongly urged the agency, in adjusting weights among the PFS components to reflect the MEI cost weight changes, to consider alternative methodologies that would mitigate the redistribution of RVUs from the PE to the work category. These commenters pointed out that the

practitioners who furnish services with a higher proportion of PE RVUs are hit hardest by these changes. These comments also suggested that CMS should consider postponing this adjustment of the RVUs until such a methodology can be vetted.

Several commenters suggested that, given the magnitude of the reductions, CMS should consider a phase-in of this change. These commenters pointed out that CMS has used a phase-in approach in the past to mitigate the effects of methodological changes to the calculation of payment rates under the MPFS, including a four-year phase-in of the transition from the top-down to the bottom-up methodology of calculating direct PE RVUs.

Response: We appreciate that the increase in the work RVUs relative to PE RVUs will generally result in lower payments for practitioners who furnish more services with a higher proportion of PE RVUs. However, we continue to believe that the MEI cost share weights are the best reflection of the PFS component weights. The CY 2014 revisions to the MEI, following the rebasing for 2011 and consideration by the MEI TAP, reflect the best available information. As such, we believe that the relationship among the RVU components should conform to the revised cost weights adopted for the MEI.

While we understand and recognize the general preference to avoid significant year-to-year reductions in Medicare payment, including practitioners' interests in phasing in any reduction, and we acknowledge that this revision of the PFS component weights results in an increase in work RVUs relative to PE RVUs, we note that the 2011 rebasing of the MEI resulted in a change of greater magnitude that increased the PE RVUs relative to work RVUs. That change was not phased in. Based on consideration of these comments, we are finalizing as proposed the adjustment to the relationship among the work, PE, and malpractice component RVUs to reflect the MEI cost share being finalized in this final rule with comment period, with the necessary adjustment to the conversion factor and to PE and MP RVUs to maintain budget neutrality.

4. Changes to Direct PE Inputs for Specific Services

In this section, we discuss other CY 2014 proposals and revisions related to direct PE inputs for specific services. The final direct PE inputs are included in the final rule with comment period CY 2014 direct PE input database, which is available on the CMS Web site under under downloads for the CY 2014 PFS final rule with comment period at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html.*

a. Anomalous Supply Inputs

In the CY 2013 PFS final rule with comment period, we established interim final direct PE inputs based on acceptance, with refinement, of recommendations submitted by the AMA RUC. Although we generally address public comments on the current year's interim final direct PE inputs in the following year's final rule with comment period, several commenters raised an issue regarding anomalous supply items for codes that were not subject to comment in the CY 2013 final rule with comment period. Since changes were being suggested to codes not subject to comment, we believed these comments were best addressed through proposed revisions to the direct PE inputs in the proposed rule allowing the opportunity for public comment before implementation.

For the CY 2013 interim final direct PE inputs for a series of codes that describe six levels of surgical pathology services (CPT codes 88300, 88302, 88304, 88305, 88307, 88309), we did not accept the AMA RUC recommendation to create two new direct PE supply inputs because we did not consider these items to be disposable supplies (77 FR 69074) and thus they did not meet the criteria for direct PE inputs. These items were called "specimen, solvent, and formalin disposal cost," and "courier transportation costs." In the CY 2013 PFS final rule with comment period, we explained that neither the specimen and supply disposal nor courier costs for transporting specimens are appropriately considered disposable medical supplies. Instead, we stated these costs are incorporated into the PE RVUs for these services through the indirect PE allocation. We also noted that the current direct PE inputs for these and similar services across the PFS do not include these kinds of costs as disposable supplies.

Several commenters noted that, contrary to our assertion in the CY 2013 final rule with comment period, there are items incorporated in the direct PE input database as "supplies" that are no more disposable supplies than the new items recommended by the AMA RUC for the surgical pathology codes. These commenters identified seven supply inputs in particular that they believe are analogous to the items that we did not accept in establishing CY 2013 interim final direct PE inputs. These items and their associated HCPCS codes are listed in Table 6.

TABLE 6—ITEMS IDENTIFIED BY COMMENTERS

CMS supply code	Item description	Affected CPT codes
SK106	device shipping cost	93271, 93229, 93268.
SK112	Federal Express cost (average across all zones)	64650, 88363, 64653.
SK113	communication, wireless per service	93229.
SK107	fee, usage, cycletron/accelerator, gammaknife, Lincac SRS System.	77423, 77422.
SK110	fee, image analysis	96102, 96101, 99174.
SK111	fee, licensing, computer, psychology	96102, 96101, 96103, 96120.
SD140	bag system, 1000ml (for angiographywaste fluids)	93451, 93452, 93453, 93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461.

We reviewed each of these items for consistency with the general principles of the PE methodology regarding the categorization of all costs. Within the PE methodology, all costs other than clinical labor, disposable supplies, and medical equipment are considered indirect costs. For six of the items contained in Table 6, we agreed with the commenters that the items should not be considered disposable supplies. We believed that these items are more appropriately categorized as indirect PE costs, which are reflected in the allocation of indirect PE RVUs rather than through direct PE inputs. Therefore, we proposed to remove the following six items from the direct PE

input database for CY 2014: "device shipping cost" (SK106); "Federal Express cost (average across all zones)" (SK112); "communication, wireless per service" (SK113); "fee, usage, cycletron/accelerator, gammaknife, Lincac SRS System" (SK107); "fee, image analysis" (SK110); and "fee, licensing, computer, psychology" (SK111).

In the case of the supply item called "bag system, 1000ml (for angiography waste fluids)" (SD140), we did not agree with the commenters that this item is analogous to the specimen disposal costs recommended for the surgical pathology codes. This supply input represents only the costs of the disposable material items associated with the removal of waste fluids that typically result from a particular procedure. In contrast, the item recommended by the AMA RUC for surgical pathology consisted of an amortized portion of a specimen disposal contract that includes costs for resources such as labor and transportation. Furthermore, we did not believe that the specimen disposal contract is attributable to individual procedures within the established PE methodology. We believe that a disposable supply is one that is attributable, in its entirety, to an individual patient for a particular service. An amortized portion of a specimen disposal contract does not meet these criteria. Accordingly, as stated in the CY 2013 final rule with comment period, we did not accept the AMA RUC recommendation to create a new supply item related to specimen disposal costs. We believe that many physician offices and other nonfacility settings where Medicare beneficiaries receive services incur costs related to waste management or other service contracts, but none of these costs are currently incorporated into the PE methodology as disposable supplies. Instead, these costs are appropriately categorized as indirect costs, which are reflected in the PE RVUs through the allocation of indirect PE. We clarified that we believe that supply costs related to specimen disposal attributable to individual services may be appropriately categorized as disposable supplies, but that specimen disposal costs related to an allocated portion of service contracts cannot be attributed to individual services and should not be incorporated into the direct PE input database as disposable supplies.

Moreover, because we do not agree with commenters that the "bag system, 1000ml (for angiography waste fluids)" (SD140) is analogous to a specimen disposal contract for the reasons state above, we continued to believe that SD140 is a direct expense. Accordingly, we did not propose to remove SD140 from the direct PE input database.

Comment: One commenter objected to CMS's proposal to remove the "device shipping cost" (SK106) and "communication, wireless per service" (SK113) from the direct PE input database as they are more analogous to the angiography waste fluid bag system than the other items since both items represent costs associated with a specific procedure rather than an amortization of costs associated with a service contract.

Response: We agree with the commenter that both of these items may represent costs associated with a specific procedure. However, as we articulated in making the proposal to remove these items, we do not believe these items are disposable supplies and we believe all costs other than clinical labor, disposable supplies, and medical equipment should be considered indirect costs in order to maintain consistency and relativity within the PE methodology. We believe that there are a variety of costs allocable to individual services that are appropriately considered part of indirect cost categories for purposes of the PE methodology. Were all these included as direct PE inputs for services across the PFS, regardless of whether or not the items were reasonably described as clinical labor, disposable supplies, or medical equipment, then the relationship between direct and indirect costs would be significantly skewed. This skewing could be compounded since the amount of indirect PE allocated to particular codes is partly determined by the amount of direct costs associated with the codes. Therefore, the inaccurate inclusion of indirect costs as direct costs would not only result in duplicative accounting for the items (as both indirect and direct PE costs) but also an additional allocation of indirect PE based on the item's inclusion as a direct cost. Therefore, we are finalizing removal of these items from the direct PE input database as proposed.

Comment: Several commenters suggested that CMS should change its understanding of direct and indirect practice expense items. One commenter suggested that all variable costs proportional to the number of services furnished per day be considered direct. Another commenter suggested that the only costs that can be considered indirect costs are those that are required by all services, those that do not vary from one service type to the next; and those that are not based on service volume. Therefore CMS should allow all other recommended direct PE inputs to be allowed as direct PE inputs.

Response: We note that there is a longstanding PE methodology, established through notice and comment rulemaking that includes principles for determining whether an expense is direct or indirect. Under the established PE methodology, whether or not a particular cost is variable has little bearing on the appropriate classification of a particular item as a direct or indirect cost. Although we have previously pointed out that the current methodology does not accommodate costs that cannot be allocated to particular services as direct costs, this does not mean that all costs that can be allocated to particular services are necessarily direct costs. Instead, a significant number of costs considered to be indirect for purposes of the PE methodology are variable costs proportional to the kind and number of services furnished each day. For example, administrative and clerical resource costs associated with medical billing are likely to be incurred with each service furnished. Presumably, practitioners incur greater resource cost associated with administrative and clerical labor and supplies based on the volume of services furnished. Similarly, some kinds of services may require more administrative resources than others. Some complex services, for example, may require advance or follow-up administrative work that is not required for less complex services. General office expenses may also vary depending on the number and kind of services furnished. For example, practices that furnish a greater number of services to a greater number of patients generally require larger waiting rooms and additional waiting room furniture. Other services such as those that are furnished without having the patient present may not require patient waiting rooms at all. We note that some services require a different amount of electricity than others and some require more space than others. We believe that the PE methodology accounts for these costs in the allocation of indirect PE RVUs included in the payment rate for each service furnished to Medicare beneficiaries. We do not believe it would appropriate in the current methodology to include all such variable costs as direct PE inputs. Therefore, we do not agree with commenters' assertions regarding the appropriateness of these items as direct costs. Instead, we continue to believe that these costs represent indirect costs that are incorporated in the PE RVUs for these services through the allocation of

indirect PE RVUs. We also direct readers to section II.E.2.b. of this final rule for a discussion of comments received regarding the CY 2013 interim final direct PE inputs for surgical pathology services.

After consideration of these comments, we are finalizing our proposal to remove the specified anomalous supply items from the direct PE input database. The CY 2014 direct PE input database and the PE RVUs displayed in Addendum B of this final rule with comment period reflect the finalization of this proposal.

b. Direct PE Input Refinements Based on Routine Data Review

In reviewing the direct PE input database, we identified several discrepancies that we proposed to address for CY 2014. In the following paragraphs, we identify the nature of these discrepancies, the affected codes, and the adjustments proposed in the CY 2014 proposed rule direct PE input database. As part of our internal review of information in the direct PE input database, we identified supply items that appeared without quantities for CPT code 51710 (Change of cystostomy tube; complicated). Upon reviewing these items we believed that the code should include the items at the quantities listed in Table 7.

TABLE 7—SUPPLY ITEMS AND QUANTITIES FOR CPT CODE 51710

Supply code	Description of supply item	NF quantity
SA069	tray, suturing	1.0
SB007	drape, sterile barrier 16in x 29in.	1.0
SC029	needle, 18–27g	1.0
SC051	syringe 10–12ml	1.0
SD024	catheter, Foley	1.0
SD088	Guidewire	1.0
SF036	suture, nylon, 3–0 to 6–0, c.	1.0
SG055	gauze, sterile 4in x 4in	1.0
SG079	tape, surgical paper 1in (Micropore).	6.0
SH075	water, sterile inj	3.0
SJ032	lubricating jelly (K–Y) (5gm uou).	1.0
SJ041	povidone soln (Betadine)	20.0

Upon reviewing the direct PE inputs for CPT code 51710 and the related code 51705 (Change of cystostomy tube; simple), we also noted that the direct PE input database includes an anomalous 0.5 minutes of clinical labor time in the post-service period. We believe that this small portion of clinical labor time is the result of a rounding error in our data and should be removed from the direct PE input database.

Comment: One commenter supported the inclusion of the supply items for CPT code 51710. We received no comments regarding the change in clinical labor time for codes 51710 and 51705.

Response: Based on these comments and for the reasons stated, we are finalizing the removal of these items in the CY 2014 final direct PE input database.

During our review of the data, we noted an invalid supply code (SM037) that appears in the direct PE input database for CPT codes 88312 and 88313. Upon review of the code, we believe that the supply item called "wipes, lens cleaning (per wipe) (Kimwipe)" (SM027) should be included for these codes instead of the invalid supply code. We did not receive any comments regarding this proposed revision. Therefore, we are finalizing this revision as proposed for CY 2014.

Additionally, we conducted a routine review of the codes valued in the nonfacility setting for which moderate sedation is inherent in the procedure. Consistent with the standard moderate sedation package finalized in the CY 2012 PFS final rule with comment period (76 FR 73043), we have made minor adjustments to the nurse time and equipment time for 18 of these codes. These codes appear in Table 8.

Comment: One commenter agreed with this proposal to standardize moderate sedation inputs for codes valued in the nonfacility setting. We received no comments on the correction on the invalid supply item.

Response: After considering this comment, we are finalizing the minor adjustments to the moderate sedation inputs as proposed. The CY 2014 direct PE database reflects these adjustments.

TABLE 8—CODES WITH MINOR ADJUSTMENTS TO MODERATE SEDATION INPUTS

CPT Code	Descriptor
31629 ..	Bronchoscopy/needle bx each.
31645 ..	Bronchoscopy clear airways.
31646 ..	Bronchoscopy reclear airway.
32405 ..	Percut bx lung/mediastinum.
32550 ..	Insert pleural cath.
35471 ..	Repair arterial blockage.
37183 ..	Remove hepatic shunt (tips).
37210 ..	Embolization uterine fibroid.
43453 ..	Dilate esophagus.
43458 ..	Dilate esophagus.
44394 ..	Colonoscopy w/snare.
45340 ..	Sig w/balloon dilation.
47000 ..	Needle biopsy of liver.
47525 ..	Change bile duct catheter.
49411 ..	Ins mark abd/pel for rt perq.
50385 ..	Change stent via transureth.
50386 ..	Remove stent via transureth.
57155 ..	Insert uteri tandem/ovoids.
93312 ..	Echo transesophageal.
93314 ..	Echo transesophageal.
G0341	Percutaneous islet celltrans.

c. Adjustments to Pre-Service Clinical Labor Minutes

As we noted in the CY 2014 PFS proposed rule, we had recently received a recommendation from the AMA RUC regarding appropriate pre-service clinical labor minutes in the facility setting for codes with 000-day global periods. In general, the AMA RUC recommended that codes with 000-day global period include a maximum of 30 minutes of clinical labor time in the pre-service period in the facility setting. The AMA RUC identified 48 codes that currently include more clinical labor time than this recommended maximum and provided us with recommended pre-service clinical labor minutes in the facility setting of 30 minutes or fewer for these 48 codes. We reviewed the AMA RUC's recommendation and agree that the recommended reductions would be appropriate to maintain relativity with other 000-day global codes. Therefore, we proposed to amend the pre-service clinical labor minutes for the codes listed in Table 9, consistent with the AMA RUC recommendation.

Comment: One commenter supported this proposal based on the AMA RUC's recommendation.

Response: After considering the supporting comment, we are finalizing these changes as proposed. The CY 2014 direct PE input database reflects these changes.

TABLE 9—000-DAY GLOBAL CODES WITH CHANGES TO PRE-SERVICE CL TIME

CPT code	Short descriptor	Existing CL Pre-Service facility minutes	CL Pre-Service facility minutes (AMA RUC recommendation)
20900	Removal of bone for graft	60	30
20902	Removal of bone for graft	60	30
33224	Insert pacing lead & connect	35	30
33226	Reposition l ventric lead	35	30
36800	Insertion of cannula	60	0
36861	Cannula declotting	37	0
37202	Transcatheter therapy infuse	45	0
50953	Endoscopy of ureter	60	30
50955	Ureter endoscopy & biopsy	60	30
51726	Complex cystometrogram	41	30
51785	Anal/urinary muscle study	34	30
52250	Cystoscopy and radiotracer	37	30
52276	Cystoscopy and treatment	32	30
52277	Cystoscopy and treatment	37	30
52282	Cystoscopy implant stent	31	30
52290	Cystoscopy and treatment	31	30
52300	Cystoscopy and treatment	36	30
52301	Cystoscopy and treatment	36	30
52334	Create passage to kidney	31	30
52341	Cysto w/ureter stricture tx	42	30
52342	Cysto w/up stricture tx	42	30
52343	Cysto w/renal stricture tx	42	30
52344	Cysto/uretero stricture tx	55	30
52345	Cysto/uretero w/up stricture	55	30
52346	Cystouretero w/renal strict	55	30
52351	Cystouretero & or pyeloscope	45	30
52352	Cystouretero w/stone remove	50	30
52353	Cystouretero w/lithotripsy	50	30
52354	Cystouretero w/biopsy	50	30
52355	Cystouretero w/excise tumor	50	30
54100	Biopsy of penis	33	30
61000	Remove cranial cavity fluid	60	15
61001	Remove cranial cavity fluid	60	15
61020	Remove brain cavity fluid	60	15
61026	Injection into brain canal	60	15
61050	Remove brain canal fluid	60	15
61055	Injection into brain canal	60	15
61070	Brain canal shunt procedure	60	15
62268	Drain spinal cord cyst	36	30
67346	Biopsy eye muscle	42	30
68100	Biopsy of eyelid lining	32	30
93530	Rt heart cath congenital	35	30
93531	R & l heart cath congenital	35	30
93532	R & l heart cath congenital	35	30
93533	R & l heart cath congenital	35	30
93580	Transcath closure of asd	35	30
93581	Transcath closure of vsd	35	30

d. Price Adjustment for Laser Diode

As we noted in the CY 2013 PFS proposed rule, it has come to our attention that the price associated with the equipment item called "laser, diode, for patient positioning (Probe)" (ER040) in the direct PE input database is $7,678 instead of $18,160 as listed in the CY 2013 PFS final rule with comment period (77 FR 68922). We proposed to revise the direct PE input database to reflect the corrected price.

Comment: Several commenters expressed support for this proposal.

Response: We appreciate the commenters' support and have revised the CY 2014 final direct PE input database as proposed.

e. Direct PE Inputs for Stereotactic Radiosurgery (SRS) Services (CPT Codes 77372 and 77373)

Since 2001, Medicare has used HCPCS G-codes, in addition to the CPT codes, for stereotactic radiosurgery (SRS) to distinguish robotic and non-robotic methods of delivery. Based on our review of the current SRS technology, it is our understanding that most services currently furnished with linac-based SRS technology, including services currently billed using the non-robotic codes, incorporate some type of robotic feature. Therefore, we believe that it is no longer necessary to continue to distinguish robotic versus non-robotic linac-based SRS through the HCPCS G-codes. For purposes of the hospital outpatient prospective payment system (OPPS), we proposed to replace the existing four SRS HCPCS G-codes G0173 (Linear accelerator based stereotactic radiosurgery, complete course of therapy in one session),

G0251(Linear accelerator based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, maximum five sessions per course of treatment), G0339 (Image-guided robotic linear accelerator-based stereotactic radiosurgery, complete course of therapy in one session or first session of fractionated treatment), and G0340 (Image-guided robotic linear accelerator-based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, second through fifth sessions, maximum five sessions per course of treatment), with the SRS CPT codes 77372 (Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based) and 77373 (Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions) that do not distinguish between robotic and non-robotic methods of delivery. We refer readers to section II.C.3 of the CY 2014 OPPS proposed rule for more discussion of that proposal. We also refer readers to the CY 2007 OPPS final rule (71 FR 68023 through 68026) for a detailed discussion of the history of the SRS codes.

Two of the four current SRS G-codes are paid in the nonfacility setting through the PFS. These two codes, G0339 and G0340, describe robotic SRS treatment delivery and are contractor-priced. CPT codes 77372 and 77373, which describe SRS treatment delivery without regard to the method of delivery, are currently paid in the nonfacility setting based on resource-based RVUs developed through the standard PE methodology. We noted in the proposed rule that if the CY 2014 OPPS proposal were finalized, it would appear that there would no longer be a need for G-codes to describe robotic SRS treatment and delivery. We did not propose to replace the contractor-priced G-codes for PFS payment but did seek comment from the public and stakeholders, including the AMA RUC, regarding whether or not the direct PE inputs for CPT codes 77372 and 77373 would continue to accurately estimate the resources used in furnishing typical SRS delivery were there no coding distinction between robotic and non-robotic methods of delivery.

Comment: Several commenters, including the AMA RUC, responded to our request for information regarding whether the direct PE inputs for CPT codes 77372 and 77373 would continue to accurately estimate the resources used in furnishing typical SRS delivery were there no coding distinction between robotic and non-robotic methods of delivery. Most commenters, including the AMA RUC, stated that the most recently recommended direct PE inputs for these services would accurately estimate the resources. One commenter suggested this was not the case and that CMS should maintain the G-codes for purposes of PFS payment.

Response: We appreciate stakeholders' responsiveness to our request for information. We will consider the information submitted in public comments as we consider future rulemaking for these codes.

2. Using OPPS and ASC Rates in Developing PE RVUs

We typically establish two separate PE RVUs for services that can be furnished in either a nonfacility setting, like a physician's office, or a facility setting, like a hospital. The nonfacility PE RVUs reflect all of the direct and indirect practice expenses involved in furnishing a particular service when the entire service is furnished in a nonfacility setting. The facility PE RVUs reflect the direct and indirect practice expenses associated with furnishing a particular service in a setting such as a hospital or ASC where those facilities incur a portion or all of the costs and receive a separate Medicare payment for the service.

When services are furnished in the facility setting, such as a HOPD or an ASC, the total combined Medicare payment (made to the facility and the professional) typically exceeds the Medicare payment made for the same service when furnished in the physician office or other nonfacility setting. We believe that this payment difference generally reflects the greater costs that facilities incur than those incurred by practitioners furnishing services in offices and other nonfacility settings. For example, hospitals incur higher overhead costs because they maintain the capability to furnish services 24 hours a day and 7 days per week, generally furnish services to higher acuity patients than those who receive services in physicians' offices, and have additional legal obligations such as complying with the Emergency Medical Treatment and Labor Act (EMTALA). Additionally, hospitals must meet conditions of participation and ASCs must meet conditions for coverage in order to participate in Medicare.

However, we have found that for some services, the total Medicare payment when the service is furnished in the physician office setting exceeds the total Medicare payment when the service is furnished in an HOPD or an ASC. When this occurs, we believe it is not the result of appropriate payment differentials between the services furnished in different settings. Rather, we believe it is due to anomalies in the data we use under the PFS and in the application of our resource-based PE methodology to the particular services.

The PFS PE RVUs rely heavily on the voluntary submission of information by individuals furnishing the service and who are paid at least in part based on the data provided. Currently, we have little means to validate whether the information is accurate or reflects typical resource costs. Furthermore, in the case of certain direct costs, like the price of high-cost disposable supplies and expensive capital equipment, even voluntary information has been very difficult to obtain. In some cases the PE RVUs are based upon single price quotes or one paid invoice. We have addressed these issues extensively in previous rulemaking (for example, 75 FR 73252). Such incomplete, small sample, potentially biased or inaccurate resource input costs may distort the resources used to develop nonfacility PE RVUs used in calculating PFS payment rates for individual services.

In addition to the accuracy issues with some of the physician PE resource inputs, the data used in the PFS PE methodology can often be outdated. As we have previously noted (77 FR 68921) there is no practical means for CMS or stakeholders to engage in a complete simultaneous review of the input resource costs for all HCPCS codes paid under the PFS on an annual or even regular basis. Thus, the information used to estimate PE resource costs for PFS services is not routinely updated. Instead, we strive to maintain relativity by reviewing at the same time the work RVUs, physician time, and direct PE inputs for a code, and reviewing all codes within families of codes where appropriate. Nonetheless, outdated resource input costs may distort RVUs used to develop nonfacility PFS payment rates for individual services. In the case of new medical devices for which a high growth in the volume of a service as it diffuses into clinical practice may lead to a decrease in the cost of expensive items, outdated price inputs can result in significant overestimation of resource costs.

Such inaccurate resource input costs may distort the nonfacility PE RVUs used to calculate PFS payment rates for individual services. As we have previously noted, OPPS payment rates are based on auditable hospital data and are updated annually. Given the

differences in the validity of the data used to calculate payments under the PFS and OPPS, we believe that the nonfacility PFS payment rates for procedures that exceed those for the same procedure when furnished in a facility result from inadequate or inaccurate direct PE inputs, especially in price or time assumptions, as compared to the more accurate OPPS data. On these bases, we proposed a change in the PE methodology beginning in CY 2014. To improve the accuracy of PFS nonfacility payment rates for each calendar year, we proposed to use the current year OPPS or ASC rates as a point of comparison in establishing PE RVUs for services under the PFS. In setting PFS rates, we proposed to compare the PFS payment rate for a service furnished in an office setting to the total combined Medicare payment to practitioners and facilities for the same service when furnished in a hospital outpatient setting. For services on the ASC list, we proposed to make the same comparison except we would use the ASC rate as the point of comparison instead of the OPPS rate.

We proposed to limit the nonfacility PE RVUs for individual codes so that the total nonfacility PFS payment amount would not exceed the total combined amount that Medicare would pay for the same code in the facility setting. That is, if the nonfacility PE RVUs for a code would result in a higher payment than the corresponding combined OPPS or ASC payment rate and PFS facility PE RVUs (when applicable) for the same code, we would reduce the nonfacility PE RVU rate so that the total nonfacility payment does not exceed the total Medicare payment made for the service in the facility setting. To maintain the greatest consistency and transparency possible, we proposed to use the current year PFS conversion factor. Similarly, we proposed to use current year OPPS or ASC rates in the comparison. For services with no work RVUs, we proposed to compare the total nonfacility PFS payment to the OPPS payment rates directly since no PFS payment is made for these services when furnished in the facility setting.

We proposed to exempt the following services from this policy:

- *Services Without Separate OPPS Payment Rates:* We proposed to exclude services without separately payable OPPS rates from this methodical change since there would be no OPPS rate to which we could compare the PFS nonfacility PE RVUs. We note that there would also be no ASC rate for these services since ASCs are only approved to furnish a subset of OPPS services.
- *Codes Subject to the DRA Imaging Cap:* We proposed to exclude from this policy services capped at the OPPS payment rate in accordance with the Deficit Reduction Act of 2005 (DRA) (Pub. L. 109–171). The DRA provision limits PFS payment for most imaging procedures to the amount paid under the OPPS system. This policy applies to the technical component of imaging services, including X-ray, ultrasound, nuclear medicine, MRI, CT, and fluoroscopy services. Screening and diagnostic mammograms are exempt. Since payment for these procedures is capped by statute we proposed to exclude them from this policy.
- *Codes with Low Volume in the OPPS or ASC:* We proposed to exclude any service for which 5 percent or less of the total number of services are furnished in the OPPS setting relative to the total number of PFS/OPPS allowed services.
- *Codes with ASC Rates Based on PFS Payment Rates:* To avoid issues of circularity, we proposed to exclude ASC services that are subject to the "office-based" procedure payment policies for which payment rates are based on the PFS nonfacility PE RVUs. We directed interested readers to the CY 2013 OPPS final rule (77 FR 68444) for additional information regarding this payment policy.
- *Codes Paid in the Facility at Nonfacility PFS Rates:* To avoid issues of circularity, we also proposed to exclude services that are paid in the facility setting at nonfacility payment rates.

This would include certain professional-only services where the resource costs for practitioners are assumed to be similar in both settings.

- *Codes with PE RVUs Developed Outside the PE Methodology:* We also proposed to exclude services with PE RVUs established through notice and comment rulemaking outside the PE Methodology.

Addendum B of the proposed rule displayed the PE RVUs that would result from implementation of the proposed change in the PE methodology.

In discussing resource input issues, some stakeholders have previously suggested that the direct costs (for example, clinical labor, disposable supplies and medical equipment) involved in furnishing a service are similar in both the nonfacility and facility settings. Others have suggested that facilities, like hospitals, have greater purchasing power for medical equipment and disposable supplies so that the direct costs for a facility to furnish a service can be lower than costs for a physician practice furnishing the same service. Our proposed policy did not assume that the direct costs to furnish a service in the nonfacility setting are always lower than in the facility setting. Medicare payment methodologies, including both OPPS and the PFS PE methodology, incorporate both direct and indirect costs (administrative labor, office expenses, and all other expenses). Our proposed policy was premised on the idea that there are significantly greater indirect resource costs that are carried by facilities even in the event that the direct costs involved in furnishing a service in the office and facility settings are comparable.

We stated our belief that our proposal provides a reliable means for Medicare to set upper payment limits for office-based procedures based on relatively more reliable cost information available for the same procedures when furnished in a facility setting where the cost structure would be expected to be somewhat, if not significantly, higher than the office setting. We believe that the current basis for estimating the resource costs involved in furnishing a PFS service is significantly encumbered by our current inability to obtain accurate information regarding supply and equipment prices, as well as procedure time assumptions. We believe that our proposed policy would mitigate the negative impact of these difficulties on both the appropriate relativity of PFS services and overall Medicare spending. A wide range of stakeholders and public commenters have pointed to the nonfacility setting as the most cost-effective location for services. Given the significantly higher cost structure of facilities (as discussed above) we believe that this presumption is accurate. In its March 2012 report to Congress, MedPAC recommended that Medicare should seek to pay similar amounts for similar services across payment settings, taking into account differences in the definitions of services and patient severity. (MedPAC March 2012 Report to Congress, page 46) We believe that the proposed change to our PFS PE methodology would more appropriately reflect resource costs in the nonfacility setting.

Comment: One commenter representing primary care physicians supported the proposal and indicated a belief that the proposed policy would help to correct misvaluation between primary care services and the services affected by the policy. Another commenter supported the policy as an interim step until an expedited review of the services could be conducted. Other commenters, while not

supporting the proposal due to the financial impact on certain services, stated that hospitals and ASCs do typically incur higher overhead costs in delivering services than physician offices.

The overwhelmingly majority of commenters objected to the proposed policy. Several commenters believed the services impacted by the policy were potentially misvalued, but still opposed our policy. Many commenters questioned whether facilities' costs for providing all services are necessarily higher than the costs of physicians or other practitioners. Commenters stated that the resources required to furnish services in nonfacility physician settings cannot be accurately measured using the OPPS methodology and that our proposal would result in rank order anomalies. Commenters indicated that it was inappropriate to base PFS payment on OPPS payment since a single APC contains multiple services that can involve a wide a range of costs that are averaged under the OPPS methodology. Many commenters also stated that since OPPS payment rates rely on the accuracy of APC payments, developed through hospitals accurately allocating their costs and charges to particular departments/APCs. These commenters stated that hospitals may have little incentive to accurately allocate their costs and charges to particular departments/APCs since they typically provide a broad range of services and therefore have the ability to make up for losses on one service with profits on another. The argument is that this ability makes the precise pricing of individual services less important in the OPPS system than it is in the physician setting. Also, the argument is that if physicians are going to be paid based upon the OPPS system it should be for all services so that like the hospitals they benefit from those overpaid in the hospital. Many commenters also questioned CMS' authority to use payment rates from other Medicare payment methodologies to cap PFS rates since they asserted the policy violated the statutory requirement that the PFS PE relative values be based on the resources used in furnishing the service. Some commenters also cited the financial impact of our proposed policy on the PFS rates as a further reason that the policy was inappropriate.

For all of these reasons, these commenters recommended that we not adopt the proposed policy. Many of these commenters also suggested modifications to the policy if CMS did decide to move forward. Commenters suggested that since the ASC rates reflect the OPPS relative weights to determine payment rates under the ASC payment system, and are not based on cost information collected from ASCs, the ASC rates should not be used in the proposed policy.

Commenters also stated a strong preference to use prospective year OPPS rates instead of current year OPPS rates as the point of comparison to prospective year PFS rates. The CY 2014 OPPS proposed rule proposed significant packaging that raised payment for many APCs, and therefore, raised the associated PFS cap rate.

Some commenters stated that they believed that CMS does not have authority to use any conversion factor in the policy other than the one calculated under existing law for CY 2014.

Commenters stated that the low-volume threshold (a minimum of 5 percent in the hospital outpatient setting) was proposed with insufficient rationale and recommended either a 50 percent threshold or an absolute volume threshold. Commenters also argued that there should be an ASC low-volume threshold for using ASC rates.

Commenters urged CMS to establish a means for stakeholders to demonstrate the validity of office costs relative to OPPS payments prior to implementing a cap for any particular code. Commenters also suggested that the AMA RUC should examine each code prior to the implementation of the policy for that code.

Commenters suggested excluding codes recently revalued, such as certain surgical pathology codes, from the cap as their resource inputs and costs are more accurate than those less recently revalued.

Commenters suggested that CMS should make the cap more transparent by identifying all affected codes and displaying the data used in establishing the capped values.

Several commenters suggested using the individual OPPS HCPCS code costs that are used to calculate the APC payment, rather than the APC payment rate itself, as a way of avoiding the problems caused by the averaging that goes on in calculating the APC rates. These commenters argued that individual code costs are a more appropriate comparison than APC payment rates.

Response: As we stated in the proposed rule, when services are furnished in the facility setting, such as an HOPD or ASC, the total Medicare payment (made to the facility and the professional combined) typically exceeds the Medicare payment made for the same service when furnished in the physician office or other nonfacility setting. We continue to believe that this payment difference generally reflects the greater costs that facilities incur compared to those incurred by practitioners furnishing services in offices and other non-facility settings. We also continue to believe that if the total Medicare payment when a service is furnished in the physician office setting exceeds the total Medicare payment when a service is furnished in an HOPD or an ASC, this is generally not the result of appropriate payment differentials between the services furnished in different settings. Rather, we continue to believe that it is primarily due to anomalies in the data we use under the PFS and in the application of our resource-based PE methodology to the particular services.

We greatly appreciate all of the comments that we received on our proposal. Given the many thoughtful and detailed technical comments that we received, we are not finalizing our proposed policy in this final rule with comment period. We will consider more fully all the comments received, including those suggesting technical improvements to our proposed methodology. After further consideration of the comments, we expect to develop a revised proposal for using OPPS and ASC rates in developing PE RVUs which we will propose through future notice and comment rulemaking.

At this time, we do not believe that our standard process for evaluating potentially misvalued codes, including the use of the AMA RUC is an effective means of addressing these codes. As we stated in the proposed rule, we do not believe that the direct practice expense information we currently use to value these codes is accurate or reflects typical resource costs. We have addressed these issues extensively in previous rulemaking (for example, 75 FR 73252) and again in section II.B.4. of this final rule with comment period. We believe the current review process for direct PE inputs only accommodates incomplete, small sample, and potentially biased or inaccurate resource input costs that may distort the resources used to develop nonfacility PE RVUs used in calculating PFS payment rates for individual services.

3. Ultrasound Equipment Recommendations

In the CY 2012 PFS proposed rule (76 FR 42796), we asked the AMA RUC to review the ultrasound equipment described in the direct PE input database. We specifically asked for review of the ultrasound equipment items described in the direct PE input database and whether the ultrasound

equipment listed for specific procedure codes is clinically necessary.

In response, the AMA RUC recommended creating several new equipment inputs in addition to the revision of current equipment inputs for ultrasound services. The AMA RUC also forwarded pricing information for new and existing equipment items from certain medical specialty societies that represent the practitioners who furnish these services. In the following paragraphs, we summarize the AMA RUC recommendations, address our review of the provided information, and describe a series of changes we proposed to the direct PE inputs used in developing PE RVUs for these services for CY 2014.

(1) Equipment Rooms

The AMA RUC made a series of recommendations regarding the ultrasound equipment items included in direct PE input equipment packages called "rooms." Specifically, the AMA RUC recommended adding several new equipment items to the equipment packages called "room, ultrasound, general" (EL015) and "room, ultrasound, vascular" (EL016). The AMA RUC also recommended creating a similar direct PE input equipment package called "room, ultrasound, cardiovascular." In considering these recommendations, we identified a series of new concerns regarding the makeup of these equipment packages and because there are several different ways to handle these concerns. In the CY 2014 PFS proposed rule we sought public comment from stakeholders prior to proposing to implement any of these recommended changes through future rulemaking.

We noted that the existing "rooms" for ultrasound technology include a greater number of individual items than the "rooms" for other kinds of procedures. For example, the equipment package for the "room, basic radiology" (EL012) contains only two items: an x-ray machine and a camera. Ordinarily under the PFS, direct PE input packages for "rooms" include only equipment items that are typically used in furnishing every service in that room. When equipment items beyond those included in a "room" are typically used in furnishing a particular procedure, the additional equipment items for that procedure are separately reflected in the direct PE input database in addition to the "room" rather than being included in the room. When handled in this way, the room includes only those inputs that are common to all services furnished in that room type, and thus the direct PE inputs are appropriate for the typical case of each particular service. When additional equipment items are involved in furnishing a particular service, they are included as an individual PE input only for that particular service.

In contrast, the equipment items currently included in the "room, ultrasound, general" are: the ultrasound system, five different transducers, two probe starter kits, two printers, a table, and various other items. In the proposed rule, we stated that we do not believe that it is likely that all of these items would be typically used in furnishing each service. For example, we do not believe that the typical ultrasound study would require the use of five different ultrasound transducers. However, the costs of all of these items are incorporated into the resource inputs for every service for which the ultrasound room is a direct PE input, regardless of whether each of those items is typically used in furnishing the particular service. This increases the resource cost for every service that uses the room regardless of whether or not each of the individual items is typically used in furnishing a particular procedure.

Instead of proposing to incorporate the AMA RUC's recommendation to add more equipment items to these ultrasound equipment "room" packages, we stated our intention to continue to consider the appropriateness of the full number of items in the ultrasound "rooms" in the context of maintaining appropriate relativity with other services across the PFS. We sought comment from stakeholders, including the AMA RUC, on the items included in the ultrasound rooms, especially as compared to the items included in other equipment "rooms." We stated that we thought that it would be appropriate to consider these comments in future rulemaking instead of proposing to alter the existing "rooms" just for ultrasound equipment items for CY 2014. Specifically we sought comment on whether equipment packages called "rooms" should include all of the items that might be included in an actual room, just the items typically used for every service in such a room, or all of the items typically used in typical services furnished in the room. We stated that we believed that it would be most appropriate to propose changes to the "room, ultrasound, general" (EL015) and "room, ultrasound, vascular" (EL016) in the context of considering comments on this broader issue. We also stated that we believed that consideration of the broader issue will help determine whether it would be appropriate to create a "room, ultrasound, cardiovascular," and if so, what items would be included in this equipment package.

Comment: Several commenters, including the AMA RUC, suggested that equipment room packages should include all items that are typically in the room and cannot be used for another patient, in order to furnish all typical services performed in that room. In its comment letter, the AMA RUC urged CMS to adopt its previous recommendations and pointed out that CMS has previously stated that equipment time is comprised of any time that clinical labor is using the piece of equipment, plus any additional time the piece of equipment is not available for use with another patient due to its use during the procedure in question. Therefore, any time a piece of equipment is not available for use with another patient, the equipment should be allocated minutes. The AMA RUC also pointed out, as an example, that the equipment item called "otoscope-ophthalmoscope (wall unit)" (EQ189) is a standard equipment input for all E/M codes even though it may not be typically used for each E/M service. Therefore, items included in the room but not necessarily typically used in furnishing particular services should be included as equipment minutes for all codes that typically use the room.

Response: We appreciate the responses of the AMA RUC and others regarding our questions regarding equipment packages. We remain concerned about the appropriate estimate of resources regarding equipment items, especially those in room packages. We note that in our previous statements regarding allocation of equipment minutes, we have articulated that equipment minutes should be allocated to particular items when those items are unavailable for use with another patient "due to its use during the procedure in question." Based on the recommended equipment room packages, we are concerned that this definition may not apply consistently in the direct PE input database. While we understand the example of the "otoscope-ophthalmoscope (wall unit)" (EQ189) for E/M services, we believe that there may be other medical equipment items in a typical evaluation room in addition to the otoscope-ophthalmoscope (wall unit) and an exam table.

These comments reinforce our belief that, for the sake of relativity and accuracy, changes to particular equipment room packages should be made in the context of a broader examination of all equipment packages, as well as assumed equipment utilization rates for these packages.

In addition to the concerns regarding the contents of the ultrasound "room" packages, we also expressed concerned about the pricing information submitted through the AMA RUC to support its recommendation to add equipment to the ultrasound room packages. The highest-price item used in pricing the existing equipment input called "room, ultrasound, general" (EL015), is a "GE Logic 9 ultrasound system," currently priced at $220,000. As part of the AMA RUC recommendation described in the proposal, a medical specialty society recommended increasing the price of that item to $314,500. However, that recommendation did not include documentation to support the pricing level, such as a copy of a paid invoice for the equipment. Furthermore, the recommended price conflicts with certain publicly available information. For example, the *Milwaukee Sentinel-Journal* reported in a February 9, 2013 article that the price for GE ultrasound equipment ranges from "$7,900 for a hand-held ultrasound to $200,000 for its most advanced model." The same article points to an item called the "Logiq E9" as the ultrasound machine most used by radiologists and priced from $150,000 to $200,000. *http://www.jsonline.com/business/ge-sees-strong-future-with-its-ultrasound-business-uj8mn79-190533061.html.*

In the proposed rule, we noted that we were unsure how to best reconcile the information disclosed by the manufacturer to the press and the prices submitted by the medical specialty society for use in updating the direct PE input prices. We believe discrepancies, such as these, exemplify the potential problem with updating prices for particular items based solely on price quotes or information other than copies of paid invoices. However, copies of paid invoices must also be evaluated carefully. The information presented in the article regarding the price for hand-held ultrasound devices raises questions about the adequacy of paid invoices, too, in determining appropriate input costs. The direct PE input described in the database as "ultrasound unit, portable" (EQ250) is currently priced at $29,999 based on a submitted invoice, while the article cites that GE sells a portable unit for as low as $7,900. We sought comment on the appropriate price to use as the typical for portable ultrasound units.

Comment: We received several comments regarding the appropriate means to price the direct PE inputs. The AMA RUC and several specialty expressed concern that it is difficult for medical specialty societies to obtain paid invoices for equipment and supplies, especially for large equipment items that are bought infrequently.

Several medical specialty societies suggested that their members are often uncomfortable sending invoices for expensive items since the prices are often proprietary and even though identifying information is redacted, the invoices are sometimes distributed to all AMA RUC meeting participants and available to the public once submitted to CMS. The specialty society suggested that certain stakeholders in the marketplace are often able to identify the individual practice submitting the invoice through this process and that such public revelation of the propriety pricing information may have major implications for the provider in future price negotiations and service lines in local markets for any practitioner volunteering such information.

The AMA RUC expressed a shared concern with CMS about pricing information submitted as supporting documentation for the ultrasound room packages and stated that it will work with medical specialty societies to provide paid invoices as soon as possible. The AMA RUC also noted that it will work with the specialties to ensure that paid invoices, rather than quotes, are submitted to CMS. Several commenters objected to CMS' suggestion that a newspaper article might more accurately reflect typical resource costs than an invoice.

Response: We appreciate the response of the AMA RUC to these concerns. We also appreciate that in many cases the staff of medical specialty societies may have difficulty obtaining paid invoices. However, we believe the difficulty in obtaining invoices due to market sensitivity does not negate or lessen the critical importance of using accurate pricing information in establishing direct PE inputs. We believe it is likely that the pricing information would be less market sensitive if the information served to confirm the assumptions we already display in the direct PE input database. We appreciate the concerns shared by the AMA RUC's and we continue to seek the best means to identify typical resource costs associated with disposable supplies and medical equipment. While we believe that a copy of a paid invoice is the minimal amount of necessary information for pricing a disposable supply or medical equipment input, we reiterate our concerns that, even when proffered, a sole paid invoice is not necessarily the optimal source for identifying typical resource costs. We agree with commenters that information a manufacturer provides the news media is not necessarily accurate. However, when such information stands in stark contrast to single invoices, we believe it is imperative to attempt to reconcile that information to identify the best available information regarding the typical cost. We will continue to consider the perspectives offered by these commenters in developing future proposals regarding the pricing of individual items and equipment packages.

(2) New Equipment Inputs and Price Updates

Ultrasound Unit, portable, breast procedures. The AMA RUC recommended that a new direct PE input, "ultrasound unit, portable, breast procedures," be created for breast procedures that are performed in a surgeon's office and where ultrasound imaging is included in the code descriptor. These services are described by CPT codes 19105 (Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma), 19296 (Placement of radiotherapy afterloading expandable catheter (single or multichannel) into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; on date separate from partial mastectomy), and 19298 (Placement of radiotherapy afterloading brachytherapy catheters (multiple tube and button type) into the breast for interstitial radioelement application following (at the time of or subsequent to) partial mastectomy, includes imaging guidance). As we noted in the proposed rule, we are creating this input. The pricing information submitted for this item is a paid invoice and two price quotes. As we have previously stated, we believe that copies of paid invoices are more likely to reflect actual resource costs associated with equipment and supply items than quotes or other information. Therefore, we proposed a price of $33,930, which reflects the price displayed on the submitted copy of the paid invoice. We are not using the quotes as we do not believe that quotes provide reliable information about the prices that are actually paid for medical equipment. We did not receive any additional information regarding the price for this equipment item. Therefore the CY 2014 direct PE input database reflects the price as proposed.

Endoscopic Ultrasound Processor. The AMA RUC recommended creating a new direct PE input called "endoscopic ultrasound processor," for use in furnishing the service described by CPT code 31620 (Endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s) (List

separately in addition to code for primary procedure[s])). We created this equipment item to use as an input in the direct PE input database. The price associated with the "endoscopic ultrasound processor" is $59,925, which reflects the price documented on the copy of the paid invoice submitted with the recommendation. We did not receive any additional information regarding the price for this equipment item. Therefore the CY 2014 direct PE input database reflects the price as proposed.

Bronchofibervideoscope. The AMA RUC recommended creating a new direct PE input called "Bronchofibervideoscope," for use in furnishing the service described by CPT code 31620 (Endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s) (List separately in addition to code for primary procedure[s])). We created this new equipment item to use as an input in the direct PE input database. However, this item had no price associated with it in the proposed direct PE input database because we did not receive any information that would allow us to price the item accurately. Consequently, we sought copies of paid invoices for this equipment item in the CY 2014 proposed rule so that we could price the item accurately in the future.

Comment: One commenter reported that the current sales price for the bronchofibervideoscope ranges from $30,000–$50,000. The commenter provided an invoice for the equipment that reflected a price of $35,200.

Response: Based on the submission of the invoice information, we have updated the direct PE input database to reflect a price of $35,200 for the Bronchofibervideoscope (ER093).

Endoscope, ultrasound probe, drive (ES015). The AMA RUC forwarded pricing information to us regarding the existing input called "endoscope, ultrasound probe, drive" (ES015), including a copy of a paid invoice. Based on this information, we proposed to change the price associated with ES015 to $13,256.25, which reflects the price documented on the submitted copy of the paid invoice. We did not receive any additional information regarding the price for this equipment item. Therefore, we the CY 2014 direct PE input database reflects the price as proposed.

(2) Ultrasound Equipment Input Recommendations for Particular Services

The AMA RUC made recommendations regarding the typical ultrasound items used in furnishing particular services. In general, the AMA RUC recommended that the existing equipment items accurately described the typical equipment used in furnishing particular services. However, for some CPT codes the AMA RUC recommended changing the associated equipment inputs that appear in the direct PE input database. Based on our review of these recommendations, we generally agreed with the AMA RUC regarding these recommended changes, and the recommended changes are reflected in the direct PE input database. Table 10 displays the codes with changes to ultrasound equipment. However, for certain codes we did not agree with the recommendations of the AMA RUC. The following paragraphs address the changes we proposed that differ from the recommendations of the AMA RUC.

For a series of cardiovascular services that include ultrasound technology, the AMA RUC recommended removing certain equipment items and replacing those items with a new item called "room, ultrasound, cardiovascular." As we described in the preceding paragraphs, we did not propose to create the "room, ultrasound, cardiovascular" and therefore did not propose to add this "room" as an input for these services. However, we noted that the newly recommended equipment package incorporates many of the same kinds of items as the currently existing "room, ultrasound, vascular" (EL016). We agreed with the AMA RUC's suggestion that the existing equipment inputs for the relevant services listed in Table 10 do not reflect typical resource costs of furnishing the services. We believed that, pending our further consideration of the ultrasound "room" equipment packages, it would be appropriate to use the existing "room, ultrasound, vascular" (EL016) as a proxy for resource costs for these services.

Comment: Several commenters urged CMS to accept the AMA RUC's recommendations. Most of these commenters suggested that if CMS were not to accept the AMA RUC's recommendation to create the new "cardiovascular ultrasound room" for CY 2014, then the inputs for the existing "room, ultrasound, vascular" (EL016) should be used. A few commenters representing some of the practitioners who furnish some of these services objected to the change in equipment inputs based on their assertion that the members of their specialty societies typically use more resource intensive equipment than reflected in the AMA RUC recommendations. One of these commenters suggested that the CPT codes for fetal echocardiography (CPT codes 76825, 76826, 78627, and 78628) previously included the same equipment items as the other echocardiography codes with equipment updates. This commenter suggested that the equipment for these codes should be updated to correspond with the equipment for other, similar services.

Response: As we noted in the proposed rule, we believe that the issue of equipment room packages should be addressed in future rulemaking. Based on these comments, we are finalizing the use of the existing "room, ultrasound, vascular" (EL016) as a proxy for resource costs for these services pending future consideration of equipment room packages. We note that the AMA RUC based its recommendation on information obtained from the medical specialty societies that represent the specialty of the practitioners who furnish the majority of allowed services for each of these codes using recent Medicare claims data. We examined the comments we received objecting to the finalization of the AMA RUC-recommended equipment recommendations and, in each case, confirmed that the commenters did not represent the practitioners who typically furnish each service according to the Medicare claims data. In the case of the fetal echocardiography codes, we agree with the commenter's suggestion that the equipment for these codes should correspond with the equipment for the similar services, especially since the AMA RUC recommended replacing these items for all other codes in the direct PE inputs database. Based on that review, we remain confident that our proposal is appropriate and we are finalizing the changes in the ultrasound equipment items as proposed, with the exception of updating the equipment items for fetal echocardiography to be consistent with other echocardiography services. These changes are displayed in Table 10 and incorporated in the CY 2014 direct PE input database.

In the case of CPT code 76942 (Ultrasonic guidance for needle placement (for example, biopsy, aspiration, injection, localization device), imaging supervision and interpretation), we agreed with the AMA RUC's recommendation to replace the current equipment input of the "room, ultrasound, general" (EL015) with "ultrasound unit, portable" (EQ250). We note that this service is typically reported with other codes that describe the needle placement procedures and that the recommended change in equipment from a room to a

portable device reflects a change in the typical kinds of procedures reported with this image guidance service. Given this change, we believe that it is appropriate to reconsider the procedure time assumption currently used in establishing the direct PE inputs for this code, which is 45 minutes. We reviewed the services reported with CPT code 76942 to identify the most common procedures furnished with this image guidance. The code most frequently reported with CPT code 76942 is CPT 20610 (Arthrocentesis, aspiration and/or injection; major joint or bursa (for example, shoulder, hip, knee joint, subacromial bursa). The assumed procedure time for this service is five minutes. The procedure time assumptions for the vast majority of other procedures frequently reported with CPT code 76942 range from 5 to 20 minutes. Therefore, in addition to proposing the recommended change in equipment inputs associated with the code, we proposed to change the procedure time assumption used in establishing direct PE inputs for the service from 45 to 10 minutes, based on our analysis of 30 needle placement procedures most frequently reported with CPT code 76942. We noted that this reduced the clinical labor and equipment minutes associated with the code from 58 to 23 minutes.

Comment: Several commenters noted that the AMA RUC is planning to conduct surveys and review the assumptions regarding the code and that CMS will be in a better position to make more accurate determinations if it waits for that data from the AMA RUC. One commenter stated that CMS should not make a change in the direct PE input database based on information in the Medicare claims data without input from the medical specialty societies whose members furnish and report the ultrasound guidance as described with CPT code 76942 and that a recommendation from the AMA RUC may provide better data than the information contained on Medicare claims.

Response: We appreciate the partnership of the AMA RUC in the misvalued code initiative, but as a general principle, we do not believe that we should refrain from making appropriate changes to code values solely because the AMA RUC is planning to review a service in the future. In some cases, we believe that we should examine claims information and other sources of data and make proposals regarding the appropriate inputs used to develop the amount Medicare pays for PFS services. We believe that notice and comment rulemaking itself provides a means for the public, including medical specialty societies and the AMA RUC, to respond substantively to proposed changes in resource inputs for particular services. Furthermore, in cases like this one, we do not believe that the information reflected in the Medicare claims data is subjective or open to differing interpretations.

Comment: Several commenters, including the AMA RUC, pointed out that CPT code 76942 includes supervision and interpretation, which represents both time and work that is separate from the surgical code and that the additional time included in the direct PE inputs may reflect time in addition to the base procedure.

Response: We appreciate the response of the AMA RUC and others in pointing out concerns with our assumptions. We note that the proposed clinical labor service period of 23 minutes includes the 10 minutes of intra-service time in addition to 2 minutes for preparing the room, equipment, and supplies, 3 minutes for preparing and positioning the patient, 3 minutes for cleaning the room, and 5 minutes for processing images, completing data sheet, and presenting images and data to the interpreting physician. We did not receive information from any commenters suggesting that the time allocated for these tasks was inadequate. Therefore, we are finalizing our adjustment to the clinical labor minutes associated with this code, as proposed.

TABLE 10—CODES WITH CHANGES TO ULTRASOUND EQUIPMENT FOR CY 2014

CPT code	Descriptor	CY 2013 CMS equipment code	CY 2013 equipment description	CY 2014 equipment CMS code	CY 2014 equipment description
19105	Cryosurg ablate fa each	EQ250	ultrasound unit, portable	NEW	ultrasound unit, portable, breast procedures.
19296	Place po breast cath for rad	EL015	room, ultrasound, general	NEW	ultrasound unit, portable, breast procedures.
19298	Place breast rad tube/caths	EL015	room, ultrasound, general	NEW	ultrasound unit, portable, breast procedures.
31620	Endobronchial us add-on	n/a		NEW	Bronchofibervideoscope.
		n/a		NEW	Endoscopic ultrasound processor.
52649	Prostate laser enucleation	EQ255	ultrasound, noninvasive bladder scanner w-cart.	EQ250	ultrasound unit, portable.
76376	3d render w/o postprocess	EL015	room, ultrasound, general		Remove input.
76775	Us exam abdo back wall lim	EL015	room, ultrasound, general	EQ250	ultrasound unit, portable.
76820	Umbilical artery echo	EQ249	ultrasound color doppler, transducers and vaginal probe.	EL015	room, ultrasound, general.
76825	Echo exam of fetal heart	EQ254	ultrasound, echocardiography w-4 transducers (Sequoia C256).	EL016	room, ultrasound, vascular.
		EQ252	ultrasound, echocardiography analyzer software (ProSolv).		
76826	Echo exam of fetal heart	EQ254	ultrasound, echocardiography w-4 transducers (Sequoia C256).	EL016	room, ultrasound, vascular.
		EQ252	ultrasound, echocardiography analyzer software (ProSolv).		
76827	Echo exam of fetal heart	EQ254	ultrasound, echocardiography w-4 transducers (Sequoia C256).	EL016	room, ultrasound, vascular.

TABLE 10—CODES WITH CHANGES TO ULTRASOUND EQUIPMENT FOR CY 2014—Continued

CPT code	Descriptor	CY 2013 CMS equipment code	CY 2013 equipment description	CY 2014 equipment CMS code	CY 2014 equipment description
76828	Echo exam of fetal heart	EQ254	ultrasound, echocardiography w-4 transducers (Sequoia C256).	EL016	room, ultrasound, vascular.
76857	Us exam pelvic limited	EL015	room, ultrasound, general	EQ250	ultrasound unit, portable.
76870	Us exam scrotum	EL015	room, ultrasound, general	EQ250	ultrasound unit, portable.
76872	Us transrectal	EL015	room, ultrasound, general	EQ250	ultrasound unit, portable.
76942	Echo guide for biopsy	EL015	room, ultrasound, general	EQ250	ultrasound unit, portable.
93303	Echo guide for biopsy	EQ253	ultrasound, echocardiography digital acquisition (Novo Microsonics, TomTec).	EL016	room, ultrasound, vascular.
		EQ254	ultrasound, echocardiography w-4 transducers (Sequoia C256).		
		EQ252	ultrasound, echocardiography analyzer software (ProSolv).		
93304	Echo transthoracic	EQ252	ultrasound, echocardiography analyzer software (ProSolv).	EL016	room, ultrasound, vascular.
		EQ253	ultrasound, echocardiography digital acquisition (Novo Microsonics, TomTec).		
		EQ254	ultrasound, echocardiography w-4 transducers (Sequoia C256).		
93306	Tte w/doppler complete	EQ253	ultrasound, echocardiography digital acquisition (Novo Microsonics, TomTec).	EL016	room, ultrasound, vascular.
		EQ254	ultrasound, echocardiography w-4 transducers (Sequoia C256).		
		EQ252	ultrasound, echocardiography analyzer software (ProSolv).		
93307	Tte w/o doppler complete	EQ252	ultrasound, echocardiography analyzer software (ProSolv).	EL016	room, ultrasound, vascular.
		EQ253	ultrasound, echocardiography digital acquisition (Novo Microsonics, TomTec).		
		EQ254	ultrasound, echocardiography w-4 transducers (Sequoia C256).		
93308	Tte f-up or lmtd	EQ252	ultrasound, echocardiography analyzer software (ProSolv).	EL016	room, ultrasound, vascular.
		EQ253	ultrasound, echocardiography digital acquisition (Novo Microsonics, TomTec).		
		EQ254	ultrasound, echocardiography w-4 transducers (Sequoia C256).		
93312	Echo transesophageal	EQ253	ultrasound, echocardiography digital acquisition (Novo Microsonics, TomTec).	EL016	room, ultrasound, vascular.
		EQ252	ultrasound, echocardiography analyzer software (ProSolv).		
		EQ256	ultrasound, transducer (TEE Omniplane II).		
		EQ254	ultrasound, echocardiography w-4 transducers (Sequoia C256).		
93314	Echo transesophageal	EQ254	ultrasound, echocardiography w-4 transducers (Sequoia C256).	EL016	room, ultrasound, vascular.
		EQ256	ultrasound, transducer (TEE Omniplane II).		
		EQ252	ultrasound, echocardiography analyzer software (ProSolv).		
		EQ253	ultrasound, echocardiography digital acquisition (Novo Microsonics, TomTec).		
93320	Doppler echo exam heart	EQ252	ultrasound, echocardiography analyzer software (ProSolv).	EL016	room, ultrasound, vascular.
		EQ253	ultrasound, echocardiography digital acquisition (Novo Microsonics, TomTec).		
		EQ254	ultrasound, echocardiography w-4 transducers (Sequoia C256).		
93321	Doppler echo exam heart	EQ252	ultrasound, echocardiography analyzer software (ProSolv).	EL016	room, ultrasound, vascular.

TABLE 10—CODES WITH CHANGES TO ULTRASOUND EQUIPMENT FOR CY 2014—Continued

CPT code	Descriptor	CY 2013 CMS equipment code	CY 2013 equipment description	CY 2014 equipment CMS code	CY 2014 equipment description
		EQ254	ultrasound, echocardiography w-4 transducers (Sequoia C256).		
93325	Doppler color flow add-on	EQ252	ultrasound, echocardiography analyzer software (ProSolv).	EL016	room, ultrasound, vascular.
		EQ253	ultrasound, echocardiography digital acquisition (Novo Microsonics, TomTec).		
		EQ254	ultrasound, echocardiography w-4 transducers (Sequoia C256).		
93350	Stress tte only	EQ252	ultrasound, echocardiography analyzer software (ProSolv).	EL016	room, ultrasound, vascular.
		EQ253	ultrasound, echocardiography digital acquisition (Novo Microsonics, TomTec).		
		EQ254	ultrasound, echocardiography w-4 transducers (Sequoia C256).		
93351	Stress tte complete	EQ254	ultrasound, echocardiography w-4 transducers (Sequoia C256).	EL016	room, ultrasound, vascular.
93980	Penile vascular study	EL015	room, ultrasound, general	EQ249	ultrasound color doppler, transducers and vaginal probe.
93981	Penile vascular study	EL015	room, ultrasound, general	EQ249	ultrasound color doppler, transducers and vaginal probe.

B. Misvalued Services

1. Valuing Services Under the PFS

Section 1848(c) of the Act requires the Secretary to determine relative values for physicians' services based on three components: work, PE, and malpractice. Section 1848(c)(1)(A) of the Act defines the work component to include "the portion of the resources used in furnishing the service that reflects physician time and intensity in furnishing the service." In addition, section 1848(c)(2)(C)(i) of the Act specifies that "the Secretary shall determine a number of work relative value units (RVUs) for the service based on the relative resources incorporating physician time and intensity required in furnishing the service." Section 1848(c)(1)(B) of the Act defines the PE component as "the portion of the resources used in furnishing the service that reflects the general categories of expenses (such as office rent and wages of personnel, but excluding malpractice expenses) comprising practice expenses." (See section I.B.1.b. for more detail on the development of the PE component.) Section 1848(c)(1)(C) of the Act defines the malpractice component as "the portion of the resources used in furnishing the service that reflects malpractice expenses in furnishing the service." Sections 1848 (c)(2)(C)(ii) and (iii) of the Act specify that PE and malpractice RVUs shall be determined based on the relative PE/malpractice resources involved in furnishing the service.

Section 1848(c)(2)(B) of the Act directs the Secretary to conduct a periodic review, not less often than every 5 years, of the RVUs established under the PFS. Section 3134(a) of the Affordable Care Act added a new section 1848(c)(2)(K) to the Act, which requires the Secretary to periodically identify potentially misvalued services using certain criteria and to review and make appropriate adjustments to the relative values for those services. Section 3134(a) of the Affordable Care Act also added a new section 1848(c)(2)(L) to the Act, which requires the Secretary to develop a process to validate the RVUs of certain potentially misvalued codes under the PFS, identified using the same criteria used to identify potentially misvalued codes, and to make appropriate adjustments.

As discussed in section II.B.1. of this final rule with comment period, each year we develop and propose appropriate adjustments to the RVUs, taking into account the recommendations provided by the American Medical Association/Specialty Society Relative Value Scale Update Committee (AMA RUC), the Medicare Payment Advisory Commission (MedPAC), and others. For many years, the AMA RUC has provided us with recommendations on the appropriate relative values for new, revised, and potentially misvalued PFS services. We review these recommendations on a code-by-code basis and consider these recommendations in conjunction with analyses of other data, such as claims data, to inform the decision-making process as authorized by the law. We may also consider analyses of physician time, work RVUs, or direct PE inputs using other data sources, such as Department of Veteran Affairs (VA), National Surgical Quality Improvement Program (NSQIP), the Society for Thoracic Surgeons (STS) National Database, and the Physician Quality Reporting System (PQRS) databases. In addition to considering the most recently available data, we also assess the results of physician surveys and specialty recommendations submitted to us by the AMA RUC. We conduct a clinical review to assess the appropriate RVUs in the context of contemporary medical practice. We note that section 1848(c)(2)(A)(ii) of the Act authorizes the use of extrapolation and other techniques to determine the RVUs for physicians' services for which specific data are not available in addition to taking into account the results of consultations with organizations representing physicians. In accordance with section 1848(c) of the Act, we determine appropriate adjustments to the RVUs, explain the basis of these adjustments, and respond to public comments in the PFS proposed and final rules.

2. Identifying, Reviewing, and Validating the RVUs of Potentially Misvalued Services

a. Background

In its March 2006 Report to the Congress, MedPAC noted that "misvalued services can distort the price signals for physicians' services as well as for other health care services that physicians order, such as hospital services." In that same report MedPAC postulated that physicians' services under the PFS can become misvalued over time. MedPAC stated, "when a new service is added to the physician fee schedule, it may be assigned a relatively high value because of the time, technical skill, and psychological stress that are often required to furnish that service. Over time, the work required for certain services would be expected to decline as physicians become more familiar with the service and more efficient in furnishing it." We believe services can also become overvalued when PEs decline. This can happen when the costs of equipment and supplies fall, or when equipment is used more frequently than is estimated in the PE methodology, reducing its cost per use. Likewise, services can become undervalued when physician work increases or PEs rise. In the ensuing years since MedPAC's 2006 report, additional groups of potentially misvalued services have been identified by the Congress, CMS, MedPAC, the AMA RUC, and other stakeholders.

In recent years, CMS and the AMA RUC have taken increasingly significant steps to identify and address potentially misvalued codes. As MedPAC noted in its March 2009 Report to Congress, in the intervening years since MedPAC made the initial recommendations, "CMS and the AMA RUC have taken several steps to improve the review process." Most recently, section 1848(c)(2)(K)(ii) of the Act (as added by section 3134(a) of the Affordable Care Act) directed the Secretary to specifically examine, as determined appropriate, potentially misvalued services in the following seven categories:

- Codes and families of codes for which there has been the fastest growth;
- Codes and families of codes that have experienced substantial changes in PEs;
- Codes that are recently established for new technologies or services;
- Multiple codes that are frequently billed in conjunction with furnishing a single service;
- Codes with low relative values, particularly those that are often billed multiple times for a single treatment;
- Codes which have not been subject to review since the implementation of the RBRVS (the so-called 'Harvard-valued codes'); and
- Other codes determined to be appropriate by the Secretary.

Section 1848(c)(2)(K)(iii) of the Act also specifies that the Secretary may use existing processes to receive recommendations on the review and appropriate adjustment of potentially misvalued services. In addition, the Secretary may conduct surveys, other data collection activities, studies, or other analyses, as the Secretary determines to be appropriate, to facilitate the review and appropriate adjustment of potentially misvalued services. This section also authorizes the use of analytic contractors to identify and analyze potentially misvalued codes, conduct surveys or collect data, and make recommendations on the review and appropriate adjustment of potentially misvalued services. Additionally, this section provides that the Secretary may coordinate the review and adjustment of any RVU with the periodic review described in section 1848(c)(2)(B) of the Act. Finally, section 1848(c)(2)(K)(iii)(V) of the Act specifies that the Secretary may make appropriate coding revisions (including using existing processes for consideration of coding changes) that may include consolidation of individual services into bundled codes for payment under the physician fee schedule.

b. Progress in Identifying and Reviewing Potentially Misvalued Codes

To fulfill our statutory mandate, we have identified and reviewed numerous potentially misvalued codes in all seven of the categories specified in section 1848(c)(2)(K)(ii) of the Act, and we plan to continue our work examining potentially misvalued codes in these areas over the upcoming years. In the current process, we identify potentially misvalued codes for review, and request recommendations from the AMA RUC and other public commenters on revised work RVUs and direct PE inputs for those codes. The AMA RUC, through its own processes, also identifies potentially misvalued codes for review. Through our public nomination process for potentially misvalued codes established in the CY 2012 PFS final rule with comment period, other individuals and stakeholder groups submit nominations for review of potentially misvalued codes as well.

Since CY 2009, as a part of the annual potentially misvalued code review and Five-Year Review process, we have reviewed more than 1,000 potentially misvalued codes to refine work RVUs and direct PE inputs. We have adopted appropriate work RVUs and direct PE inputs for these services as a result of these reviews. A more detailed discussion of the extensive prior reviews of potentially misvalued codes is included in the CY 2012 PFS final rule with comment period (76 FR 73052 through 73055). In the CY 2012 PFS proposed rule, we proposed to identify and review potentially misvalued codes in the category of "Other codes determined to be appropriate by the Secretary," referring to a list of the highest PFS expenditure services, by specialty, that had not been recently reviewed (76 FR 73059 through 73068).

In the CY 2012 final rule with comment period, we finalized our policy to consolidate the review of physician work and PE at the same time (76 FR 73055 through 73958), and established a process for the annual public nomination of potentially misvalued services.

One of the priority categories for review of potentially misvalued codes is services that have not been subject to review since the implementation of the PFS (the so-called "Harvard-valued codes"). In the CY 2009 PFS proposed rule, we requested that the AMA RUC engage in an ongoing effort to review the remaining Harvard-valued codes, focusing first on the high-volume, low intensity codes (73 FR 38589). For the Fourth Five-Year Review (76 FR 32410), we requested that the AMA RUC review services that have not been reviewed since the original implementation of the PFS with annual utilization greater than 30,000 (Harvard-valued—Utilization > 30,000). In the CY 2013 final rule with comment period, we identified for review the potentially misvalued codes for Harvard-valued services with annual allowed charges that total at least $10,000,000 (Harvard-valued—Allowed charges ≥$10,000,000).

In addition to the Harvard-valued codes, in the same rule we finalized for review a list of potentially misvalued codes that have stand-alone PE (these are codes with clinical labor procedure time assumptions not connected or dependent on physician time assumptions; see 77 FR 68918 for detailed information).

c. Validating RVUs of Potentially Misvalued Codes

In addition to identifying and reviewing potentially misvalued codes, section 3134(a) of the Affordable Care Act added section 1848(c)(2)(L) of the Act, which specifies that the Secretary shall establish a formal process to validate RVUs under the PFS. The validation process may include

validation of work elements (such as time, mental effort and professional judgment, technical skill and physical effort, and stress due to risk) involved with furnishing a service and may include validation of the pre-, post-, and intra-service components of work. The Secretary is directed, as part of the validation, to validate a sampling of the work RVUs of codes identified through any of the seven categories of potentially misvalued codes specified by section 1848(c)(2)(K)(ii) of the Act. Furthermore, the Secretary may conduct the validation using methods similar to those used to review potentially misvalued codes, including conducting surveys, other data collection activities, studies, or other analyses as the Secretary determines to be appropriate to facilitate the validation of RVUs of services.

In the CY 2011 PFS proposed rule (75 FR 40068) and CY 2012 PFS proposed rule (76 FR 42790), we solicited public comments on possible approaches, methodologies, and data sources that we should consider for a validation process. A summary of the comments along with our responses are included in the CY 2011 PFS final rule with comment period (75 FR 73217) and the CY 2012 PFS final rule with comment period (73054 through 73055).

As we indicated in the CY 2014 PFS proposed rule (78 FR 43304), we have entered into two contracts with outside entities to develop validation models for RVUs. During a 2-year project, the RAND Corporation will use available data to build a validation model to predict work RVUs and the individual components of work RVUs, time and intensity. The model design will be informed by the statistical methodologies and approach used to develop the initial work RVUs and to identify potentially misvalued procedures under current CMS and AMA RUC processes. RAND will use a representative set of CMS-provided codes to test the model. RAND will consult with a technical expert panel on model design issues and the test results.

The second contract is with the Urban Institute. Given the central role of time in establishing work RVUs and the concerns that have been raised about the current time values, a key focus of the project is collecting data from several practices for selected services. The data will be used to develop time estimates. Urban Institute will use a variety of approaches to develop objective time estimates, depending on the type of service, which will be a very resource-intensive part of the project. Objective time estimates will be compared to the current time values used in the fee schedule. The project team will then convene groups of physicians from a range of specialties to review the new time data and their potential implications for work and the ratio of work to time.

The research being performed under these two contracts continues. For additional information, please visit our Web site (*http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/RVUs-Validation-Model.pdf*).

3. CY 2014 Identification and Review of Potentially Misvalued Services

a. Public Nomination of Potentially Misvalued Codes

The public and stakeholders may nominate potentially misvalued codes for review by submitting the code with supporting documentation during the 60-day public comment period following the release of the annual PFS final rule with comment period under a process we finalized in the CY 2012 PFS final rule with comment period (76 FR 73058). Supporting documentation for codes nominated for the annual review of potentially misvalued codes may include the following:

- Documentation in the peer-reviewed medical literature or other reliable data that there have been changes in physician work due to one or more of the following: technique; knowledge and technology; patient population; site-of-service; length of hospital stay; and physician time.
- An anomalous relationship between the code being proposed for review and other codes.
- Evidence that technology has changed physician work, that is, diffusion of technology.
- Analysis of other data on time and effort measures, such as operating room logs or national and other representative databases.
- Evidence that incorrect assumptions were made in the previous valuation of the service, such as a misleading vignette, survey, or flawed crosswalk assumptions in a previous evaluation.
- Prices for certain high cost supplies or other direct PE inputs that are used to determine PE RVUs are inaccurate and do not reflect current information.
- Analyses of physician time, work RVU, or direct PE inputs using other data sources (for example, Department of Veteran Affairs (VA) National Surgical Quality Improvement Program (NSQIP), the Society for Thoracic Surgeons (STS) National Database, and the Physician Quality Reporting System (PQRS) databases).
- National surveys of physician time and intensity from professional and management societies and organizations, such as hospital associations.

After we receive the nominated codes during the 60-day comment period following the release of the annual PFS final rule with comment period, we evaluate the supporting documentation and assess whether the nominated codes appear to be potentially misvalued codes appropriate for review under the annual process. In the following year's PFS proposed rule, we publish the list of nominated codes and indicate whether we are proposing each nominated code as a potentially misvalued code. We encourage the public to submit nominations for potentially misvalued codes during the comment period for this CY 2014 PFS final rule with comment period.

We did not receive any public nominations of codes for consideration as potentially misvalued codes in response to the CY 2013 final rule with comment period. As a result, we did not propose any publicly nominated potentially misvalued codes in the CY 2014 proposed rule.

b. Potentially Misvalued Codes

i. Contractor Medical Director Identified Potentially Misvalued Codes

We began considering additional ways to broaden participation in the process of identifying potentially misvalued codes; we solicited the input of Medicare Administrative Contractor medical directors (CMDs) in making suggestions for codes to consider proposing as potentially misvalued codes.

In the proposed rule, we noted several reasons why we believed that CMD input would be valuable in developing our proposal. As a group, CMDs represent a variety of medical specialties, which makes them a diverse group of physicians capable of providing opinions across the vast scope of services covered under the PFS. They are on the front line of administering the Medicare program, with their offices often serving as the first point of contact for practitioners with questions regarding coverage, coding and claims processing. CMDs spend a significant amount of time communicating directly with practitioners and the health care industry discussing more than just the broad aspects of the Medicare program but also engaging in and facilitating specific discussions around individual services. Through their development of evidence-based local coverage determinations (LCDs), CMDs also have

experience developing policy based on research.

Comment: Many commenters supported our seeking input from the CMDs in developing our proposal for codes to be considered as potentially misvalued codes, while others expressed concern about using input from CMDs. Some asked for details on the process that the CMDs used to identify codes and some questioned whether CMDs possess the specialty-related expertise to determine if a service is misvalued when that service is not generally performed by a CMD's designated specialty. In addition, several commenters believe that the identification of misvalued codes (in addition to review and revision of those codes) should be carried out through the AMA RUC process with input from the medical community. These commenters oppose any effort by CMS to unilaterally change code values.

Response: The commenters are correct in noting that CMDs do not represent all specialties. We would note that in their role as CMDs, they do work on issues involving all specialties. Moreover, their role in this process was simply to assist us in identifying codes that we could consider proposing as potentially misvalued codes. After our evaluation, we proposed them as potentially misvalued codes in the CY 2014 proposed rule and sought public comment. Thus the affected specialties and other stakeholders had the opportunity to provide us with public comments as to whether or not these codes should be evaluated as potentially misvalued. If, following our consideration of public comments, we determine that these codes are potentially misvalued, the AMA RUC and others will have further opportunity to submit information and public comment about the appropriate value of the codes before we would determine the codes are in fact misvalued and make changes to the values.

Given the importance of ensuring that codes are appropriately valued, we believe it is appropriate to call upon the experience of CMDs in developing our proposal. Accordingly, we will proceed as we proposed in the CY 2014 proposed rule to consider the codes identified by CMDs as potentially misvalued codes.

In consultation with our CMDs, the following lists of codes in Tables 11 and 12 were identified as potentially misvalued in the CY 2014 proposed rule.

TABLE 11—CODES PROPOSED AS POTENTIALLY MISVALUED IDENTIFIED IN CONSULTATION WITH CMDS

CPT code	Short descriptor
17311 ..	Mohs 1 stage h/n/hf/g.
17313 ..	Mohs 1 stage t/a/l.
21800 ..	Treatment of rib fracture.
22305 ..	Closed tx spine process fx.
27193 ..	Treat pelvic ring fracture.
33960 ..	External circulation assist.
33961 ..	External circulation assist, each subsequent day.
47560 ..	Laparoscopy w/cholangio.
47562 ..	Laparoscopic cholecystectomy.
47563 ..	Laparo cholecystectomy/graph.
55845 ..	Extensive prostate surgery.
55866 ..	Laparo radical prostatectomy.
64566 ..	Neuroeltrd stim post tibial.
76942 ..	Echo guide for biopsy.

CPT codes 17311 (Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histpathologic preparation including routine stain(s) (for example, hematoxylin and eosin, toluidine blue), head, neck, hands, feet genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; first stage, up to 5 tissue blocks) and 17313 (Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stains(s) (for example, hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; first stage, up to 5 tissue blocks) were proposed as potentially misvalued codes because we believe that these codes may be overvalued based on CMD comments suggesting excessive utilization.

Comment: All commenting on CPT codes 17311 and 17313 stated that these codes were being reviewed by the AMA RUC in 2013, and two suggested that we accept the AMA RUC recommended work values (6.2 and 5.56 respectively) in the 2014 PFS final rule with comment period. One commenter asserted that these codes were not misvalued and should be removed from consideration as potentially misvalued but did not supply any information to support this view.

Response: The commenters are correct that the codes were under review by the AMA RUC. Since the publication of the proposed rule, we have received recommendations from the AMA RUC for these codes. Rather than finalizing them as potentially misvalued codes, since we have the AMA RUC recommendations we are proposing interim final values for these codes per our usual process. (See section II.E.3.a.i.) These values are open for comment during the comment period for this final rule.

CPT codes 21800 (Closed treatment of rib fracture, uncomplicated, each), 22305 (Closed treatment of vertebral process fracture(s)) and 27193 (Closed treatment of pelvic ring fracture, dislocation, diastasis or subluxation, without manipulation) were proposed for review as potentially misvalued codes.

Comment: We received no comments on these codes.

Response: We are finalizing our proposal to review these codes as potentially misvalued codes.

CPT codes 33960 (Prolonged extracorporeal circulation for cardiopulmonary insufficiency; initial day) and 33961 (Prolonged extracorporeal circulation for cardiopulmonary insufficiency; each subsequent day) were proposed for review because the service was originally valued when it was used primarily in premature neonates; but the service is now being furnished to adults with severe influenza, pneumonia and respiratory distress syndrome. We also noted in the proposed rule that, while the code currently includes 523 minutes of total physician time with 133 minutes of intraservice time, physicians are not typically furnishing the service over that entire time interval; rather, hospital-employed pump technicians are furnishing much of the work.

Comment: We received no comments on these codes.

Response: We are finalizing our proposal to review these codes as potentially misvalued codes.

CPT codes 47560 (Laparoscopy, surgical; with guided transhepatic cholangiography, without biopsy), 47562 (Laparoscopy, surgical; cholecystectomy) and 47563 (Laparoscopy, surgical; cholecystectomy with cholangiography) were proposed as potentially misvalued because the more extensive code (CPT 47560) has lower work RVUs than the less extensive codes (CPT 47562 and CPT 47563).

Comment: We received a comment suggesting that these codes were not potentially misvalued and urging us not to finalize our proposal, stating that 47562 and 47563 describe more complex surgical procedures and both have a 090-day global period while 47560 has a 000-day global period.

Response: We acknowledge that the codes have different global periods, but believe that questions remain about how these codes should be valued. Therefore, we are finalizing our proposal to review these codes as potentially misvalued codes.

CPT codes 55845 (Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes) and 55866 (Laparoscopy, surgical prostatectomy, retropubic radial, including nerve sparing, includes robotic assistance, when performed) were proposed as potentially misvalued because the RVUs for the laparoscopic procedure (CPT 55866) are higher than those for the open procedure (CPT 55845) and we believe that, in general, a laparoscopic procedure would not require greater resources than the open procedure.

Comment: A few comments suggested that these codes were not potentially misvalued because the laparoscopic code (CPT 55866) does require a higher level of work than the open procedure (CPT 55845) so the codes are in the appropriate rank order. One commenter stated that they had submitted an action plan for the review of these codes at the October 2013 AMA RUC meeting, and suggested that we defer any action on these codes until the AMA RUC review process is complete. Another commenter agreed that they were potentially misvalued saying that we should pay the same rate for both codes.

Response: Although most of the commenters indicated that it was appropriate that RVUs be higher for CPT code 55866 (laparoscopic procedure) than for CPT code 55845 (open procedure), we believe that there is enough question about how these codes should be valued that we are finalizing the proposal to review these codes as potentially misvalued codes. We note that we consider AMA RUC recommendations through our usual review of potentially misvalued codes.

We proposed CPT 64566 (Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming) as a potentially misvalued code because the current valuation is based on the procedure being furnished by a physician, but we think that the procedure typically is furnished by auxiliary personnel with physician supervision (rather than by a physician).

Comment: We received a few comments stating that this code is not misvalued and urged us not to finalize our proposal. One commenter disagrees that CPT code 64566 is potentially misvalued and stated that the current work RVU of 0.60 is appropriate and should be maintained.

Response: We believe that further review is needed to determine if this procedure is typically performed by the physician, or the auxiliary personnel with physician supervision. Therefore, we are finalizing our proposal to review the codes described above as potentially misvalued codes.

We proposed CPT code 76942 (Ultrasonic guidance for needle placement (for example, biopsy, aspiration, injection, localization device), imaging supervision and interpretation) as a potentially misvalued code because of the high frequency with which it is billed with CPT code 20610 (Arthrocentesis, aspiration and/or injection; major joint or bursa (for example, shoulder, hip, knee joint, subacromial bursa). As we noted in the proposed rule, we are concerned about potential overutilization of these codes and it was suggested that the payment for CPT code 76942 and CPT code 20610 should be bundled to reduce the incentive for providers to always provide and bill separately for ultrasound guidance.

We also noted in the proposed rule that we were proposing to revise the direct PE inputs for CPT code 76942 because claims data shows that the procedure time assumption for CPT code 76942 is longer than that for the typical procedure with which the code is billed (CPT code 20610). The direct PE inputs and procedure time for CPT code 76942 are addressed in detail in section II.B.4.f. of this final rule with comment period. We further explained in the proposed rule that the discrepancy in procedure times and the resulting potentially inaccurate payment raises a fundamental concern regarding the incentive to furnish ultrasound guidance.

Comment: We received a comment saying that this code is undervalued, several comments indicating that the reduction of time and other inputs would be inappropriate and some comments suggesting that we should delay action until the AMA RUC can review and provide its recommendation.

Response: Based on the diversity of the comments received about the valuation of this code, we are finalizing our proposal to review it as a potentially misvalued code. This action is consistent with the comment recommending that we delay action until the AMA RUC acts because we routinely consider AMA RUC recommendations through our usual review of potentially misvalued codes. Thus, we would seek the AMA RUC recommendation before re-valuing.

As we noted in the proposed rule that given our concerns with CPT code 76942, we have similar concerns with other codes for ultrasound guidance. Accordingly, we proposed the following additional ultrasound guidance codes as potentially misvalued.

TABLE 12—ULTRASOUND GUIDANCE CODES PROPOSED AS POTENTIALLY MISVALUED

CPT code	Short descriptor
76930 ..	Echo guide cardiocentesis.
76932 ..	Echo guide for heart biopsy.
76936 ..	Echo guide for artery repair.
76940 ..	US guide tissue ablation.
76948 ..	Echo guide ova aspiration.
76950 ..	Echo guidance radiotherapy.
76965 ..	Echo guidance radiotherapy.

Comment: We received some comments asking us not to treat 76930, 76932, and 76936 as potentially misvalued codes stating that these codes are not misvalued but without providing information to support the contention. One commenter stated that 76936 should be removed from the list because it is not an image guidance technique used to supplement a surgical procedure.

Response: We agree that code 76936 is not a code used to supplement a surgical procedure and therefore does not raise the concerns we discussed in the proposed rule. Accordingly, it will not be included on the list of potentially misvalued codes. The comments on codes 76930 and 76932 provided insufficient information to persuade us that these codes should not be considered potentially misvalued. Given that the identification of a code as potentially misvalued merely assures that the current values are evaluated to determine whether changes are warranted, we are finalizing our proposal to consider codes 76930 and 76932 as potentially misvalued.

In summary, the following codes are finalized as potentially misvalued codes.

TABLE 13—POTENTIALLY MISVALUED CPT CODES

CPT code	Short descriptor
21800 ..	Treatment of rib fracture.
22305 ..	Closed tx spine process fx.
27193 ..	Treat pelvic ring fracture.
33960 ..	External circulation assist.
33961 ..	External circulation assist, each subsequent day.
47560 ..	Laparoscopy w/cholangio.

TABLE 13—POTENTIALLY MISVALUED CPT CODES—Continued

CPT code	Short descriptor
47562 ..	Laparoscopic cholecystectomy.
47563 ..	Laparo cholecystectomy/graph.
55845 ..	Extensive prostate surgery.
55866 ..	Laparo radical prostatectomy.
64566 ..	Neuroeltrd stim post tibial.
76930 ..	Echo guide cardiocentesis.
76932 ..	Echo guide for heart biopsy.
76940 ..	US guide tissue ablation.
76942 ..	Echo guide for biopsy.
76948 ..	Echo guide ova aspiration.
76950 ..	Echo guidance radiotherapy.
76965 ..	Echo guidance radiotherapy.

We will accept public nominations of potentially misvalued codes with supporting documentation as described in section II.C.3.a. of this final rule with comment period in the CY 2015 proposed rule.

ii. Number of Visits and Physician Time in Selected Global Surgical Packages

In the CY 2013 proposed rule, we sought comments on methods of obtaining accurate and current data on E/M services furnished as part of a global surgical package. Commenters provided a variety of suggestions including setting the all surgical services to a 0-day global period, requiring all E/M services to be separately billed, validating the global surgical packages with the hospital Diagnosis-Related Group length of stay data, and setting auditable documentation standards for post-operative E/M services. In addition to the broader comments, the AMA RUC noted that many surgical procedures did not have the correct hospital and discharge day management services in the global period, resulting in incorrect times in the time file. The AMA RUC submitted post-operative visits and times for the services that we had displayed with zero visits in the CMS time file with the CY 2013 proposed rule. The AMA RUC suggested that the errors may have resulted from the inadvertent removal of the visits from the time file in 2007. We responded to this comment in the CY 2013 final rule with comment period by saying that we would review this file and, if appropriate, propose modifications. We noted in the CY 2013 final rule with comment period that if time had been removed from the physician time file inadvertently, it would have resulted in a small impact on the indirect allocation of PE at the specialty level, but it would not have affected the physician work RVUs or direct PE inputs for these services. It would have a small impact on the indirect allocation of PE at the specialty level, which we would review when we explore this potential time file change.

After extensive review, we believe that the data were deleted from the time file due to an inadvertent error as noted by the AMA RUC. To correct this inadvertent error, in the CY2014 proposed rule, we proposed to replace the missing post-operative hospital E/M visit information and time for the 117 codes that were identified by the AMA RUC and displayed in Table 14. Thus, we believe this correction will populate the physician time file with data that, absent the inadvertent error, would have been present in the time file.

TABLE 14—GLOBAL SURGICAL PACKAGE VISITS AND PHYSICIAN TIME CHANGES

CPT code	Short descriptor	Visits included in Global Package [1]				CY 2013 physician time	CY 2014 physician time
		99231	99232	99238	99291		
19368	Breast reconstruction	4.00		1.00		712.00	770.00
19369	Breast reconstruction	3.00		1.00		657.00	690.00
20100	Explore wound neck	2.00		1.00		218.00	266.00
20816	Replantation digit complete	5.00		1.00		671.00	697.00
20822	Replantation digit complete	3.00		1.00		587.00	590.00
20824	Replantation thumb complete	5.00		1.00		646.00	690.00
20827	Replantation thumb complete	4.00		1.00		610.00	625.00
20838	Replantation foot complete	8.00		1.00		887.00	986.00
20955	Fibula bone graft microvasc	6.00		1.00	1.00	867.00	957.00
20969	Bone/skin graft microvasc	8.00		1.00		1018.00	1048.00
20970	Bone/skin graft iliac crest	8.00		1.00		958.00	988.00
20973	Bone/skin graft great toe	5.00		1.00		1018.00	988.00
21139	Reduction of forehead	1.00		1.00		400.00	466.00
21151	Reconstruct midface lefort	2.00		1.00	1.00	567.00	686.00
21154	Reconstruct midface lefort	2.50		1.00	1.50	664.00	853.00
21155	Reconstruct midface lefort	2.00		1.00	2.00	754.00	939.00
21175	Reconstruct orbit/forehead		1.00	1.00	2.00	549.00	767.00
21182	Reconstruct cranial bone		1.00	1.00	2.00	619.00	856.00
21188	Reconstruction of midface	1.00		1.00		512.00	572.00
22100	Remove part of neck vertebra	2.00		1.00		397.00	372.00
22101	Remove part thorax vertebra	3.00		1.00		392.00	387.00
22110	Remove part of neck vertebra	6.00		1.00		437.00	479.00
22112	Remove part thorax vertebra	6.50		1.00		507.00	530.00
22114	Remove part lumbar vertebra	6.50		1.00		517.00	530.00
22210	Revision of neck spine	7.00		1.00		585.00	609.00
22212	Revision of thorax spine	7.00		1.00		610.00	640.00
22214	Revision of lumbar spine	7.00		1.00		585.00	624.00
22220	Revision of neck spine	6.50		1.00		565.00	585.00
22222	Revision of thorax spine	7.50		1.00		630.00	651.00
22224	Revision of lumbar spine	7.50		1.00		620.00	666.00
22315	Treat spine fracture	1.00		1.00		257.00	252.00
22325	Treat spine fracture	5.50		1.00		504.00	528.00
22326	Treat neck spine fracture	5.50		1.00		452.00	480.00
22327	Treat thorax spine fracture	9.00		1.00		505.00	604.00
22548	Neck spine fusion	8.00		1.00	1.00	532.00	673.00
22556	Thorax spine fusion	3.00		1.00	1.00	525.00	557.00
22558	Lumbar spine fusion	2.00		1.00	1.00	502.00	525.00

TABLE 14—GLOBAL SURGICAL PACKAGE VISITS AND PHYSICIAN TIME CHANGES—Continued

CPT code	Short descriptor	Visits included in Global Package [1]				CY 2013 physician time	CY 2014 physician time
		99231	99232	99238	99291		
22590	Spine & skull spinal fusion	3.00		1.00		532.00	501.00
22595	Neck spinal fusion	6.00		1.00		492.00	521.00
22600	Neck spine fusion	6.00		1.00		437.00	490.00
22610	Thorax spine fusion	7.50		1.00		468.00	549.00
22630	Lumbar spine fusion	3.00		1.00		501.00	487.00
22800	Fusion of spine	7.00		1.00		517.00	571.00
22802	Fusion of spine	4.00		1.00		552.00	538.00
22804	Fusion of spine	5.00		1.00		630.00	595.00
22808	Fusion of spine	5.00		1.00		553.00	530.00
22810	Fusion of spine	5.00		1.00		613.00	595.00
22812	Fusion of spine	7.50		1.00		666.00	700.00
31582	Revision of larynx	8.00		1.00		489.00	654.00
32650	Thoracoscopy w/pleurodesis	2.00		1.00		322.00	290.00
32656	Thoracoscopy w/pleurectomy	3.00		1.00		419.00	377.00
32658	Thoracoscopy w/sac fb remove	1.00		1.00		362.00	330.00
32659	Thoracoscopy w/sac drainage	2.00		1.00		414.00	357.00
32661	Thoracoscopy w/pericard exc	1.00		1.00		342.00	300.00
32664	Thoracoscopy w/th nrv exc	1.00		1.00		362.00	330.00
32820	Reconstruct injured chest	3.50		1.00	4.50	631.00	854.00
33236	Remove electrode/thoracotomy	4.00		1.00		258.00	346.00
33237	Remove electrode/thoracotomy	5.00		1.00		378.00	456.00
33238	Remove electrode/thoracotomy	5.00		1.00		379.00	472.00
33243	Remove eltrd/thoracotomy	5.00		1.00		504.00	537.00
33321	Repair major vessel	8.00		1.00		751.00	754.00
33332	Insert major vessel graft	8.00		1.00		601.00	604.00
33401	Valvuloplasty open	8.00		1.00		830.00	661.00
33403	Valvuloplasty w/cp bypass	8.00		1.00		890.00	638.00
33417	Repair of aortic valve	2.50		1.00	2.50	740.00	750.00
33472	Revision of pulmonary valve	0.50		1.00	4.50	665.00	780.00
33502	Coronary artery correction	2.50		1.00	2.50	710.00	688.00
33503	Coronary artery graft	5.50		1.00	2.50	890.00	838.00
33504	Coronary artery graft	4.50		1.00	2.50	740.00	789.00
33600	Closure of valve	6.00		1.00		800.00	628.00
33602	Closure of valve	6.00		1.00		770.00	628.00
33606	Anastomosis/artery-aorta	8.00		1.00		860.00	728.00
33608	Repair anomaly w/conduit	5.00		1.00		800.00	668.00
33690	Reinforce pulmonary artery	2.50		1.00	2.50	620.00	636.00
33702	Repair of heart defects	0.50		1.00	3.50	663.00	751.00
33722	Repair of heart defect	5.00		1.00		770.00	608.00
33732	Repair heart-vein defect	5.00		1.00		710.00	578.00
33735	Revision of heart chamber	2.50		1.00	3.50	740.00	770.00
33736	Revision of heart chamber	5.00		1.00		710.00	548.00
33750	Major vessel shunt	2.00		1.00	3.00	680.00	722.00
33764	Major vessel shunt & graft	1.50		1.00	3.50	710.00	750.00
33767	Major vessel shunt	5.00		1.00		800.00	608.00
33774	Repair great vessels defect	0.50		1.00	6.50	845.00	998.00
33788	Revision of pulmonary artery	2.50		1.00	2.50	770.00	736.00
33802	Repair vessel defect	2.50		1.00	1.50	558.00	556.00
33803	Repair vessel defect	2.50		1.00	1.50	618.00	586.00
33820	Revise major vessel	1.00		1.00	1.00	430.00	414.00
33824	Revise major vessel	0.50		1.00	2.50	588.00	615.00
33840	Remove aorta constriction	1.50		1.00	2.50	588.00	639.00
33845	Remove aorta constriction	1.00		1.00	3.00	710.00	726.00
33851	Remove aorta constriction	2.00		1.00	3.00	603.00	700.00
33852	Repair septal defect	2.00		1.00	3.00	663.00	719.00
33853	Repair septal defect	8.00		1.00		800.00	668.00
33917	Repair pulmonary artery	5.00		1.00		740.00	608.00
33920	Repair pulmonary atresia	6.00		1.00		800.00	658.00
33922	Transect pulmonary artery	5.00		1.00		618.00	546.00
33974	Remove intra-aortic balloon	1.00		1.00		406.00	314.00
34502	Reconstruct vena cava	6.00		1.00		793.00	741.00
35091	Repair defect of artery	11.00		1.00	2.00	597.00	790.00
35694	Arterial transposition	2.00		1.00		468.00	456.00
35901	Excision graft neck	4.00		1.00		484.00	482.00
35903	Excision graft extremity	3.00		1.00		408.00	416.00
47135	Transplantation of liver	23.00		1.00		1501.00	1345.00
47136	Transplantation of liver	28.00		1.00		1301.00	1329.00
49422	Remove tunneled ip cath	1.00		1.00		154.00	182.00
49429	Removal of shunt	6.00		1.00		249.00	317.00
50320	Remove kidney living donor	4.00		1.00		480.00	524.00

TABLE 14—GLOBAL SURGICAL PACKAGE VISITS AND PHYSICIAN TIME CHANGES—Continued

CPT code	Short descriptor	Visits included in Global Package [1]				CY 2013 physician time	CY 2014 physician time
		99231	99232	99238	99291		
50845	Appendico-vesicostomy	5.00		1.00		685.00	613.00
56632	Extensive vulva surgery	7.00		1.00		835.00	683.00
60520	Removal of thymus gland	2.00		1.00	2.00	406.00	474.00
60521	Removal of thymus gland	5.00		1.00		457.00	445.00
60522	Removal of thymus gland	7.00		1.00		525.00	533.00
61557	Incise skull/sutures	3.00		1.00		529.00	510.00
63700	Repair of spinal herniation	3.00		1.00		399.00	401.00
63702	Repair of spinal herniation	3.00		1.00		469.00	463.00
63704	Repair of spinal herniation	8.00		1.00		534.00	609.00
63706	Repair of spinal herniation	8.00		1.00		602.00	679.00

[1] We note that in the CY 2014 proposed rule, this table displayed only whole numbers of visits, although the actual time file and our ratesetting calculations use data to two places beyond the decimal point.

iii. Codes With Higher Total Medicare Payments in Office Than in Hospital or ASC

In the CY 2014 proposed rule with comment period, we proposed to address nearly 200 codes that we believe to have misvalued resource inputs. These are codes for which the total PFS payment when furnished in an office or other nonfacility setting would exceed the total Medicare payment (the combined payment to the facility and the professional) when the service is furnished in a facility, either a hospital outpatient department or an ASC.

For services furnished in a facility setting we would generally expect the combined payment to the facility and the practitioner to exceed the PFS payment made to the professional when the service is furnished in the nonfacility setting. This payment differential is expected because it reflects the greater costs we would expect to be incurred by facilities relative to physicians furnishing services in offices and other non-facility settings. These greater costs are due to higher overhead resulting from differences in regulatory requirements and for facilities, such as hospitals, maintaining the capacity to furnish services 24 hours per day and 7 days per week. However, when we analyzed such payments, we identified nearly 300 codes that would result in greater Medicare payment in the nonfacility setting than in the facility setting. We believe these anomalous site-of-service payment differentials are the result of inaccurate resource input data used to establish rates under the PFS.

We proposed to address these misvalued codes by refining the PE methodology to limit the nonfacility PE RVUs for individual codes so that the total nonfacility PFS payment amount would not exceed the total combined payment under the PFS and the OPPS (or the ASC payment system) when the service is furnished in the facility setting.

Section II.B.3 discusses the comment received on this misvalued code proposal and our response to these comments.

4. Multiple Procedure Payment Reduction Policy

Medicare has long employed multiple procedure payment reduction (MPPR) policies to adjust payment to more appropriately reflect reduced resources involved with furnishing services that are frequently furnished together. Under these policies, we reduce payment for the second and subsequent services within the same MPPR category furnished in the same session or same day. These payment reductions reflect efficiencies that typically occur in either the PE or professional work or both when services are furnished together. With the exception of a few codes that are always reported with another code, the PFS values services independently to recognize relative resources involved when the service is the only one furnished in a session. Although some of our MPPR policies precede the Affordable Care Act, MPPRs can address the fourth category of potentially misvalued codes identified in section 1848(c)(2)(K) of the Act, as added by the Affordable Care Act, which is "multiple codes that are frequently billed in conjunction with furnishing a single service" (see 75 FR 73216). The following sections describe the history of MPPRs and the services currently covered by MPPRs.

a. Background

Medicare has a longstanding policy to reduce payment by 50 percent for the second and subsequent surgical procedures furnished to the same beneficiary by a single physician or physicians in the same group practice on the same day, largely based on the presence of efficiencies in the PE and pre- and post-surgical physician work. Effective January 1, 1995, the MPPR policy, with this same percentage reduction, was extended to nuclear medicine diagnostic procedures (CPT codes 78306, 78320, 78802, 78803, 78806, and 78807). In the CY 1995 PFS final rule with comment period (59 FR 63410), we indicated that we would consider applying the policy to other diagnostic tests in the future.

Consistent with recommendations of MedPAC in its March 2005 Report to the Congress on Medicare Payment Policy, for CY 2006 PFS, we extended the MPPR policy to the TC of certain diagnostic imaging procedures furnished on contiguous areas of the body in a single session (70 FR 70261). This MPPR policy recognizes that for the second and subsequent imaging procedures furnished in the same session, there are some efficiencies in clinical labor, supplies, and equipment time. In particular, certain clinical labor activities and supplies are not duplicated for subsequent imaging services in the same session and, because equipment time and indirect costs are allocated based on clinical labor time, adjustment to those figures is appropriate as well.

The imaging MPPR policy originally applied to computed tomography (CT) and computed tomographic angiography (CTA), magnetic resonance imaging (MRI) and magnetic resonance angiography (MRA), and ultrasound services within 11 families of codes based on imaging modality and body region, and only applied to procedures furnished in a single session involving contiguous body areas within a family of codes. Additionally, this MPPR policy originally applied to TC-only services and to the TC of global services, but not to professional component (PC) services.

There have been several revisions to this policy since it was originally adopted. Under the current imaging MPPR policy, full payment is made for the TC of the highest paid procedure, and payment for the TC is reduced by 50 percent for each additional procedure subject to this MPPR policy. We originally planned to phase in the imaging MPPR policy over a 2-year period, with a 25 percent reduction in CY 2006 and a 50 percent reduction in CY 2007 (70 FR 70263). However, section 5102(b) of the Deficit Reduction Act of 2005 (DRA) (Pub. L. 109–171, enacted on December 20, 2006) amended the statute to place a cap on the PFS payment amount for most imaging procedures at the amount paid under the hospital OPPS. In view of this new OPPS payment cap, we decided in the CY 2006 PFS final rule with comment period that it would be prudent to retain the imaging MPPR at 25 percent while we continued to examine the appropriate payment levels (71 FR 69659). The DRA also exempted reduced expenditures attributable to the imaging MPPR policy from the PFS budget neutrality provision. Effective July 1, 2010, section 1848(b)(4)(C) of the Act increased the MPPR on the TC of imaging services under the policy established in the CY 2006 PFS final rule with comment period from 25 to 50 percent. Section 1848(c)(2)(B)(v)(IV) of the Act exempted the reduced expenditures attributable to this further change from the PFS budget neutrality provision.

In the July 2009 U.S. Government Accountability Office (GAO) report entitled, *Medicare Physician Payments: Fees Could Better Reflect Efficiencies Achieved when Services are Provided Together,* the GAO recommended that we take further steps to ensure that fees for services paid under the PFS reflect efficiencies that occur when services are furnished by the same physician to the same beneficiary on the same day. The GAO report recommended the following: (1) Expanding the existing imaging MPPR policy for certain services to the PC to reflect efficiencies in physician work for certain imaging services; and (2) expanding the MPPR to reflect PE efficiencies that occur when certain nonsurgical, nonimaging services are furnished together. The GAO report also encouraged us to focus on service pairs that have the most impact on Medicare spending.

In its March 2010 report, MedPAC noted its concerns about mispricing of services under the PFS. MedPAC indicated that it would explore whether expanding the unit of payment through packaging or bundling would improve payment accuracy and encourage more efficient use of services. In the CY 2009 and CY 2010 PFS proposed rules (73 FR 38586 and 74 FR 33554, respectively), we stated that we planned to analyze nonsurgical services commonly furnished together (for example, 60 to 75 percent of the time) to assess whether an expansion of the MPPR policy could be warranted. MedPAC encouraged us to consider duplicative physician work, as well as PE, in any expansion of the MPPR policy.

Section 1848(c)(2)(K) of the Act specifies that the Secretary shall identify potentially misvalued codes by examining multiple codes that are frequently billed in conjunction with furnishing a single service, and review and make appropriate adjustments to their relative values. As a first step in applying this provision, in the CY 2010 final rule with comment period, we implemented a limited expansion of the imaging MPPR policy to additional combinations of imaging services.

Effective January 1, 2011, the imaging MPPR applies regardless of code family; that is, the policy applies to multiple imaging services furnished within the same family of codes or across families. This policy is consistent with the standard PFS MPPR policy for surgical procedures that does not group procedures by body region. The current imaging MPPR policy applies to CT and CTA, MRI and MRA, and ultrasound procedures furnished to the same beneficiary in the same session, regardless of the imaging modality, and is not limited to contiguous body areas.

As we noted in the CY 2011 PFS final rule with comment period (75 FR 73228), although section 1848(c)(2)(B)(v)(VI) of the Act specifies that reduced expenditures attributable to the increase in the imaging MPPR from 25 to 50 percent (effective for fee schedules established beginning with 2010 and for services furnished on or after July 1, 2010) are excluded from the PFS budget neutrality adjustment, it does not apply to reduced expenditures attributable to our policy change regarding additional code combinations across code families (noncontiguous body areas) that are subject to budget neutrality under the PFS. The complete list of codes subject to the CY 2011 MPPR policy for diagnostic imaging services is included in Addendum F.

As a further step in applying the provisions of section 1848(c)(2)(K) of the Act, on January 1, 2011, we implemented an MPPR for therapy services. The MPPR applies to separately payable "always therapy" services, that is, services that are only paid by Medicare when furnished under a therapy plan of care. As we explained in the CY 2011 PFS final rule with comment period (75 FR 73232), the therapy MPPR does not apply to contractor-priced codes, bundled codes, or add-on codes.

This MPPR for therapy services was first proposed in the CY 2011 proposed rule (75 FR 44075) as a 50 percent payment reduction to the PE component of the second and subsequent therapy services for multiple "always therapy" services furnished to a single beneficiary in a single day. It applies to services furnished by an individual or group practice or "incident to" a physician's service. However, in response to public comments, in the CY 2011 PFS final rule with comment period (75 FR 73232), we adopted a 25 percent payment reduction to the PE component of the second and subsequent therapy services for multiple "always therapy" services furnished to a single beneficiary in a single day.

Subsequent to publication of the CY 2011 PFS final rule with comment period, section 3 of the Physician Payment and Therapy Relief Act of 2010 (PPTRA) (Pub. L. 111–286) revised the payment reduction percentage from 25 percent to 20 percent for therapy services for which payment is made under a fee schedule under section 1848 of the Act (which are services furnished in office settings, or non-institutional services). The payment reduction percentage remained at 25 percent for therapy services furnished in institutional settings. Section 4 of the PPTRA exempted the reduced expenditures attributable to the therapy MPPR policy from the PFS budget neutrality provision. Section 633 of the ATRA revised the reduction to 50 percent of the PE component for all settings, effective April 1, 2013. Therefore, full payment is made for the service or unit with the highest PE and payment for the PE component for the second and subsequent procedures or additional units of the same service is reduced by 50 percent for both institutional and non-institutional services.

This MPPR policy applies to multiple units of the same therapy service, as well as to multiple different "always therapy" services, when furnished to the same beneficiary on the same day. The MPPR applies when multiple therapy services are billed on the same date of service for one beneficiary by the same practitioner or facility under the same National Provider Identifier (NPI), regardless of whether the services are furnished in one therapy discipline or multiple disciplines, including physical

therapy, occupational therapy, or speech-language pathology.

The MPPR policy applies in all settings where outpatient therapy services are paid under Part B. This includes both services that are furnished in the office setting and paid under the PFS, as well as institutional services that are furnished by outpatient hospitals, home health agencies, comprehensive outpatient rehabilitation facilities (CORFs), and other entities that are paid for outpatient therapy services at rates based on the PFS.

In its June 2011 Report to Congress, MedPAC highlighted continued growth in ancillary services subject to the in-office ancillary services exception. The in-office ancillary exception to the physician self-referral prohibition in section 1877 of the Act, also known as the Stark law, allows physicians to refer Medicare beneficiaries to their own group practices for designated health services, including imaging, radiation therapy, home health care, clinical laboratory tests, and physical therapy, if certain conditions are met. MedPAC recommended that we curb overutilization by applying a MPPR to the PC of diagnostic imaging services furnished by the same practitioner in the same session. As noted above, the GAO already had made a similar recommendation in its July 2009 report.

In continuing to apply the provisions of section 1848(c)(2)(K) of the Act regarding potentially misvalued codes that result from "multiple codes that are frequently billed in conjunction with furnishing a single service," in the CY 2012 final rule (76 FR 73071), we expanded the MPPR to the PC of Advanced Imaging Services (CT, MRI, and Ultrasound), that is, the same list of codes to which the MPPR on the TC of advanced imaging already applied. Thus, this MPPR policy now applies to the PC and the TC of certain diagnostic imaging codes. Specifically, we expanded the payment reduction currently applied to the TC to apply also to the PC of the second and subsequent advanced imaging services furnished by the same physician (or by two or more physicians in the same group practice) to the same beneficiary in the same session on the same day. However, in response to public comments, in the CY 2012 PFS final rule with comment period, we adopted a 25 percent payment reduction to the PC component of the second and subsequent imaging services.

Under this policy, full payment is made for the PC of the highest paid advanced imaging service, and payment is reduced by 25 percent for the PC for each additional advanced imaging service furnished to the same beneficiary in the same session. This policy was based on the expected efficiencies in furnishing multiple services in the same session due to duplication of physician work, primarily in the pre- and post-service periods, but with some efficiencies in the intraservice period.

This policy is consistent with the statutory requirement for the Secretary to identify, review, and adjust the relative values of potentially misvalued services under the PFS as specified by section 1848(c)(2)(K) of the Act. This policy is also consistent with our longstanding policies on surgical and nuclear medicine diagnostic procedures, under which we apply a 50 percent payment reduction to second and subsequent procedures. Furthermore, it was responsive to continued concerns about significant growth in imaging spending, and to MedPAC (March 2010 and June 2011) and GAO (July 2009) recommendations regarding the expansion of MPPR policies under the PFS to account for additional efficiencies.

In the CY 2013 final rule (77 FR 68933), we expanded the MPPR to the TC of certain cardiovascular and ophthalmology diagnostic tests. Although we proposed a 25 percent reduction for both diagnostic cardiovascular and ophthalmology services, we adopted a 20 percent reduction for ophthalmology services in the final rule with comment period (77 FR 68941) in response to public comments. For diagnostic cardiovascular services, full payment is made for the procedure with the highest TC payment, and payment is reduced by 25 percent for the TC for each additional procedure furnished to the same patient on the same day. For diagnostic ophthalmology services, full payment is made for the procedure with the highest TC payment, and payment is reduced by 20 percent for the TC for each additional procedure furnished to the same patient on the same day.

We did not propose and are not adopting any new MPPR policies for CY 2014. However, we continue to look at expanding the MPPR based on efficiencies when multiple procedures are furnished together.

The complete list of services subject to the MPPRs on diagnostic imaging services, therapy services, diagnostic cardiovascular services and diagnostic ophthalmology services is shown in Addenda F, H, I, and J. We note that Addenda H, which lists services subject to the MPPR on therapy services, contains four new CPT codes. Specifically, CPT code 92521 (Evaluation of speech fluency), 92522 (Evaluate speech sound production), 92523 (Speech sound language comprehension) and 92524 (Behavioral and qualitative analysis of voice and resonance) are being added to the list. These codes replace CPT code 92506 (Speech/hearing evaluation) for CY 2014. Accordingly, CPT 92506 has been deleted from Addenda H. Like CPT 92506, these new codes are "always therapy" services that are only paid by Medicare when furnished under a therapy plan of care. Thus, like CPT 92506, they are subject to the MPPR for therapy services. They have been added to the list of services subject to the MPPR on therapy services on an interim final basis, and are open to public comment on this final rule with comment period.

C. Malpractice RVUs

Section 1848(c) of the Act requires that each service paid under the PFS be composed of three components: work, PE, and malpractice. From 1992 to 1999, malpractice RVUs were charge-based, using weighted specialty-specific malpractice expense percentages and 1991 average allowed charges. Malpractice RVUs for new codes after 1991 were extrapolated from similar existing codes or as a percentage of the corresponding work RVU. Section 4505(f) of the BBA, which amended section 1848(c) of the Act, required us to implement resource-based malpractice RVUs for services furnished beginning in 2000. Therefore, initial implementation of resource-based malpractice RVUs occurred in 2000.

The statute also requires that we review and, if necessary, adjust RVUs no less often than every 5 years. The first review and corresponding update of resource-based malpractice RVUs was addressed in the CY 2005 PFS final rule with comment period (69 FR 66263). Minor modifications to the methodology were addressed in the CY 2006 PFS final rule with comment period (70 FR 70153). In the CY 2010 PFS final rule with comment period, we implemented the second review and corresponding update of malpractice RVUs. For a discussion of the second review and update of malpractice RVUs, see the CY 2010 PFS proposed rule (74 FR 33537) and final rule with comment period (74 FR 61758).

As explained in the CY 2011 PFS final rule with comment period (75 FR 73208), malpractice RVUs for new codes, revised codes and codes with revised work RVUs (new/revised codes) effective before the next five-year review of malpractice RVUs (for example, effective CY 2011 through CY 2014,

assuming that the next review of malpractice RVUs occurs for CY 2015) are determined either by a direct crosswalk from a similar source code or by a modified crosswalk to account for differences in work RVUs between the new/revised code and the source code. For the modified crosswalk approach, we adjust (or "scale") the malpractice RVU for the new/revised code to reflect the difference in work RVU between the source code and the new/revised work value (or, if greater, the clinical labor portion of the PE RVU) for the new code. For example, if the proposed work RVU for a revised code is 10 percent higher than the work RVU for its source code, the malpractice RVU for the revised code would be increased by 10 percent over the source code malpractice RVU. This approach presumes the same risk factor for the new/revised code and source code but uses the work RVU for the new/revised code to adjust for the difference in risk attributable to the variation in work between the two services.

For CY 2014, we use this approach for determining malpractice RVUs for new/revised codes. A list of new/revised codes and the malpractice crosswalks used to determine their malpractice RVUs are in Sections II.E.2.c and 3.c in this final rule with comment period. The CY 2014 malpractice RVUs for interim final codes are being implemented in the CY 2014 PFS final rule with comment period. These RVUs are subject to public comment. After considering public comments, they will then be finalized in the CY 2015 PFS final rule with comment period.

D. Medicare Economic Index (MEI)

1. Revising of the Medicare Economic Index (MEI)

a. Background

The Medicare Economic Index (MEI) is authorized under section 1842(b)(3) of the Act, which states that prevailing charge levels beginning after June 30, 1973 may not exceed the level from the previous year except to the extent that the Secretary finds, on the basis of appropriate economic index data, that such a higher level is justified by year-to-year economic changes. Beginning July 1, 1975, and continuing through today, the MEI has met this requirement by reflecting the weighted-average annual price change for various inputs involved in furnishing physicians' services. The MEI is a fixed-weight input price index, with an adjustment for the change in economy-wide, private nonfarm business multifactor productivity. This index is comprised of two broad categories: (1) physicians' own time; and (2) physicians' practice expense (PE).

The current general form of the MEI was described in the November 25, 1992 **Federal Register** (57 FR 55896) and was based in part on the recommendations of a Congressionally-mandated meeting of experts held in March 1987. Since that time, the MEI has been updated or revised on four instances. First, the MEI was rebased in 1998 (63 FR 58845), which moved the cost structure of the index from 1992 data to 1996 data. Second, the methodology for the productivity adjustment was revised in the CY 2003 PFS final rule with comment period (67 FR 80019) to reflect the percentage change in the 10-year moving average of economy-wide private nonfarm business multifactor productivity. Third, the MEI was rebased in 2003 (68 FR 63239), which moved the cost structure of the index from 1996 data to 2000 data. Fourth, the MEI was rebased in 2011 (75 FR 73262), which moved the cost structure of the index from 2000 data to 2006 data.

The terms "rebasing" and "revising," while often used interchangeably, actually denote different activities. Rebasing refers to moving the base year for the structure of costs of a price index, while revising relates to other types of changes such as changing data sources, cost categories, or price proxies used in the price index. For CY 2014, we proposed to revise the MEI based on the recommendations of the MEI Technical Advisory Panel (TAP). We did not propose to rebase the MEI and will continue to use the data from 2006 to estimate the cost weights, since these are the most recently available, relevant, and complete data we have available to develop these weights.

b. MEI Technical Advisory Panel (TAP) Recommendations

The MEI–TAP was convened to conduct a technical review of the MEI, including the inputs, input weights, price-measurement proxies, and productivity adjustment. After considering these issues, the MEI–TAP was asked to assess the relevance and accuracy of inputs relative to current physician practices. The MEI–TAP's analysis and recommendations were to be considered in future rulemaking to ensure that the MEI accurately and appropriately meets its intended statutory purpose.

The MEI–TAP consisted of five members and held three meetings in 2012: May 21; June 25; and July 11. It produced eight findings and 13 recommendations for consideration by CMS. Background on the MEI–TAP members, meeting transcripts for all three meetings, and the MEI–TAP's final report, including all findings and recommendations, are available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/FACA/MEITAP.html*. We have determined, as noted in the proposed rule, that it is possible to implement some of the recommendations immediately, while more in-depth research is required to address several of the other recommendations.

For CY 2014, we proposed to implement 10 of the 13 recommendations made by the MEI–TAP. The remaining recommendations require more in-depth research, and we will continue evaluating these three recommendations and will propose any further changes to the MEI in future rulemaking. The CY 2014 changes only involve revising the MEI categories, cost shares, and price proxies. Again, we did not propose to rebase the MEI for CY 2014 since the MEI–TAP concluded that there is not a newer, reliable, or ongoing source of data to maintain the MEI.

c. Overview of Revisions

The MEI was last rebased and revised in the CY 2011 PFS final rule with comment period (75 FR 73262—73275). The current base year for the MEI is 2006, which means that the cost weights in the index reflect physicians' expenses in 2006. The details of the methodology used to determine the 2006 cost shares were provided in the CY 2011 PFS proposed rule and finalized in the CY 2011 PFS final rule with comment period (75 FR 40087 and 75 FR 73262, respectively). For CY 2014 we proposed to make the following revisions to the 2006-based MEI:

(1) Reclassify and revise certain cost categories:

- Reclassify expenses for non-physician clinical personnel that can bill independently from non-physician compensation to physician compensation.
- Revise the physician wage and benefit split so that the cost weights are more in line with the definitions of the price proxies used for each category.
- Add an additional subcategory under non-physician compensation for health-related workers.
- Create a new cost category called "All Other Professional Services" that includes expenses covered in the current MEI categories: "All Other Services" and "Other Professional Expenses." The "All Other Professional Services" category would be further disaggregated into appropriate occupational subcategories.
- Create an aggregate cost category called "Miscellaneous Office Expenses"

that would include the expenses for "Rubber and Plastics," "Chemicals," "All Other Products," and "Paper."

(2) Revise price proxies:

- Revise the price proxy for physician wages and salaries from the Average Hourly Earnings (AHE) for the Total Private Nonfarm Economy for Production and Nonsupervisory Workers to the ECI for Wages and Salaries, Professional and Related Occupations, Private Industry.
- Revise the price proxy for physician benefits from the ECI for Benefits for the Total Private Industry to the ECI for Benefits, Professional and Related Occupations, Private Industry.
- Use the ECI for Wages and Salaries and the ECI for Benefits of Hospital, Civilian workers (private industry) as the price proxies for the new category of non-physician health-related workers.
- Use ECIs to proxy the Professional Services occupational subcategories that reflect the type of professional services purchased by physicians' offices.
- Revise the price proxy for the fixed capital category from the CPI for Owners' Equivalent Rent of Residences to the PPI for Lessors of Nonresidential Buildings (NAICS 53112).

d. Revising Expense Categories in the MEI

We did not propose any changes in the methodology for estimating the cost shares as finalized in the CY 2011 PFS final rule with comment period (75 FR 73263–73267). For CY 2014, we proposed to revise the classification of certain expenses within the 2006-based MEI. The details of the proposed revisions and the MEI–TAP recommendation that is the impetus for each of the revisions can be found in the CY 2014 PFS proposed rule (78 FR 43312–43316). The following sections summarize the proposed revisions to the cost weights for CY 2014.

(1) Overall MEI Cost Weights.

Table 15 lists the set of mutually exclusive and exhaustive cost categories and weights that were proposed for CY 2014. A comparison of the proposed revised MEI cost categories and cost shares to the 2006-based MEI cost categories and cost shares as finalized in the CY 2011 PFS final rule can be found at 78 FR 43312–43313.

Based on the proposed revisions to the MEI for CY 2014, the proposed physician compensation cost weight under the revised MEI is 2.600 percentage points higher than the physician compensation weight in the current MEI. This change occurs because of the reclassification of expenses for non-physician clinical staff that can bill independently from non-physician compensation to physician compensation. This change lowers the PE cost weight by 2.600 percent as well, all of which comes from a lower weight for non-physician compensation. The remaining MEI cost weights are unchanged.

The proposed revised MEI includes four new detailed cost categories and two new sub-aggregate cost categories. The new detailed cost categories are:

- Health-related, non-physician wages and salaries.
- Professional, scientific, and technical services.
- Administrative support and waste management services.
- All other services.

The new sub-aggregate categories are:

- Non-health, non-physician wages.
- Miscellaneous office expenses.

The proposed revised MEI excludes two sub-aggregate categories that were included in the current 2006-based MEI. The sub-aggregate categories removed are:

- Office expenses.
- Drugs & supplies.

TABLE 15—REVISED 2006 MEI COST CATEGORIES AND, WEIGHTS

[Revised MEI (2006=100), CY2014]

Revised cost category	Revised weights (percent)
Physician Compensation	50.866
Wages and Salaries	43.641
Benefits	7.225
Practice Expense	49.134
Non-physician compensation	16.553
Non-physician wages	11.885
Non-health, non-physician wages	7.249
Professional and Related	0.800
Management	1.529
Clerical	4.720
Services	0.200
Health related, non-physician wages	4.636
Non-physician benefits	4.668
Other Practice Expense	32.581
Utilities	1.266
Miscellaneous Office Expenses	2.478
Chemicals	0.723
Paper	0.656
Rubber & Plastics	0.598
All other products	0.500
Telephone	1.501
Postage	0.898
All Other professional services	8.095
Professional, scientific, & technical services	2.592
Administrative support & waste management	3.052
All other services	2.451
Capital	10.310
Fixed Capital	8.957
Moveable Capital	1.353
Professional Liability Insurance	4.295
Medical Equipment	1.978

TABLE 15—REVISED 2006 MEI COST CATEGORIES AND, WEIGHTS—Continued

[Revised MEI (2006=100), CY2014]

Revised cost category	Revised weights (percent)
Medical supplies	1.760
Total MEI	100.000

* The term (2006=100) refers to the base year of the MEI.

(2) Physician Compensation (Own Time)

The component of the MEI that reflects the physician's own time is represented by the net income portion of business receipts. The 2006 cost weight associated with the physician's own time (otherwise referred to as the Physician's Compensation cost weight) is based on 2006 AMA PPIS data for mean physician net income (physician compensation) for self-employed physicians and for the selected self-employed specialties. Expenses for employed physician compensation are combined with expenses for self-employed physician compensation to obtain an aggregate Physician Compensation cost weight. Based on this methodology, the Physician Compensation cost weight in the current MEI is 48.266 percent. For CY 2014, we proposed to reclassify the expenses for non-physician practitioners that can bill independently from the non-physician cost category in the MEI to the physician compensation cost category for several reasons:

- These types of practitioners furnish services that are similar to those furnished by physicians.
- If billing independently, these practitioners would be paid at a percentage of the physicians' services or in certain cases at the same rate as physicians.
- The expenses related to the work components for the RVUs would include work from clinical staff that can bill independently. Therefore, it would improve consistency with the RVU payments to include these expenses as physician compensation in the MEI.

The effect of moving the expenses related to clinical staff that can bill independently is to increase the physician compensation cost share by 2.600 percentage points and to reduce the non-physician compensation cost share by the same amount. The physician compensation cost share for the proposed revised MEI is 50.866 percent compared to the physician compensation cost share of 48.266 percent in the current MEI.

Within the physician compensation cost weight, the MEI includes a separate weight for wages and salaries and a separate weight for benefits. Under the current 2006-based MEI, the ratio for wages and salaries, and benefits was calculated using data from the PPIS.

Based on MEI–TAP recommendation 3.1 we proposed to revise the wage and benefit split used for physician compensation. Specifically, we proposed to apply the distribution from the Statistics of Income (SOI) data to both self-employed and employed physician compensation. In reviewing the detailed AMA PPIS survey questions, it was clear that self-employed physician benefits were mainly comprised of insurance costs while other benefits such as physician retirement, paid leave, and payroll taxes were likely included in physician wages and salaries.

By definition, the price proxy used for physician benefits, which is an Employment Cost Index (ECI) concept, includes retirement savings. Thus, using the AMA PPIS data produced a definitional inconsistency between the cost weight and the price proxy. Therefore, we proposed to use the data on wages and salaries, and employee benefits from the SOI data for Offices of Physicians and Dentists for partnerships and corporations for both self-employed and employed physicians. From the SOI data, benefit expenses were estimated by summing the partnership data for retirement plans and employee benefit programs with corporation data for pension, profit-sharing plans and employee benefit programs. For 2006, the split between wages and salaries, and benefits was 85.8 percent and 14.2 percent, respectively. Retirement/pension plans account for about 60 percent of total benefits. The SOI data do not classify paid leave and supplemental pay as a benefit.

Combining the impact of classifying compensation for non-physicians that can bill independently as physician compensation with the use of the SOI data, the physician wages and salary cost share in the revised MEI is lower than the current MEI by 0.240 percentage points. These two methodological changes result in an increase in the physician benefit cost share in the revised MEI of 2.839 percentage points. As a result, the proposed physician wages and salary cost share for the revised MEI is 43.641 percent and the proposed physician benefit cost share for the revised MEI is 7.225 percent.

(3) Physician's Practice Expenses

To determine the PE cost weights, we use mean expense data from the 2006 PPIS survey. The derivation of the weights and categories for practice expenses is the same as finalized in the CY 2011 PFS final rule with comment period (75 FR 73264–73267), except where noted below.

(a) Non-Physician Employee Compensation

For CY 2014 we proposed to exclude the expenses related to non-physician clinical staff that can bill independently from this cost category. Moving the expenses related to the clinical staff that can bill independently out of non-physician compensation costs decreases the share by 2.600 percentage points. The non-physician compensation cost share for the revised MEI is 16.553 percent compared to the current physician compensation cost share of 19.153 percent.

We are further proposed to use the same method as finalized in the CY 2011 PFS final rule to split the non-physician compensation between wages and benefits. For reference, we use 2006 BLS Employer Costs for Employee Compensation (ECEC) data for the Health Care and Social Assistance (private industry). Data for 2006 in the ECEC for Health Care and Social Assistance indicate that wages and benefits are 71.8 percent and 28.2 percent of compensation, respectively. The non-physician wage and benefit cost shares for the revised MEI are 11.885 percent and 4.668 percent, respectively.

The current 2006-based MEI further disaggregated the non-physician wages into four occupational subcategories, the details of this method can be found in the CY 2011 PFS final rule with comment period (75 FR 73264–73265). Based on the MEI–TAP

Recommendation 4.4, the Panel recommended the disaggregation of the non-physician compensation costs to include an additional category for health-related workers. The exact recommendation can be found at 78 FR 43314.

We proposed to implement this recommendation using expenses reported on the AMA PPIS for non-physician, non-health-related workers. The survey question asks for the expenses for: "non-clinical personnel involved primarily in administrative, secretarial or clerical activities (Including transcriptionists, medical records personnel, receptionists, schedulers and billing staff, coding staff, information technology staff, and custodial personnel)." Using this method, the proposed non-physician, non-health-related wage cost share for the revised MEI is 7.249 percent.

For wage costs of non-physician, health-related workers, the survey question asks for the expenses for: "other clinical staff, including RNs, LPNs, physicists, lab technicians, x-ray technicians, medical assistants, and other clinical personnel who cannot independently bill." Using this method, the proposed non-physician, health-related wage cost share for the revised MEI is 4.636 percent. Together the non-health and health-related, non-physician wage costs sum to be equal to the total non-physician wage share in the revised MEI of 11.885 percent.

We further proposed to disaggregate the non-physician, non-health-related wage cost weight of 7.249 percent into four occupational subcategories. The methodology is similar to that finalized in the CY 2011 PFS final rule with comment period (75 FR 73264), in that we are using 2006 Current Population Survey (CPS) data and 2006 BLS Occupational Employment Statistics (OES) data to develop cost weights for wages for non-physician, non-health-related occupational groups. We determined total annual earnings for offices of physicians using employment data from the CPS and mean annual earnings from the OES. To arrive at a distribution for these separate occupational categories (Professional & Related (P&R) workers, Managers, Clerical workers, and Service workers), we determined annual earnings for each using the Standard Occupational Classification (SOC) system. We then determined the overall share of the total for each. The proposed occupational distribution in the revised MEI is presented in Table 16. The comparison between the proposed revised distribution of non-physician payroll expense by occupational group to the prior comparison can be found in the CY 2014 PFS proposed rule at 78 FR43315.

TABLE 16—PERCENT DISTRIBUTION OF NON-PHYSICIAN PAYROLL EXPENSE BY OCCUPATIONAL GROUP: REVISED 2006-BASED MEI

[Revised MEI (2006=100)]

Revised weight (percent)	Revised Cost Category
16.553	Non-physician compensation.
11.885	Non-physician wages.
7.249 ...	Non-health, non-phys. wages.
0.800 ...	Professional and Related.
1.529 ...	Management.
4.720 ...	Clerical.
0.200 ...	Services.
4.636 ...	Health related, non-phys. wages.
4.668 ...	Non-physician benefits.

The health-related workers were previously included mainly in the Professional and Technical and Service Categories. The proposed reclassifications allow for health-related workers to be proxied by a health-specific ECI rather than an ECI for more general occupations.

(b) Other Practice Expense

The remaining expenses in the MEI are categorized as Other Practice Expenses. In the current 2006-based MEI we had classified other PEs in one of the following subcategories: Office Expenses; Drugs and Supplies; and All Other Professional Expenses. For CY 2014, we proposed to disaggregate these expenses in a way consistent with the MEI–TAP's recommendations, as detailed below.

We rely on the 2006 AMA PPIS data to determine the cost share for Other Practice Expenses. These expenses are the total of office expenses, medical supplies, medical equipment, Professional Liability Insurance (PLI), and all other professional expenses.

For the revised 2006-based MEI, we disaggregate Other Practice Expenses into 15 detailed subcategories as shown in Table 17.

TABLE 17—REVISED COST CATEGORIES FOR OTHER PRACTICE EXPENSE

Revised cost category	Revised weight (percent)
Other Practice Expense	32.581
Utilities	1.266
Miscellaneous Office Expenses	2.478
Chemicals	0.723
Paper	0.656
Rubber & Plastics	0.598
All other products	0.500
Telephone	1.501
Postage	0.898
All Other professional services	8.095
Professional, Scientific, and Tech. Services	2.592
Administrative support & waste mgmt	3.052
All Other Services	2.451
Capital	10.310
Fixed	8.957
Moveable	1.353
Professional Liability Insurance	4.295
Medical Equipment	1.978
Medical supplies	1.760%

For most of these categories, we use the same method as finalized in the CY 2011 PFS final rule with comment period to estimate the cost shares. In particular, the cost shares for the following categories are derived directly from expense data reported on the 2006 AMA PPIS: PLI; Medical Equipment; and Medical Supplies. In each case, the cost shares remain the same as in the current MEI. Additionally, we continue to use the Bureau of Economic Analysis (BEA) 2002–Benchmark I/O data aged to 2006 to determine the cost weights for other expenses not collected directly from the AMA PPIS. The BEA 2002-Benchmark I/O data can be accessed at the following link: *http://www.bea.gov/industry/io_benchmark.htm#2002data*

The derivation of the cost weight for each of the detailed categories under Other Practice Expenses is provided in 78 FR 43315–43316. The following categories had no revisions proposed to the cost share weight and therefore reflect the same cost share weight as finalized in the CY 2011 final rule: Utilities, Telephone, Postage, Fixed Capital, Moveable Capital, PLI, Medical Equipment, and Medical Supplies. The following section provides a review of the categories for which we proposed revisions to the cost categories and cost share weights (Miscellaneous Office Expenses, and All Other Services).

• *Miscellaneous Office Expenses:* Based on MEI–TAP recommendation 3.4 we proposed to include an aggregate category of detailed office expenses that were stand-alone categories in the current 2006-based MEI. During the CY 2011 PFS proposed rule comment period, several commenters expressed confusion as to the relevance of these categories to their practice costs. The MEI–TAP discussed the degree of granularity needed in both the calculation and reporting of the MEI. The MEI–TAP concluded that it might be prudent to collapse some of the non-labor PE categories with other categories for presentation purposes.

• *All Other Professional Services:* Based on MEI–TAP recommendation 3.3, we proposed to combine the All Other Services cost weight and All Other Professional Expenses into a single cost category. The proposed weight for the All Other Professional Services category is 8.095 percent, which is the sum of the current MEI weight for All Other Services (3.581 percent) and All Other Professional Expenses (4.513 percent), and is more in line with the GPCI Purchased Services index as finalized in the CY2012 PFS final rule with comment period (76 FR 73085).—

We then proposed to further disaggregate the 8.095 percent of expenses into more detail based on the BEA I–O data, allowing for specific cost weights for services such as contract billing services, accounting, and legal services. We considered various levels of aggregation; however, in considering the level of aggregation, the available corresponding price proxies had to be considered. Given the price proxies that are available from the BLS Employment Cost Indexes (ECI), we proposed to disaggregate these expenses into three categories:

• *NAICS 54 (Professional, Scientific, and Technical Services):* The Professional, Scientific, and Technical Services sector comprises establishments that specialize in performing professional, scientific, and technical activities for others. These activities require a high degree of expertise and training. The establishments in this sector specialize according to expertise and provide these services to clients in a variety of industries, including but not limited to: legal advice and representation; accounting, and payroll services; computer services; management consulting services; and advertising services and have a 2.592 percent weight.

• *NAICS 56 (Administrative and Support and Waste Management and Remediation Services):* The Administrative and Support and Waste Management and Remediation Services sector comprises establishments performing routine support activities for the day-to-day operations of other organizations. The establishments in this sector specialize in one or more of these support activities and provide these services to clients in a variety of industries including but not limited to: office administration; temporary help services; security services; cleaning and janitorial services; and trash collection services. These services have a 3.052 percent weight.

• *All Other Services, a residual category of these expenses:* The residual All Other Services cost category is mostly comprised of expenses associated with service occupations, including but not limited to: lab and blood specimen transport; catering and food services; collection company services; and dry cleaning services and have a 2.451 percent weight.

2. Selection of Price Proxies for Use in the MEI

After developing the cost category weights for the revised 2006-based MEI, we reviewed all the price proxies based on the recommendations from the MEI–TAP. As was the case in the development of the current 2006-based MEI, most of the proxy measures we considered are based on BLS data and are grouped into one of the following four categories:

• *Producer Price Indices (PPIs):* PPIs measure price changes for goods sold in markets other than retail markets. These fixed-weight indexes are measures of price change at the intermediate or final stage of production. They are the preferred proxies for physician purchases as these prices appropriately reflect the product's first commercial transaction.

• *Consumer Price Indices (CPIs):* CPIs measure change in the prices of final goods and services bought by consumers. Like the PPIs, they are fixed weight indexes. Since they may not represent the price changes faced by producers, CPIs are used if there are no appropriate PPIs or if the particular expenditure category is likely to contain purchases made at the final point of sale.

• *Employment Cost Indices (ECIs) for Wages & Salaries:* These ECIs measure the rate of change in employee wage rates per hour worked. These fixed-weight indexes are not affected by employment shifts among industries or occupations and thus, measure only the pure rate of change in wages.

• *Employment Cost Indices (ECIs) for Employee Benefits:* These ECIs measure the rate of change in employer costs of employee benefits, such as the employer's share of Social Security taxes, pension and other retirement plans, insurance benefits (life, health, disability, and accident), and paid leave. Like ECIs for wages & salaries, the ECIs for employee benefits are not affected by employment shifts among industries or occupations.

When choosing wage and price proxies for each expense category, we evaluate the strengths and weaknesses of each proxy variable using the following four criteria.

• *Relevance:* The price proxy should appropriately represent price changes for specific goods or services within the expense category. Relevance may encompass judgments about relative efficiency of the market generating the price and wage increases.

• *Reliability:* If the potential proxy demonstrates a high sampling variability, or inexplicable erratic patterns over time, its viability as an appropriate price proxy is greatly diminished. Notably, low sampling variability can conflict with relevance—since the more specifically a price variable is defined (in terms of service, commodity, or geographic area), the

higher the possibility of high sampling variability. A well-established time series is also preferred.

• *Timeliness of actual published data:* For greater granularity and the need to be as timely as possible, we prefer monthly and quarterly data to annual data.

• *Public availability:* For transparency, we prefer to use data sources that are publicly available.

The price proxy selection for every category in the proposed revised MEI is detailed in 78 FR 43316–43319. Below we discuss the price and wage proxies for each cost category in the proposed revised MEI.

a. Physician Compensation (Physician's Own Time)

(1) Physician Wages and Salaries

Based on recommendations from the MEI–TAP, we proposed to use the ECI for Wages and Salaries for Professional and Related Occupations (Private Industry) (BLS series code CIU2020000120000I) to measure price growth of this category in the revised 2006-based MEI. The current 2006-based MEI used Average Hourly Earnings (AHE) for Production and Non-Supervisory Employees for the Private Nonfarm Economy.

The MEI–TAP had two recommendations concerning the price proxy for physician Wages and Salaries. The first recommendation from the MEI–TAP was Recommendation 4.1, which stated that: ". . . GACT revise the price proxy associated with Physician Wages and Salaries from an Average Hourly Earnings concept to an Employment Cost Index concept." AHEs are calculated by dividing gross payrolls for wages and salaries by total hours. The AHE proxy was representative of actual changes in hourly earnings for the nonfarm business economy, including shifts in employment mix. The recommended alternative, the ECI concept, measures the rate of change in employee wage rates per hour worked. ECIs measure the pure rate of change in wages by industry and/or occupation and are not affected by shifts in employment mix across industries and occupations. The MEI–TAP believed that the ECI concept better reflected physician wage trends compared to the AHE concept.

The second recommendation related to the price proxy for physician wages and salaries was Recommendation 4.2, which stated that:

"CMS revise the price proxy associated with changes in Physician Wages and Salaries to use the Employment Cost Index for Wages and Salaries, Professional and Related, Private Industry. The Panel believes this change would maintain consistency with the guidance provided in the 1972 Senate Finance Committee report titled 'Social Security Amendments of 1972,' which stated that the index should reflect changes in practice expenses and 'general earnings.' In the event this change would be determined not to meet the legal requirement that the index reflect "general earnings," the Panel recommended replacing the current proxy with the Employment Cost Index for Wages and Salaries, All Workers, Private Industry." The Panel believed this change would maintain consistency with the guidance provided in the 1972 Senate Finance Committee report titled "Social Security Amendments of 1972," which stated that the index should reflect changes in practice expenses and "general earnings." [2]

We agree that switching the proxy to the ECI for Wages and Salaries for Professional and Related Occupations would be consistent with the authority provided in the statute and reflect a wage trend more consistent with other professionals that receive advanced training. Additionally, we believe the ECI is a more appropriate concept than the AHE because it can isolate wage trends without being impacted by the change in the mix of employment.

(2) Physician Benefits

The MEI–TAP states in Recommendation 4.3 that, ". . . any change in the price proxy for Physician Wages and Salaries be accompanied by the selection and incorporation of a Physician Benefits price proxy that is consistent with the Physician Wages and Salaries price proxy." We proposed to use the ECI for Benefits for Professional and Related Occupations (Private Industry) to measure price growth of this category in the revised 2006-based MEI. The ECI for Benefits for Professional and Related Occupations is derived using BLS's Total Compensation for Professional and Related Occupations (BLS series ID CIU2010000120000I) and the relative importance of wages and salaries within total compensation. We believe this series is technically appropriate because it better reflects the benefit trends for professionals requiring advanced training. The current 2006-based MEI market basket used the ECI for Total Benefits for the Total Private Industry.

[2] U.S. Senate, Committee on Finance, *Social Security Amendments of 1972.* "Report of the Committee on Finance United States Senate to Accompany H.R. 1," September 26, 1972, p. 191.

b. Practice Expense

(1) Non-Physician Employee Compensation

(a) Non-Physician Wages and Salaries

(i) Non-Physician, Non-Health-Related Wages and Salaries

• *Professional and Related:* We proposed to continue using the ECI for Wages and Salaries for Professional and Related Occupation (Private Industry) (BLS series code CIU2020000120000I) to measure the price growth of this cost category.

• *Management:* We proposed to continue using the ECI for Wages and Salaries for Management, Business, and Financial (Private Industry) (BLS series code CIU2020000110000I) to measure the price growth of this cost category.

• *Clerical:* We proposed to continue using the ECI for Wages and Salaries for Office and Administrative Support (Private Industry) (BLS series code CIU2020000220000I) to measure the price growth of this cost category. This is the same proxy used in the current 2006-based MEI.

• *Services:* We proposed to continue using the ECI for Wages and Salaries for Service Occupations (Private Industry) (BLS series code CIU2020000300000I) to measure the price growth of this cost category.

(ii) Non-Physician, Health-Related Wages and Salaries

In Recommendation 4.4, the MEI–TAP ". . . recommend[ed] the disaggregation of the Non-Physician Compensation costs to include an additional category for health-related workers. This disaggregation would allow for health-related workers to be separated from non-health-related workers. CMS should rely directly on PPIS data to estimate the health-related non-physician compensation cost weights. The non-health, non-physician wages should be further disaggregated based on the Current Population Survey and Occupational Employment Statistics data. The new health-related cost category should be proxied by the ECI, Wages and Salaries, Hospital (NAICS 622), which has an occupational mix that is reasonably close to that in physicians' offices. The Non-Physician Benefit category should be proxied by a composite benefit index reflecting the same relative occupation weights as the non-physician wages." We proposed to use the ECI for Wages and Salaries for Hospital Workers (Private Industry) (BLS series code CIU2026220000000I) to measure the price growth of this cost category in the final revised 2006-based MEI. The ECI for Hospital workers has

an occupational mix that approximates that in physicians' offices. This cost category was not broken out separately in the current 2006-based MEI.

(b) Non-Physician Benefits

We proposed to continue using a composite ECI for non-physician employee benefits in the revised 2006-based MEI. However, we also proposed to expand the number of occupations from four to five by adding detail on Non-Physician Health-Related Benefits. The weights and price proxies for the composite benefits index will be revised to reflect the addition of the new category. Table 18 lists the five ECI series and corresponding weights used to construct the revised composite benefit index for non-physician employees in the revised 2006-based MEI.

TABLE 18—CMS COMPOSITE PRICE INDEX FOR NON-PHYSICIAN EMPLOYEE BENEFITS IN THE REVISED 2006-BASED MEI

ECI Series	2006 Weight (%)
Benefits for Professional and Related Occupation (Private Industry)	7
Benefits for Management, Business, and Financial (Private Industry)	12
Benefits for Office and Administrative Support (Private Industry)	40
Benefits for Service Occupations (Private Industry)	2
Benefits for Hospital Workers (Private Industry)	39

(3) Other Practice Expense

(a) All Other Professional Services

As discussed previously, MEI–TAP Recommendation 3.3 was that:

". . . OACT create a new cost category entitled Professional Services that should consist of the All Other Services cost category (and its respective weight) and the Other Professional Expenses cost category (and its respective weight). The Panel further recommends that this category be disaggregated into appropriate occupational categories consistent with the relevant price proxies." We are proposed to implement this recommendation in the revised 2006-based MEI using a cost category titled "All Other Professional Services." Likewise, the MEI–TAP stated in Recommendation 4.7 that ". . . price changes associated with the Professional Services category be proxied by an appropriate blend of Employment Cost Indexes that reflect the types of professional services purchased by physician offices." We agree with this recommendation and proposed to use the following price proxies for each of the new occupational categories:

- *Professional, Scientific, and Technical Services:* We proposed to use the ECI for Total Compensation for Professional, Scientific, and Technical Services (Private Industry) (BLS series code CIU20154000000001) to measure the price growth of this cost category. This cost category was not broken out separately in the current 2006-based MEI.
- *Administrative and Support Services:* We proposed to use the ECI for Total Compensation for Administrative, Support, Waste Management, and Remediation Services (Private Industry) (BLS series code CIU20156000000001) to measure the price growth of this cost category. This cost category was not broken out separately in the current 2006-based MEI.
- *All Other Services:* We proposed to use the ECI for Compensation for Service Occupations (Private Industry) (BLS series code CIU20100003000001) to measure the price growth of this cost category.

(b) Miscellaneous Office Expenses

- *Chemicals:* We proposed to continue using the PPI for Other Basic Organic Chemical Manufacturing (BLS series code #PCU32519–32519) to measure the price growth of this cost category.
- *Paper:* We proposed to continue using the PPI for Converted Paper and Paperboard (BLS series code #WPU0915) to measure the price growth of this cost category.
- *Rubber & Plastics:* We proposed to continue using the PPI for Rubber and Plastic Products (BLS series code #WPU07) to measure the price growth of this cost category.
- *All Other Products:* We proposed to continue using the CPI–U for All Products less Food and Energy (BLS series code CUUR0000SA0L1E) to measure the price growth of this cost category.
- *Utilities:* We proposed to continue using the CPI for Fuel and Utilities (BLS series code CUUR0000SAH2) to measure the price growth of this cost category.
- *Telephone:* We proposed to continue using the CPI for Telephone Services (BLS series code CUUR0000SEED) to measure the price growth of this cost category.
- *Postage:* We proposed to continue using the CPI for Postage (BLS series code CUUR0000SEEC01) to measure the price growth of this cost category.
- *Fixed Capital:* In Recommendation 4.5, "The Panel recommends using the Producer Price Index for Lessors of Nonresidential Buildings (NAICS 53112) for the MEI Fixed Capital cost category as it represents the types of fixed capital expenses most likely faced by physicians. The MEI–TAP noted the volatility in the index, which is greater than the Consumer Price Index for Owners' Equivalent Rent of Residences. This relative volatility merits ongoing monitoring and evaluation of alternatives." We are proposed to use the PPI for Lessors of Nonresidential Buildings (BLS series code PCU531120531120) to measure the price growth of this cost category in the revised 2006-based MEI. The current 2006-based MEI used the CPI for Owner's Equivalent Rent. We believe the PPI for Lessors of Nonresidential Buildings is more appropriate as fixed capital expenses in physician offices should be more congruent with trends in business office space costs than residential costs.
- *Moveable Capital:* In Recommendation 4.6, the MEI–TAP states that ". . . CMS conduct research into and identify a more appropriate price proxy for Moveable Capital expenses. In particular, the MEI–TAP believes it is important that a proxy reflect price changes in the types of non-medical equipment purchased in the production of physicians' services, as well as the price changes associated with Information and Communication Technology expenses (including both hardware and software)." We intend to continue to investigate possible data sources that could be used to proxy the physician expenses related to moveable capital in more detail. However, we proposed to continue using the PPI for Machinery and Equipment (series code WPU11) to measure the price growth of this cost category in the revised 2006-based MEI.

• *Professional Liability Insurance:* Unlike the other price proxies based on data from BLS and other public sources, the proxy for PLI is based on data collected directly by CMS from a sample of commercial insurance carriers. The MEI–TAP discussed the methodology of the CMS PLI index, as well as considered alternative data sources for the PLI price proxy, including information available from BLS and through state insurance commissioners. MEI–TAP Finding 4.3 states:

"The Panel finds the CMS-constructed professional liability insurance price index used to proxy changes in professional liability insurance premiums in the MEI represents the best currently available method for its intended purpose. The Panel also believes the pricing patterns of commercial carriers, as measured by the CMS PLI index, are influenced by the same driving forces as those observable in policies underwritten by physician-owned insurance entities; thus, the Panel believes the current index appropriately reflects the price changes in premiums throughout the industry." Given this MEI–TAP finding, we proposed to continue using the CMS Physician PLI index to measure the price growth of this cost category in the revised 2006-based MEI.

• *Medical Equipment:* We proposed to continue using the PPI for Medical Instruments and Equipment (BLS series code WPU1562) as the price proxy for this category.

• *Medical Materials and Supplies:* We proposed to continue using a blended index comprised of a 50/50 blend of the PPI for Surgical Appliances (BLS series code WPU156301) and the CPI–U for Medical Equipment and Supplies (BLS series code CUUR0000SEMG).

TABLE 19—REVISED 2006-BASED MEI COST CATEGORIES, WEIGHTS, AND PRICE PROXIES

Cost category	2006 weight (percent)	Price proxy
Total MEI	100.000	
Physician Compensation	50.866	
Wages and Salaries	43.641	ECI—Wages and salaries—Professional and Related (Private).
Benefits	7.225	ECI—Benefits—Professional and Related (Private).
Practice Expense	49.134	
Non-physician Compensation	16.553	
Non-physician Wages	11.885	
Non-health, non-physician wages	7.249	
Professional and Related	0.800	ECI—Wages And Salaries—Professional and Related (Private).
Management	1.529	ECI—Wages And Salaries—Management, Business, and Financial (Private).
Clerical	4.720	ECI—Wages And Salaries—Office and Admin. Support (Private).
Services	0.200	ECI—Wages And Salaries—Service Occupations (Private).
Health related, non-phys. Wages	4.636	ECI—Wages and Salaries—Hospital (Private).
Non-physician Benefits	4.668	Composite Benefit Index.
Other Practice Expense	32.581	
Miscellaneous Office Expenses	2.478	
Chemicals	0.723	PPI—Other Basic Organic Chemical Manufacturing.
Paper	0.656	PPI—Converted Paper and Paperboard.
Rubber and Plastics	0.598	PPI—Rubber and Plastic Products.
All other products	0.500	CPI—All Items Less Food And Energy.
Telephone	1.501	CPI—Telephone.
Postage	0.898	CPI—Postage.
All Other Professional Services	8.095	
Prof., Scientific, and Tech. Svcs	2.592	ECI—Compensation—Prof., Scientific, and Technical (Private).
Admin. and Support Services	3.052	ECI—Compensation—Admin., Support, Waste Management (Private).
All Other Services	2.451	ECI—Compensation—Service Occupations (Private).
Capital		
Fixed Capital	8.957	PPI—Lessors of Nonresidential Buildings.
Moveable Capital	1.353	PPI—Machinery and Equipment.
Professional Liability Insurance	4.295	CMS—Professional Liability Phys. Prem. Survey.
Medical Equipment	1.978	PPI—Medical Instruments and Equipment.
Medical Supplies	1.760	Composite—PPI Surgical Appliances & CPI–U Medical Supplies.

3. Productivity Adjustment to the MEI

The MEI has been adjusted for changes in productivity since its inception. In the CY 2003 PFS final rule with comment period (67 FR 80019), we implemented a change in the way the MEI was adjusted to account for changes in productivity. The MEI used for the 2003 physician payment update incorporated changes in the 10-year moving average of private nonfarm business (economy-wide) multifactor productivity that were applied to the entire index. Previously, the index incorporated changes in productivity by adjusting the labor portions of the index by the 10-year moving average of economy-wide private nonfarm business labor productivity.

The MEI–TAP was asked to review this approach. In Finding 5.1, "[t]he Panel reviewed the basis for the current economy-wide multifactor productivity adjustment (Private Nonfarm Business Multifactor Productivity) in the MEI and finds such an adjustment continues to be appropriate. This adjustment prevents 'double counting' of the effects of productivity improvements, which would otherwise be reflected in both (i) the increase in compensation and other input price proxies underlying the MEI, and (ii) the growth in the number of physician services performed per unit of input resources, which results from advances in productivity by individual physician practices."

Based on the MEI–TAP's finding, we proposed to continue to use the current method for adjusting the full MEI for multifactor productivity in the revised 2006-based MEI. As described in the CY 2003 PFS final rule with comment period, we believe this adjustment is appropriate because it explicitly reflects the productivity gains associated with all inputs (both labor and non-labor).

We believe that using the 10-year moving average percent change in economy-wide multifactor productivity is appropriate for deriving a stable measure that helps alleviate the influence that the peak (or a trough) of a business cycle may have on the measure. The adjustment will be based on the latest available historical economy-wide nonfarm business multifactor productivity data as measured and published by BLS.

4. Results of Revisions on the MEI Update

Table 20 shows the average calendar year percent change from CY 2005 to CY 2013 for both the revised 2006-based MEI and the current 2006-based MEI, both excluding the productivity adjustment. The average annual percent change in the revised 2006-based MEI is 0.1 percent lower than the current 2006-based MEI over the 2005–2013 period. On an annual basis over this period, the differences vary by up to plus or minus 0.7 percentage point. In the two most recent years (CY 2012 and CY 2013), the annual percent change in the revised 2006-based MEI was within 0.1 percentage point of the percent change in the current 2006-based MEI. The majority of these differences over the historical period can be attributed to the revised price proxy for physician wages and salaries and benefits and the revised price proxy for fixed capital.

TABLE 20—ANNUAL PERCENT CHANGE IN THE REVISED 2006-BASED MEI, NOT INCLUDING PRODUCTIVITY ADJUSTMENT AND THE CURRENT 2006-BASED MEI, NOT INCLUDING PRODUCTIVITY ADJUSTMENT *

Update year	Revised 2006-based MEI excl. MFP	Current 2006-based MEI, excl. MFP
CY 2005	3.8	3.1
CY 2006	4.0	3.3
CY 2007	3.2	3.2
CY 2008	3.2	3.4
CY 2009	2.9	3.1
CY 2010	2.4	2.8
CY 2011	0.9	1.6
CY 2012	1.7	1.8
CY 2013	1.7	1.8
Avg. Change for CYs 2005–2013	2.6	2.7

*Update year based on historical data through the second quarter of the prior calendar year. For example, the 2014 update is based on historical data through the second quarter 2013, prior to the MFP adjustment.

5. Summary of Comments and the Associated Responses

Comment: Many commenters appreciate the efforts of CMS to implement the recommendations of the MEI–TAP. They agree with the MEI–TAP's analysis and recommendations and believe these changes successfully bring the "market basket" of MEI inputs up to date and improve the accuracy of the index going forward. Nearly all commenters supported the following proposals:

- The increase in the physician benefits cost weight in order to ensure consistency with the benefits price proxy.
- The use of professional workers' earnings as the price proxy for the physician compensation portion of the index. Specifically, the price proxies for physician wages would change from general economy-wide earnings to a wages index for "Professional and related occupations" and the price proxy for physician benefits would be changed from general economy-wide benefits to a benefit index for "Professional and related occupations."
- The use of commercial rent data for the fixed capital price proxy, replacing the CPI residential rent proxy.
- The creation of a health sector wage category within the index.
- The creation of an "all other professional services" category, encompassing purchased services such as contract billing, legal, and accounting services.

Response: We agree with the commenters that implementing the TAP recommendations identified above improve the accuracy of the index.

Comment: Several commenters concur with the proposal to reclassify expenses for non-physician clinical personnel that can bill independently from non-physician compensation to physician compensation. They agree with the proposal based on the reasons CMS outlines and because this policy is more consistent with how services by non-physician practitioners are treated in the resource-based relative value scale (RBRVS).

Response: We appreciate the commenters support for the decision to reclassify expenses related to non-physician clinical personnel that can bill independently from non-physician compensation to physician compensation. We also agree with the commenter that classifying the expenses with physician compensation is more consistent with how services by non-physician practitioners are treated in the RBRVS since services related to direct patient care from non-physician practitioners are reported with the work component in the RBRVS methodology. We also believe that non-physician practitioners will continue to perform services that are direct substitutes for services furnished by physicians, such as office visits.

Comment: Many commenters believe that it is not technically appropriate to reclassify all expenses for non-physician clinical personnel that can bill independently from non-physician compensation to physician compensation. They note that the MEI–TAP recommended that the OACT consider "the extent to which those who can bill independently actually do so." They also note that non-physician clinical personnel often spend much of their time on activities other than providing services that are billed independently. They suggested that only the portion of the time the non-physician clinical personnel spend providing services that are billed independently should be reclassified to physician compensation. They believe that the increase in the physician compensation cost share by 2.600 percentage points, and the reduction in non-physician compensation by the same amount, is too high. The commenters encourage CMS to conduct real analysis of the time spent on activities that are billed independently prior to implementing this re-allocation of costs.

Response: We understand that non-physician clinical personnel may spend some of their time on activities other than providing services that are billed independently. We would note that physicians also spend some of their time on work that is not direct patient care. We proposed to only reclassify the expenses related to the non-physician clinical personnel that can bill independently; that is, we are not reclassifying the expenses for non-physician clinical personnel that cannot bill independently. We believe that the increase in physician compensation is technically correct.

The commenters suggested that the non-physician clinical staff that can bill independently spend much of their time on activities other than providing services that are billed separately; however, the commenters did not provide any evidence to support this claim. Based on part B claims data we have found that nurse practitioners and physician assistants bill Medicare for the same top HCPCS codes as other primary care specialties, including office/outpatient visits, subsequent hospital care, emergency department visits, and nursing facility care subsequent visits. Based on this, we do

not believe further analysis is needed to conclude that the non-physician practitioners that can bill independently are furnishing services that are substitutes for services furnished by physicians. As such, we continue to believe that it is appropriate to classify their costs in the physician compensation category.

Comment: A few commenters suggested that multiple states preclude non-physicians from practicing and billing independently and therefore the reclassification of expenses for these services would affect those states differently than the states where non-physician practitioners are allowed to practice and bill independently.

Response: We understand that state laws governing the practice rules for non-physician practitioners can vary by State; however, we do not believe that this is relevant to the decision to include in the physician compensation cost category the expenses for non-physician practitioners that can independently bill under Medicare. These expenses were collected on the AMA PPIS where we expect that physicians would have reported the expenses that coincided with the state laws for non-physician clinical staff for the state in which they practiced. For a state in which the laws do not permit non-physician practitioners to bill independently, the expenses would have been allocated to the category for clinical staff that cannot bill independently.

Comment: Several commenters questioned the implementation of the MEI–TAP recommendation concerning payroll for non-physician personnel. The commenters stated that the recommendation was more nuanced than we had conveyed and that it only directed CMS to evaluate making the change. The commenters suggested that the recommendation required CMS to consider several factors including but not limited to, the statutory definition of "physician" as it relates to the recommended change; how time for non-physician practitioners is currently treated in the PFS RVU methodology; whether there is evidence these non-physician practitioners do not spend the majority of their time providing "physicians' services;" and the extent to which these practitioners actually do bill independently for the services they furnish.

Response: When evaluating the MEI–TAP recommendation 3.2 and formulating our proposal, we did consider the specific factors that the MEI–TAP included in the recommendation to reclassify the expenses related to non-physician clinical staff that can bill Medicare independently. However, we disagree with the commenters' interpretation that the recommendation intended CMS to only evaluate making the change. We believe that the intent of all of the recommendations of the MEI–TAP was for CMS to evaluate the recommendations and propose and implement those changes as soon as possible.

As we indicated in the proposed rule, there are several reasons for our proposal to reclassify these expenses which were: (1) These types of practitioners furnish services that are similar to those furnished by physicians; (2) if billing independently, these practitioners would be paid at a percentage of the physicians' services or in certain cases at the same rate as physicians; and (3) the expenses related to the work components for the RVUs would include work from clinical staff that can bill independently. Therefore, it would improve consistency with the RVU payments to include these expenses as physician compensation in the MEI.

In response to this comment, we explain further our consideration of each of the factors as follows:

First, we do not believe the definition of physician under current law limits CMS' ability to make the proposed change in the MEI. No provisions of the Social Security Act address the classification of costs in the MEI. The goal of the MEI is to appropriately estimate the change in the input prices of the goods and services used to furnish physician services over time. Therefore, we believe that classifying costs for those non-physician practitioners that can bill independently with physician compensation is the most technically appropriate classification, given their role in the healthcare delivery system today. We believe that since non-physician practitioners (NPPs) who bill independently furnish services that substitute for physician work and that the salary costs for these types of providers would grow at a similar rate to those of physicians, it is appropriate to classify these expenses within the physician compensation component of the MEI.

Second, the expenses for non-physician practitioners that can independently bill are reflected in the physician work component in the PFS RVU methodology since their services are substituting for physician work. Expenses for other clinical staff, including RNs, LPNs, physicists, lab technicians, x-ray technicians, medical assistants, and other clinical personnel who cannot independently bill are reported in the PE component in the RVU methodology.

Third, we have found no evidence that these types of providers do not spend the majority of their time performing "physicians' services," as defined under the PFS. We looked at 2012 claims data for the nurse practitioners (NPs) (specialty code 50) and physician assistants (PAs) (specialty code 97) and compared their top Part B HCPCS codes reported on claims to the top Part B HCPCS codes reported on claims of the following three physician specialties: General Practice (specialty code 01), Family Practice (specialty code 08), and Internal Medicine (specialty code 11). We found that 7 out of the 10 top HCPCS codes for PAs and NPs are the same as those reported for physicians in General Practice, Family Practice, and/or Internal Medicine. HCPCS code 99213 and 99214 (both codes for office/outpatient visits) were the top two HCPCS codes for all five specialties listed. Approximately 40 percent of claims for PAs and 50 percent of claims for NPs were for HCPCS codes that were also submitted by one of the three primary care specialties (general practice, family practice, and internal medicine). Based on this Medicare claims analysis, we believe that these types of non-physician practitioners do spend the majority of their time performing "physicians' services."

Fourth, we believe that non-physician practitioners who are able to bill independently actually do so in the majority of circumstances where it is financially beneficial for the practice as a whole. We understand that different states may have different rules on how non-physician practitioners are permitted to furnish physician services; but, in general, if the non-physician practitioner can independently bill, particularly if the reimbursement for the service is similar to or the same as that provided to a physician, they usually do so. We reviewed data on mean annual wages published in the May 2012 Occupational Employment Survey (OES) (*http://www.bls.gov/oes/current/oes_stru.htm*), and found that wages for PAs and NPs are significantly higher than RNs and LPNs/LVNs. Specifically, the mean annual wages for OES Category 29–1071 "Physician Assistants" is $92,460 and for OES Category 29–1171 "Nurse Practitioners" it is $91,450 whereas for OES Category 29–1141 "Registered Nurses" it is $67,930 and for OES Category 29–2061 "Licensed Practical and Licensed Vocational Nurses" it is $42,400. In addition, wages for PAs and NPs are also significantly higher than

technologist and technician wages. Select technologist and technician wages are OES Category 29–2051 "Dietetic Technicians" at $28,680, OES Category 29–2052 "Pharmacy Technicians" at $30,430, OES Category 29–2053 "Psychiatric Technicians" at $33,140, OES Category 29–2054 "Respiratory Therapy Technicians" $47,510, and OES Category 29–2055 "Surgical Technologists" at $43,480. Given the significantly higher wages for PAs and NPs, we believe it makes economic sense for PAs and NPs to furnish and bill for "physicians' services" to the extent permitted by law rather than to serve as clinical staff members who only furnish services incident to a physician's services.

Comment: One commenter believes that the MEI is intended to be a reflection of physician compensation and physician expenses, and that it must conform to the definitions of "physician" and "physicians' services," which includes affirmation of the distinct definitions of physician and nurse practitioner. The commenter claims the reasons for our proposal fail to account for this foundational distinction between physicians and "physicians' services" as opposed to other types of practitioners and their services. The commenter believes that to lump the two definitions together, which is what we are doing, is not justifiable and in excess of authority.

Response: We disagree with the commenter that classifying the non-physician independent billers' expenses in the same category as the physician expenses "is not justifiable and in excess of authority." The definition of physician that exists under current law does not limit CMS' ability to make this change in the MEI. As mentioned previously, no provisions of the Social Security Act address the classification of costs in the MEI. We believe that since non-physician practitioners that bill independently serve as substitutes for physician work, and the growth in the salary costs for these types of providers would grow at a similar rate to physicians, then classifying the expenses related to non-physician practitioners that bill independently with physician compensation is the most technically appropriate classification, given their role in the healthcare delivery system today.

Comment: It is unclear to several commenters why the productivity assumptions for physicians are twice that used for the hospital outpatient department and ambulatory surgery centers. Although they understood that these are two different calculations, they found it hard to imagine that individual physicians would have twice the capability of increasing productivity than would facilities. They note that all of the productivity adjustments should be based on 10-year averages of private non-farm business multifactor productivity growth, but the OPPS and ASC adjustments, are about half the MEI adjustment for CY 2014.

Response: The productivity adjustments included in the MEI and those that apply to ASCs and HOPDs are based on the 10-year moving average of economy-wide private nonfarm business multifactor productivity (MFP). The differences in the MFP adjustments between the ASC and HOPD payment systems and the PFS are the result of differences between the applicable statutes and the time period for which the adjustment is calculated.

MEI updates have been based on the latest historical data at the time of rulemaking since its inception. For the CY 2014 rule, the proposed MEI update of 0.7 percent includes an MFP adjustment of 0.9 percent, which is based on BLS data through 2011 that represents the latest historical data available at the time of rulemaking. The proposed MFP adjustment is based on the 10-year moving average of annual MFP growth from 2002–2011; and we would note that the annual MFP growth over the 2002–2004 time period was historically high.

The ASC and HOPD MFP adjustments, on the other hand, are required by law to be based on forecasts for the appropriate payment period, in this case through CY 2014. The forecasts of the MFP are completed by IHS Global Insight, Inc. (IGI). Accordingly, the MFP adjustment applicable to ASCs and HOPDs is based on the 10-year moving average of annual MFP growth from 2005–2014. A complete description of the methodology used to calculate the MFP for the MEI can be found in the CY 2012 PFS final rule with comment period (76 FR 73300).

Comment: One commenter disagrees with CMS' assessment that there is not a reliable, ongoing source of data from which to index cost data. CMS is currently basing the MEI on 2006 data yet it accepted and has now fully transitioned the results of the Physician Practice Information Survey (PPIS) as of 2013. The data from PPIS was developed based on practice costs in 2008. They questioned why the data currently available would be any less reliable than was used the previous three times that CMS rebased the MEI. In fact, they claim that the PPIS data should be more reliable. The commenter acknowledges that data developed by the MGMA are derived primarily from large urban and suburban practices and do not adequately capture costs from small and solo practitioners who do not enjoy the same economies of scale and practice efficiencies afforded to larger groups. However, the commenter would support another updated survey of practice costs similar to PPIS that would also include any elements included within the MEI that were not previously captured. The commenter suggests that if the time and resources are going to go into such a study, the survey should include and be used to update all physician practice expenses.

Response: We believe the commenter misunderstood our statement. We do believe the AMA PPIS is a reliable data source; however, the PPIS is not an ongoing data source that is published regularly, such as the IPPS, SNF, and HHA cost reports. The 2006 AMA PPIS data were used to determine nine expenditure weights in the 2006-based MEI: physicians' earnings, physicians' benefits, employed physician payroll, non-physician compensation, office expenses, PLI, medical equipment, medical supplies, and other professional expenses. It continues to be the data source used in the CY 2014 proposed revisions to the MEI. At this time, the AMA is no longer conducting the PPIS survey.

We concur with the commenter's points regarding the issues pertaining to the MGMA data and also appreciate the commenter's support of conducting another practice cost survey similar to the PPIS. We will be looking into viable options for updating the MEI cost weights going forward.

Comment: Several commenters appreciated the efforts by CMS to convene the MEI–TAP, and urged the agency to continue work on the remaining issues the MEI–TAP identified including consideration of whether: (1) using self-employed physician data for the MEI cost weights continues to be the most appropriate approach; (2) additional data sources could allow more frequent updates to the MEI's cost categories and their respective weights; and (3) there is a more appropriate price proxy for Moveable Capital expenses. The commenter noted that CMS plans to continue to investigate these three issues and the commenter looks forward to working with CMS in that effort.

Response: We will continue to investigate possible options for the three remaining MEI–TAP recommendations as they require additional research regarding possible data sources. Any further changes to the MEI, in response to MEI–TAP recommendations, will be

made through future notice and comment rulemaking.

Comment: One commenter noted that although the MEI–TAP recommended a number of data sources that could be considered to rebase the MEI, it was unable to identify a reliable, ongoing source of data to do so. The commenter recommended that CMS consider a sample cost reporting method rather than a survey similar to the American Medical Association's (AMA) Physician Practice Information Survey (PPIS) that took place between 2007 and 2008. The commenter noted that the PPIS was extraordinarily expensive for the AMA and was plagued by low response rates. In addition, the commenter noted that the disputed PPIS results led to significant payment reductions for cardiology. The commenter notes that CMS is already considering efforts to establish a cost report for provider-based clinics. The commenter suggests that this effort could be coupled with a sample of private practice clinics in order to better measure the MEI.

Response: We thank the commenter for the suggestion. We will be investigating possible data sources to use for the purpose of rebasing the MEI in the future. Our research will include the evaluation of multiple potential data sources including a sampling of clinics and/or physicians subject to agency resources. If reliable cost report data is collected for provider-based clinics in the future then we will analyze and consider its possible use at that time. We remind the commenter that any new study or survey we conduct would require approval through OMB's standard survey and auditing process (see "Standards and Guidelines for Statistical Surveys" *http://www.whitehouse.gov/sites/default/files/omb/assets/omb/inforeg/statpolicy/standards_stat_surveys.pdf* and "Guidance on Agency Survey and Statistical Information Collections" *http://www.whitehouse.gov/sites/default/files/omb/assets/omb/inforeg/pmc_survey_guidance_2006.pdf*).

Comment: One commenter strongly supports the continued monitoring of physician productivity growth as it compares to economy-wide growth. The commenter notes that medical practices have been subjected to a number of regulatory requirements in recent years that likely impacted their productivity. To ensure compliance with these regulatory requirements, physicians often must take actions that reduce practice productivity, including hiring additional office staff, retaining attorneys for legal and regulatory compliance, and contracting with accountants and billing companies to ensure proper processing of claims. Monitoring of physician productivity growth is necessary to determine if the continued use of economy-wide productivity growth in the MEI is appropriate.

Response: At the June 25, 2012 MEI–TAP meeting, we presented estimates of physician-specific productivity from 1983 to 2010. These estimates used a resource-based methodology similar to that used by Charles Fisher to estimate physician office productivity from 1983–2004 as published in the Winter 2007 Health Care Financing Review. The MEI–TAP had the following finding regarding the physician-specific productivity estimates:

Finding 5.2: The Panel finds the measures of growth in physician-specific productivity are of interest for the purpose of comparing the structure of price increases for physician services versus other sectors of the economy. The Panel does not recommend using a physician-specific measure, but does believe that continued monitoring is appropriate. Use of physician-specific productivity growth to adjust economy-wide compensation growth in the MEI could introduce inconsistencies in the calculation of the MEI that could distort the results. The Panel concludes it is appropriate to continue to require that the accounting identity between input price growth, output price growth, and the productivity adjustment be maintained (as is approximated by the current version of the index).

Per the MEI–TAP's recommendation, we will continue to monitor trends in physician productivity on a periodic basis and how those trends move relative to economy-wide productivity.

Comment: A few commenters noted that it will remain difficult for practicing clinicians to reconcile changes in the MEI with their own practice cost increases. The projected increase in the proposed MEI for 2014 is just 0.7 percent, but this amount has been reduced by economy-wide productivity growth of 0.9 percent. Excluding the productivity adjustment, inflation for medical practices is projected to be 1.6 percent for 2014. In addition, as is the case with any price index, this amount does not take into account any change in the quantity of inputs (for example, changes in the number of staff that practices employ).

Response: We believe the MEI is the most technically appropriate index available to measure the price growth of inputs involved in furnishing physician services. We agree that the updates of the MEI do not take into account any change in the quantity of inputs, since it is not a cost index. The MEI–TAP was asked to consider whether the index should continue to be a fixed-weight, Laspeyres-type index. The MEI–TAP concluded that there is not sufficient evidence that the proportions of costs represented by the index's inputs vary enough over short periods of time, nor was there a consistently updated data source available, to warrant or support a change from using the Laspeyres formulation.

Comment: One commenter believes that a driving flaw in the PE GPCI is the rent input and its weighting. The commenter indicates the proposed rule's CY 2014 cost share weight of 10.223 percent is not representative of the office rent cost share weights of other physicians. It is also not representative of what the MGMA's cost survey data seems to indicate is the national office rent cost weight.

Response: As stated in the proposed rule, the PE GPCI office rent portion (10.223 percent) includes the revised 2006-based MEI cost weights for fixed capital (reflecting the expenses for rent, depreciation on medical buildings and mortgage interest) and utilities. The methodology for determining the fixed capital cost weight (8.957 percent) and utilities cost weight (1.266) is described in the CY 2011 PFS final rule (75 FR 73265).

We believe the weights produced from the methodology are technically appropriate as it is based on the 2006 AMA PPIS data and other government data for NAICS 621A00 (Offices of physicians, dentists, and other health practitioners). We realize that although individual practice experience may vary, the MEI cost shares must reflect the cost structure of the average physician office.

Comment: One commenter supported the AMA's call for MEI recognition of the cost/staffing implications of ever-increasing private and governmental regulations upon medical practices.

Response: We believe the commenter is expressing that during the course of our future research into alternative data sources on physician expenses that we should try to find a data source that would measure the increased costs that regulations compliance imposes on physicians practice expenses (for example, additional staffing or costs associated with moving to more technically advanced record-keeping such as electronic health records (EHRs)). If we are able to identify an appropriate data source for physician expenses that is updated and published on a regular basis, then the associated costs will be reflected in the relative shares of the various cost categories. In order to determine cost shares for a year

later than 2006 we would need an alternative data source that is reliable, representative, and collected on a more consistent, regular basis.

Comment: One commenter claimed that the BEA Input-Output (I–O) tables categorize cost components differently than do medical practices; that CMS' actuarial conclusions are difficult to follow; and the industry wide I–O tables do not appear to comport with MGMA cost survey findings for medical practices. The commenter also stated that BEA I–O tables seem more focused on and designed to address how the offices of healthcare professionals utilize products in various national industries for purposes of assessing the productivity of those industries rather than to measure cost components of a medical practice. In that regard, the commenter asserts that the use of the I–O tables in developing GPCI cost share weights seems not to be an apples-to-apples relationship.

Response: We disagree with the commenter's claim that the BEA I–O tables are only to be used for purposes of assessing productivity of those industries rather than to measure cost components. As stated on the BEA Web site (*http://www.bea.gov/scb/pdf/2007/10%20October/1007_benchmark_io.pdf*), the BEA I–O data are based on the highest quality source data available. They provide an accurate and comprehensive picture of the inner workings of the economy, showing relationships among more than 400 industries and commodities. They facilitate the study of economic activity by providing a highly-detailed look at inter-industry activity. They also provide the detail that is essential in determining the quantity weights for price indexes such as the producer price index that is compiled by the Bureau of Labor Statistics (BLS). Therefore, our use of the BEA I–O data to derive the detailed cost weights for the MEI (and by extension the GPCI weights) is consistent with definition of and uses of the I–O data, as stated by BEA.

We would also note that CMS' examination of the MGMA cost data requested by the MEI–TAP found that the data: (1) reflected only group practice data (practices with greater than three physicians) rather than data for self-employed physician practices; (2) reflected more IDS and hospital-owned practices than physician-owned practices; (3) are not geographically representative; they are underrepresented in high-cost areas (NY, NJ, CA) and overrepresented in lower cost areas, such as the southern U.S.; and (4) are skewed toward primary care specialties relative to the universe of physician specialties. Additionally, the MGMA data are not publicly available. The BEA I–O data, on the other hand are based on detailed data from the quinquennial economic censuses that are conducted by the Bureau of the Census and show how industries interact at the detailed level; specifically, they show how approximately 500 industries provide input to, and use output from, each other to produce gross domestic product. The data we used in the construction of the MEI are representative of the entire broader industry as defined by NAICS 621A00, Offices of Physicians, Dentists and Other Health Professionals; and therefore we believe it is the most technically appropriate data source available to use to further disaggregate practice expenses within the MEI.

Comment: One commenter is concerned with CMS' proposal to use the Employment Cost Index (ECI) for Wages and Salaries for Hospital Workers (Private Industry) as a price proxy for Non-physician, Health-related staff compensation. The commenter does not agree with CMS' reasoning that the ECI for Hospital Workers has an occupational mix that is reasonably close to the occupational mix in physicians' offices. The commenter stated that they do not currently have an alternative price proxy suggestion.

Response: The purpose of the disaggregation of the Non-Physician Compensation costs to include an additional category for health-related workers was to be able to more accurately reflect the price inflation associated with these workers. There are limited health-related ECIs available. During the MEI–TAP discussions on July 11, 2012, this limitation was discussed (*http://www.cms.gov/Regulations-and-Guidance/Guidance/FACA/MEITAP.html*).

We continue to believe that the ECI for Wages and Salaries for Hospital Workers (Private Industry) is the most technically appropriate proxy for the compensation price inflation faced by non-physician, health related staff in physician offices as this ECI reflects the highest proportion of health-related staff (as measured by the Occupational Employment Statistics data) compared to other ECIs. Should the commenter have alternative price proxy suggestions, we will consider them in future rulemaking.

Comment: Several commenters agree with the proposed change in the price proxy for Fixed Capital, since it represents the types of fixed capital expenses most likely faced by physicians.

Response: We agree with the commenters that the price proxy proposed for Fixed Capital is more representative of the types of fixed capital expenses faced by physicians.

6. Final CY 2014 Revisions to the MEI

In general, most commenters supported all of the proposed changes to the index. The one area where there was concern from commenters was with the proposal to reclassify expenses for non-physician practitioners that can independently bill from non-physician compensation to physician compensation. Based on the public comments, we did not find any reason to reconsider our proposal, nor did we find any compelling technical reason that we should not implement this revision to the MEI. Therefore, we are finalizing our proposal to reclassify these expenses from non-physician compensation to physician compensation in the MEI. The effect of moving the expenses related to clinical staff that can bill independently to physician compensation category is to increase the physician compensation cost share by 2.600 percentage points and reduce non-physician compensation costs by the same amount. The revisions we are finalizing include:

- Reclassifying expenses for non-physician clinical personnel that can bill independently from non-physician compensation to physician compensation.
- Revising the physician wage and benefit split so that the cost weights are more in line with the definitions of the price proxies used for each category.
- Adding an additional subcategory under non-physician compensation for health-related workers.
- Creating a new cost category called "All Other Professional Services" that includes expenses covered in the current MEI categories: "All Other Services" and "Other Professional Expenses." And further disaggregating the "All Other Professional Services" category into appropriate occupational subcategories.
- Creating an aggregate cost category called "Miscellaneous Office Expenses" that would include the expenses for "Rubber and Plastics," "Chemicals," "All Other Products," and "Paper."
- Revising the price proxy for physician wages and salaries from the Average Hourly Earnings (AHE) for the Total Private Nonfarm Economy for Production and Nonsupervisory Workers to the ECI for Wages and Salaries, Professional and Related Occupations, Private Industry.

- Revising the price proxy for physician benefits from the ECI for Benefits for the Total Private Industry to the ECI for Benefits, Professional and Related Occupations, Private Industry.
- Using the ECI for Wages and Salaries and the ECI for Benefits of Hospital, Civilian workers (private industry) as the price proxies for the new category of non-physician health-related workers.
- Using ECIs to proxy the Professional Services occupational subcategories that reflect the type of professional services purchased by physicians' offices.
- Revising the price proxy for the fixed capital category from the CPI for Owners' Equivalent Rent of Residences to the PPI for Lessors of Nonresidential Buildings (NAICS 53112).

Table 21 shows the final revised 2006-based MEI update for CY 2014 PFS, which is an increase of 0.8 percent. The CY 2014 MEI update would be the same if using the current 2006-based MEI. This update is based on historical data through the second quarter of 2013.

TABLE 21—ANNUAL PERCENT CHANGE IN THE CY 2014 REVISED 2006-BASED MEI AND THE CURRENT 2006-BASED MEI *

Update year	Final revised 2006-based MEI	Current 2006-based MEI
CY 2014	0.8	0.8

*Based on historical data through the 2nd quarter 2013.

For the productivity adjustment, the 10-year moving average percent change adjustment for CY 2014 is 0.9 percent, which is based on the most historical data available from BLS at the time of the final rule, and reflects annual MFP estimates through 2012.

Table 22 shows the Cost Categories, Price Proxies, Cost Share Weights and the CY 2014 percent changes for each category in the revised 2006-based MEI. This table summarizes all of the final revisions to the MEI for CY 2014.

TABLE 22—ANNUAL PERCENT CHANGE IN THE REVISED MEI FOR CY 2014

[All categories] [1]

Revised cost category	Revised price proxy	2006 Final revised cost weight [2] (percent)	CY14 update (percent) [5]
MEI		100.000	0.8
MFP	*10-yr moving average of* Private Nonfarm Business Multifactor Productivity.	N/A	0.9
MEI without productivity adjustment		100.000	1.7
Physician Compensation [3]		50.866	1.9
Wages and Salaries	ECI—Wages and salaries—Professional and Related (private).	43.641	1.9
Benefits	ECI—Benefits—Professional and Related (private)	7.225	2.2
Practice Expense		49.134	1.4
Non-physician compensation		16.553	1.7
Non-physician wages		11.885	1.7
Non-health, non-physician wages		7.249	1.8
Professional & Related	ECI—Wages And Salaries—Professional and Related (Private).	0.800	1.9
Management	ECI—Wages And Salaries—Management, Business, and Financial (Private).	1.529	1.8
Clerical	ECI—Wages And Salaries—Office and Administrative Support (Private).	4.720	1.8
Services	ECI—Wages And Salaries—Service Occupations (Private).	0.200	1.5
Health related, non-physician wages	ECI—Wages and Salaries -Hospital (civilian)	4.636	1.4
Non-physician benefits	Composite Benefit Index	4.668	1.9
Other Practice Expense		32.581	1.2
Utilities	CPI Fuels and Utilities	1.266	0.7
Miscellaneous Office Expenses		2.478	0.3
Chemicals	Other Basic Organic Chemical Manufacturing PPI325190.	0.723	−1.2
Paper	PPI for converted paper	0.656	1.1
Rubber & Plastics	PPI for rubber and plastics	0.598	0.5
All other products	CPI—All Items Less Food And Energy	0.500	1.9
Telephone	CPI for Telephone	1.501	0.0
Postage	CPI for Postage	0.898	4.9
All Other Professional Services		8.095	1.8
Professional, Scientific, and Tech. Services	ECI—Compensation: Prof. scientific, tech	2.592	1.7
Administrative and support & waste	ECI—Compensation Administrative	3.052	1.9
All Other Services	ECI Compensation: Services Occupations	2.451	1.6
Capital		10.310	0.7
Fixed	PPI for Lessors of nonresidential buildings	8.957	0.7
Moveable	PPI for Machinery and Equipment	1.353	0.7
Professional Liability Insurance [4]	CMS—Prof. Liability. Phys. Prem. Survey	4.295	1.5
Medical Equipment	PPI—Med. Inst. & Equip.	1.978	1.2

TABLE 22—ANNUAL PERCENT CHANGE IN THE REVISED MEI FOR CY 2014—Continued

[All categories] [1]

Revised cost category	Revised price proxy	2006 Final revised cost weight [2] (percent)	CY14 update (percent) [5]
Medical supplies	Composite—PPI Surg. Appl. & CPIU Med. Supplies. (CY2006).	1.760	1.0

[1] The estimates are based upon the latest available Bureau of Labor Statistics data on the 10-year moving average of BLS private nonfarm business multifactor productivity published on July 19, 2013 *http://www.bls.gov/news.release/prod3.nr0.htm*

[2] The weights shown for the MEI components are the 2006 base-year weights, which may not sum to subtotals or totals because of rounding. The MEI is a fixed-weight, Laspeyres input price index whose category weights indicate the distribution of expenditures among the inputs to physicians' services for CY 2006. To determine the MEI level for a given year, the price proxy level for each component is multiplied by its 2006 weight. The sum of these products (weights multiplied by the price index levels) yields the composite MEI level for a given year. The annual percent change in the MEI levels is an estimate of price change over time for a fixed market basket of inputs to physicians' services.

[3] The measures of Productivity, Average Hourly Earnings, Employment Cost Indexes, as well as the various Producer and Consumer Price Indexes can be found on the Bureau of Labor Statistics (BLS) Web site at *http://stats.bls.gov*.

[4] Derived from a CMS survey of several major commercial insurers.

[5] Based on historical data through the 2nd quarter 2013. N/A Productivity is factored into the MEI as a subtraction from the total index growth rate; therefore, no explicit weight exists for productivity in the MEI.

E. Establishing RVUs for CY 2014

Section 1848(c)(2)(B) of the Act requires that we review RVUs for physicians' services no less often than every 5 years. Under section 1848(c)(2)(K) of the Act (as added by section 3134 of the Affordable Care Act), we are required to identify and revise RVUs for services identified as potentially misvalued. To facilitate the review and appropriate adjustment of potentially misvalued services, section 1848(c)(2)(K)(iii) specifies that the Secretary may use existing processes to receive recommendations; conduct surveys, other data collection activities, studies, or other analyses as the Secretary determined to be appropriate; and use analytic contractors to identify and analyze potentially misvalued services, conduct surveys or collect data. In accordance with section 1848(c)(2)(K)(iii) of the Act, we identify potentially misvalued codes, and develop and propose appropriate adjustments to the RVUs, taking into account the recommendations provided by the AMA RUC, the Medicare Payment Advisory Commission (MedPAC), and other public commenters.

For many years, the AMA RUC has provided CMS with recommendations on the appropriate relative values for PFS services. Over the past several years, CMS and the AMA RUC have identified and reviewed a number of potentially misvalued codes on an annual basis, based on various identification screens for codes at risk for being misvalued. This annual review of work RVUs and direct PE inputs for potentially misvalued codes was further bolstered by the Affordable Care Act mandate to examine potentially misvalued codes, with an emphasis on the following categories specified in section 1848(c)(2)(K)(ii) of the Act (as added by section 3134 of the Affordable Care Act):

- Codes and families of codes for which there has been the fastest growth.
- Codes or families of codes that have experienced substantial changes in practice expenses.
- Codes that are recently established for new technologies or services.
- Multiple codes that are frequently billed in conjunction with furnishing a single service.
- Codes with low relative values, particularly those that are often billed multiple times for a single treatment.
- Codes which have not been subject to review since the implementation of the RBRVS (the "Harvard-valued" codes).
- Other codes determined to be appropriate by the Secretary.

In addition to providing recommendations to CMS for work RVUs, the AMA RUC's Practice Expense Subcommittee reviews, and then the AMA RUC recommends, direct PE inputs (clinical labor, disposable supplies, and medical equipment) for individual services. To guide the establishment of malpractice RVUs for new and revised codes before each Five-Year Review of Malpractice, the AMA RUC also provides malpractice crosswalk recommendations, that is, "source" codes with a similar specialty mix of practitioners furnishing the source code and the new/revised code.

CMS reviews the AMA RUC recommendations on a code-by-code basis. For AMA RUC recommendations regarding physician work RVUs, after conducting a clinical review of the codes, we determine whether we agree with the recommended work RVUs for a service (that is, whether we agree the AMA RUC recommended valuation is accurate). If we disagree, we determine an alternative value that better reflects our estimate of the physician work for the service.

Because of the timing of the CPT Editorial Panel decisions, the AMA RUC recommendations, and our rulemaking cycle, we publish these work RVUs in the PFS final rule with comment period as interim final values, subject to public comment. Similarly, we assess the AMA RUC's recommendations for direct PE inputs and malpractice crosswalks, and establish interim final direct PE inputs and malpractice RVUs, which are also subject to comment. We note that the main aspect of our PE valuation that is open for public comment for a new, revised, or potentially misvalued code is the direct PE inputs and not the other elements of the PE valuation methodology, such as the indirect cost allocation methodology, that also contribute to establishing the PE RVUs for a code. The public comment period on the PFS final rule with comment period remains open for 60 days after the rule is issued.

In the interval between closure of the comment period and the subsequent year's PFS final rule with comment period, we consider all of the public comments on the interim final work, PE, and malpractice RVUs for the new, revised, and potentially misvalued codes and the results of the refinement panel, if applicable. Finally, we address the interim final work and malpractice RVUs and interim final direct PE inputs by providing a summary of the public comments and our responses to those comments, including a discussion of any changes to the interim final work or malpractice RVUs or direct PE inputs, in the following year's PFS final rule with comment period. We then typically finalize the direct PE inputs and the

work, PE, and malpractice RVUs for the service in that year's PFS final rule with comment period, unless we determine it would be more appropriate to continue their interim final status for another year and solicit further public comment.

1. Methodology

We conducted a review of each code identified in this section and reviewed the current work RVU, if one exists, the AMA RUC-recommended work RVUs, intensity, and time to furnish the preservice, intraservice, and postservice activities, as well as other components of the service that contribute to the value. Our review generally includes, but is not limited to, a review of information provided by the AMA RUC, Health Care Professionals Advisory Committee (HCPAC), and other public commenters, medical literature, and comparative databases, as well as a comparison with other codes within the Medicare PFS, consultation with other physicians and health care professionals within CMS and the federal government. We also assessed the methodology and data used to develop the recommendations submitted to us by the AMA RUC and other public commenters and the rationale for the recommendations. As we noted in the CY 2011 PFS final rule with comment period (75 FR 73328 through 73329), there are a variety of methodologies and approaches used to develop work RVUs, including survey data, building blocks, crosswalk to key reference or similar codes, and magnitude estimation. When referring to a survey, unless otherwise noted, we mean the surveys conducted by specialty societies as part of the formal AMA RUC process. The building block methodology is used to construct, or deconstruct, the work RVU for a CPT code based on component pieces of the code. Components used in the building block approach may include preservice, intraservice, or postservice time and post-procedure visits. When referring to a bundled CPT code, the components could be the CPT codes that make up the bundled code. Magnitude estimation refers to a methodology for valuing physician work that determines the appropriate work RVU for a service by gauging the total amount of physician work for that service relative to the physician work for similar service across the physician fee schedule without explicitly valuing the components of that work.

The PFS incorporates cross-specialty and cross-organ system relativity. Valuing services requires an assessment of relative value and takes into account the clinical intensity and time required to furnish a service. In selecting which methodological approach will best determine the appropriate value for a service, we consider the current and recommended work and time values, as well as the intensity of the service, all relative to other services.

Several years ago, to aid in the development of preservice time recommendations for new and revised CPT codes, the AMA RUC created standardized preservice time packages, The packages include preservice evaluation time, preservice positioning time, and preservice scrub, dress and wait time. Currently there are six preservice time packages for services typically furnished in the facility setting, reflecting the different combinations of straightforward or difficult procedure, straightforward or difficult patient, and without or with sedation/anesthesia. Currently there are two preservice time packages for services typically furnished in the nonfacility setting, reflecting procedures without and with sedation/anesthesia care.

We have developed several standard building block methodologies to appropriately value services when they have common billing patterns. In cases where a service is typically furnished to a beneficiary on the same day as an evaluation and management (E/M) service, we believe that there is overlap between the two services in some of the activities furnished during the preservice evaluation and postservice time. We believe that at least one-third of the physician time in both the preservice evaluation and postservice period is duplicative of work furnished during the E/M visit. Accordingly, in cases where we believe that the AMA RUC has not adequately accounted for the overlapping activities in the recommended work RVU and/or times, we adjust the work RVU and/or times to account for the overlap. The work RVU for a service is the product of the time involved in furnishing the service times the intensity of the work. Preservice evaluation time and postservice time both have a long-established intensity of work per unit of time (IWPUT) of 0.0224, which means that 1 minute of preservice evaluation or postservice time equates to 0.0224 of a work RVU. Therefore, in many cases when we remove 2 minutes of preservice time and 2 minutes of postservice time from a procedure to account for the overlap with the same day E/M service, we also remove a work RVU of 0.09 (4 minutes × 0.0224 IWPUT) if we do not believe the overlap in time has already been accounted for in the work RVU. We continue to believe this adjustment is appropriate. The AMA RUC has recognized this valuation policy and, in many cases, addresses the overlap in time and work when a service is typically provided on the same day as an E/M service.

2. Responding to CY 2013 Interim Final RVUs and CY 2014 Proposed RVUs

In this section, we address the interim final values published in the CY 2013 PFS final rule with comment period, as subsequently corrected in the correction notice (78 FR 48996), and the proposed values published in the CY 2014 PFS proposed rule. We discuss the results of the CY 2013 refinement panel for CY 2013 interim final codes the panel reviewed, respond to public comments received on specific interim final and proposed RVUs and direct PE inputs, and address the other new, revised, or potentially misvalued codes with interim final or proposed values. The direct PE inputs are listed in a file called "CY 2014 PFS Direct PE Inputs," available on the CMS Web site under downloads for the CY 2014 PFS final rule with comment period at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html*. The final CY 2014 work, PE, and malpractice RVUs are in Addendum B of a file called "CY 2014 PFS Addenda," available on the CMS Web site under downloads for the CY 2014 PFS final rule with comment period at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html*.

(a) Finalizing CY 2013 Interim Final Work RVUs for CY 2014

(i) Refinement Panel

(1) Refinement Panel Process

As discussed in the 1993 PFS final rule with comment period (57 FR 55938), we adopted a refinement panel process to assist us in reviewing the public comments on CPT codes with interim final work RVUs for a year and in developing final work values for the subsequent year. We decided the panel would be comprised of a multispecialty group of physicians who would review and discuss the work involved in each procedure under review, and then each panel member would individually rate the work of the procedure. We believed establishing the panel with a multispecialty group would balance the interests of the specialty societies who commented on the work RVUs with the budgetary and redistributive effects that could occur if we accepted extensive increases in work RVUs across a broad range of services. Depending on the

number and range of codes that are subject to refinement in a given year, we establish refinement panels with representatives from four groups of physicians: Clinicians representing the specialty identified with the procedures in question; physicians with practices in related specialties; primary care physicians; and contractor medical directors (CMDs). Typical panels have included 8 to 10 physicians across the four groups.

Following the addition of section 1848(c)(2)(K) to the Act by Section 3134 of the Affordable Care Act, which required the Secretary periodically to review potentially misvalued codes and make appropriate adjustments to the RVUs, we reassessed the refinement panel process. As detailed in the CY 2011 PFS final rule with comment period (75 FR 73306), we believed that the refinement panel process may provide an opportunity to review and discuss the proposed and interim final work RVUs with a clinically diverse group of experts, who then provide informed recommendations. Therefore, we indicated that we would continue the refinement process, but with administrative modification and clarification. We also noted that we would continue using the established composition that includes representatives from the four groups of physicians—clinicians representing the specialty identified with the procedures in question, physicians with practices in related specialties, primary care physicians, and CMDs.

At that time, we made a change in how we calculated refinement panel results. The basis of the refinement panel process is that, following discussion of the information but without an attempt to reach a consensus, each member of the panel submits an independent rating to CMS. Historically, the refinement panel's recommendation to change a work value or to retain the interim final value had hinged solely on the outcome of a statistical test on the ratings (an F-test of panel ratings among the groups of participants). Over time, we found the statistical test used to evaluate the RVU ratings of individual panel members became less reliable as the physicians in each group tended to select a previously discussed value, rather than developing a unique value, thereby reducing the observed variability needed to conduct a robust statistical test. In addition, reliance on values developed using the F-test also occasionally resulted in rank order anomalies among services (that is, a more complex procedure is assigned lower RVUs than a less complex procedure). As a result, we eliminated the use of the statistical F-test and instead used the median work value of the individual panel members' ratings. We said that this approach would simplify the refinement process administratively, while providing a result that reflects the summary opinion of the panel members based on a commonly used measure of central tendency that is not significantly affected by outlier values.

At the same time, we clarified that we have the final authority to set the work RVUs, including making adjustments to the work RVUs resulting from the refinement process, and that we will make such adjustments if warranted by policy concerns (75 FR 73307).

As we continue to strive to make the refinement panel process as effective and efficient as possible, we would like to remind readers that the refinement panels are not intended to review every code for which we did not accept the AMA RUC-recommended work RVUs. Rather, the refinement panels are designed for situations where there is new information available that might provide a reason for a change in work values and for which a multispecialty panel of physicians might provide input that would assist us in making work RVU decisions. To facilitate the selection of services for the refinement panels, we would like to remind specialty societies seeking reconsideration of interim final work RVUs, including consideration by a refinement panel, to specifically state in their public comments that they are requesting refinement panel review. Furthermore, we have asked commenters requesting refinement panel review to submit sufficient new information concerning the clinical aspects of the work assigned for a service to indicate that referral to the refinement panel is warranted (57 FR 55917).

We note that most of the information presented during the last several refinement panel discussions has been duplicative of the information provided to the AMA RUC during its development of recommendations. As detailed in section II.E.1. of this final rule with comment period, we consider information and recommendations from the AMA RUC when assigning proposed and interim final RVUs to services. Thus, if the only information that a commenter has to present is information already considered by the AMA RUC, referral to a refinement panel is not appropriate. To facilitate selection of codes for refinement, we request that commenters seeking refinement panel review of work RVUs submit supporting information that has not already been considered the AMA RUC in creating recommended work RVUs or by CMS in assigning proposed and interim final work RVUs. We can make best use of our resources as well as those of the specialties involved and physician volunteers by avoiding duplicative consideration of information by the AMA RUC, CMS, and a refinement panel. To achieve this goal, CMS will continue to critically evaluate the need to refer codes to refinement panels in future years, specifically considering any new information provided by commenters.

(2) CY 2013 Interim Final Work RVUs Considered by the Refinement Panel

We referred to the CY 2013 refinement panel 12 CPT codes with CY 2013 interim final work values for which we received a request for refinement that met the requirements described above. For these 12 CPT codes, all commenters requested increased work RVUs. For ease of discussion, we will be referring to these services as "refinement codes." Consistent with the process described above, we convened a multi-specialty panel of physicians to assist us in the review of the information submitted to support increased work RVUs. The panel was moderated by our physician advisors, and consisted of the following voting members:

- One to two clinicians representing the commenting organization.
- One to two primary care clinicians nominated by the American Academy of Family Physicians and the American College of Physicians.
- Four Contractor Medical Directors (CMDs).
- One to two clinicians with practices in related specialties, who were expected to have knowledge of the services under review.

The panel process was designed to capture each participant's independent judgment and his or her clinical experience which informed and drove the discussion of the refinement code during the refinement panel proceedings. Following the discussion, each voting participant rated the physician work of the refinement code and submitted those ratings to CMS directly and confidentially. We note that not all voting participants voted for every CPT code. There was no attempt to achieve consensus among the panel members. As finalized in the CY 2011 PFS final rule with comment period (75 FR 73307), we calculated the median value for each service based upon the individual ratings that were submitted to CMS by panel participants.

Table 23 presents information on the work RVUs for the codes considered by the refinement panel, including the refinement panel ratings and the final CY 2014 work RVUs. In section II.E.2.a.ii., we discuss each of the individual codes reviewed by the refinement panel.

TABLE 23—CODES REVIEWED BY THE 2013 MULTI-SPECIALTY REFINEMENT PANEL

HCPCS code	Short descriptor	CY 2013 interim final work RVU	AMA RUC/ HCPAC recommended work RVU	Refinement panel median rating	CY 2014 work RVU
35475	Angioplasty, arterial	5.75	6.60	6.60	6.60
35476	Angioplasty, venous	4.71	5.10	5.10	5.10
93655	Arrhythmia ablation add-on	7.50	9.00	9.00	7.50
93657	Afibablation add-on	7.50	10.00	10.00	7.50
95886	EMG extremity add-on	0.70	0.92	0.92	0.86
95887	EMG non-extremity add-on	0.47	0.73	0.73	0.71
95908	Nerve conduction studies; 3–4 studies	1.25	1.37	1.37	1.25
95909	Nerve conduction studies; 5–6 studies	1.50	1.77	1.77	1.50
95910	Nerve conduction studies; 7–8 studies	2.00	2.80	2.80	2.00
95911	Nerve conduction studies; 9–10 studies	2.50	3.34	3.34	2.50
92912	Nerve conduction studies; 11–12 studies	3.00	4.00	4.00	3.00
95913	Nerve conduction studies; 13 or more studies	3.56	4.20	4.20	3.56

(ii) Code-Specific Issues

Table 24 of this final rule with comment period lists all codes that had a CY 2013 interim final work value. This chart provides the CY 2013 work RVUs, the CY 2014 work RVUs and indicates whether we are finalizing the CY 2014 work RVUs. If there is no work RVUs listed, a letter indicates the relevant PFS procedure status indicator. A list of the PFS procedure status indicators can be found in Addendum A. If the CY 2014 Action column indicates that the CY 2014 values are interim final, public comments on these values will be accepted during the public comment period on this final rule with comment period. The comprehensive list of all CY 2014 RVUs is in Addendum B to this final rule with comment period, which is contained in the "CY 2014 PFS Addenda" available on the CMS Web site under downloads for the CY 2014 PFS final rule with comment period at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html.* The comprehensive list of all CY 2013 values is in Addendum B to the CY 2013 Correction Notice which is contained in the "CMS–1590–CN Addenda," available on the CMS Web site under downloads for the CY 2013 correction notice at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html.* The time values for all codes are listed in a file called "CY 2014 PFS Physician Time," available on the CMS Web site under downloads for the CY 2014 PFS final rule with comment period at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html.*

TABLE 24—CODES WITH CY 2013 INTERIM FINAL WORK VALUES

HCPCS code	Long descriptor	CY 2013 work RVU	CY 2014 work RVU	CY 2014 action
10120	Incision and removal of foreign body, subcutaneous tissues; simple	1.22	1.22	Finalize.
11055	Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion	0.35	0.35	Finalize.
11056	Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); 2 to 4 lesions	0.50	0.50	Finalize.
11057	Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); more than 4 lesions.	0.65	0.65	Finalize.
11300	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.5 cm or less.	0.60	0.60	Finalize.
11301	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.6 to 1.0 cm.	0.90	0.90	Finalize.
11302	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 1.1 to 2.0 cm.	1.05	1.05	Finalize.
11303	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter over 2.0 cm.	1.25	1.25	Finalize.
11305	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less.	0.80	0.80	Finalize.
11306	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm.	0.96	0.96	Finalize.
11307	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm.	1.20	1.20	Finalize.
11308	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter over 2.0 cm.	1.46	1.46	Finalize.
11310	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less.	0.80	0.80	Finalize.
11311	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm.	1.10	1.10	Finalize.

TABLE 24—CODES WITH CY 2013 INTERIM FINAL WORK VALUES—Continued

HCPCS code	Long descriptor	CY 2013 work RVU	CY 2014 work RVU	CY 2014 action
11312	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm.	1.30	1.30	Finalize.
11313	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 2.0 cm.	1.68	1.68	Finalize.
11719	Trimming of nondystrophic nails, any number	0.17	0.17	Finalize.
12035	Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 12.6 cm to 20.0 cm.	3.50	3.50	Finalize.
12036	Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 20.1 cm to 30.0 cm.	4.23	4.23	Finalize.
12037	Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); over 30.0 cm.	5.00	5.00	Finalize.
12045	Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 12.6 cm to 20.0 cm.	3.75	3.75	Finalize.
12046	Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 20.1 cm to 30.0 cm.	4.30	4.30	Finalize.
12047	Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; over 30.0 cm.	4.95	4.95	Finalize.
12055	Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 12.6 cm to 20.0 cm.	4.50	4.50	Finalize.
12056	Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 20.1 cm to 30.0 cm.	5.30	5.30	Finalize.
12057	Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; over 30.0 cm.	6.00	6.00	Finalize.
13100	Repair, complex, trunk; 1.1 cm to 2.5 cm	3.00	3.00	Finalize.
13101	Repair, complex, trunk; 2.6 cm to 7.5 cm	3.50	3.50	Finalize.
13102	Repair, complex, trunk; each additional 5 cm or less (list separately in addition to code for primary procedure).	1.24	1.24	Finalize.
13120	Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm	3.23	3.23	Finalize.
13121	Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm	4.00	4.00	Finalize.
13122	Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less (list separately in addition to code for primary procedure).	1.44	1.44	Finalize.
13131	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm.	3.73	3.73	Finalize.
13132	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm.	4.78	4.78	Finalize.
13133	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less (list separately in addition to code for primary procedure).	2.19	2.19	Finalize.
13150	Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less	3.58	D	D.
13151	Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm	4.34	4.34	Finalize.
13152	Repair, complex, eyelids, nose, ears and/or lips; 2.6 cm to 7.5 cm	4.90	5.34	Finalize.
13153	Repair, complex, eyelids, nose, ears and/or lips; each additional 5 cm or less (list separately in addition to code for primary procedure).	2.38	2.38	Finalize.
20985	Computer-assisted surgical navigational procedure for musculoskeletal procedures, image-less (list separately in addition to code for primary procedure).	2.50	2.50	Finalize.
22586	Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft when performed, l5-s1 interspace.	28.12	28.12	Finalize.
23350	Injection procedure for shoulder arthrography or enhanced ct/mri shoulder arthrography.	1.00	1.00	Finalize.
23331	Removal of foreign body, shoulder; deep (eg, neer hemiarthroplasty removal)	7.63	D	D.
23332	Removal of foreign body, shoulder; complicated (eg, total shoulder)	12.37	D	D.
23472	Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder)).	22.13	22.13	Finalize.
23473	Revision of total shoulder arthroplasty, including allograft when performed; humeral or glenoid component.	25.00	25.00	Finalize.
23474	Revision of total shoulder arthroplasty, including allograft when performed; humeral and glenoid component.	27.21	27.21	Finalize.
23600	Closed treatment of proximal humeral (surgical or anatomical neck) fracture; without manipulation.	3.00	3.00	Interim Final.
24160	Implant removal; elbow joint	8.00	18.63	Interim Final.
24363	Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow).	22.00	22.00	Finalize.
24370	Revision of total elbow arthroplasty, including allograft when performed; humeral or ulnar component.	23.55	23.55	Finalize.
24371	Revision of total elbow arthroplasty, including allograft when performed; humeral and ulnar component.	27.50	27.50	Finalize.
28470	Closed treatment of metatarsal fracture; without manipulation, each	2.03	2.03	Interim Final.
29075	Application, cast; elbow to finger (short arm)	0.77	0.77	Interim Final.
29581	Application of multi-layer compression system; leg (below knee), including ankle and foot.	0.25	0.25	Interim Final.

TABLE 24—CODES WITH CY 2013 INTERIM FINAL WORK VALUES—Continued

HCPCS code	Long descriptor	CY 2013 work RVU	CY 2014 work RVU	CY 2014 action
29582	Application of multi-layer compression system; thigh and leg, including ankle and foot, when performed.	0.35	0.35	Interim Final.
29583	Application of multi-layer compression system; upper arm and forearm	0.25	0.25	Interim Final.
29584	Application of multi-layer compression system; upper arm, forearm, hand, and fingers.	0.35	0.35	Interim Final.
29824	Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface (mumford procedure).	8.98	8.98	Interim Final.
29826	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie, arch) release, when performed (list separately in addition to code for primary procedure).	3.00	3.00	Interim Final.
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair	15.59	15.59	Finalize.
29828	Arthroscopy, shoulder, surgical; biceps tenodesis	13.16	13.16	Finalize.
31231	Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)	1.10	1.10	Finalize.
31647	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), initial lobe.	4.40	4.40	Finalize.
31648	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), initial lobe.	4.20	4.20	Finalize.
31649	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), each additional lobe (list separately in addition to code for primary procedure).	1.44	1.44	Finalize.
31651	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), each additional lobe (list separately in addition to code for primary procedure[s]).	1.58	1.58	Finalize.
31660	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 1 lobe.	4.25	4.25	Finalize.
31661	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 2 or more lobes.	4.50	4.50	Finalize.
32440	Removal of lung, pneumonectomy	27.28	27.28	Finalize.
32480	Removal of lung, other than pneumonectomy; single lobe (lobectomy)	25.82	25.82	Finalize.
32482	Removal of lung, other than pneumonectomy; 2 lobes (bilobectomy)	27.44	27.44	Finalize.
32491	Removal of lung, other than pneumonectomy; with resection-plication of emphysematous lung(s) (bullous or non-bullous) for lung volume reduction, sternal split or transthoracic approach, includes any pleural procedure, when performed.	25.24	25.24	Finalize.
32551	Tube thoracostomy, includes connection to drainage system (eg, water seal), when performed, open (separate procedure).	3.29	3.29	Finalize.
32554	Thoracentesis, needle or catheter, aspiration of the pleural space; without imaging guidance.	1.82	1.82	Finalize.
32555	Thoracentesis, needle or catheter, aspiration of the pleural space; with imaging guidance.	2.27	2.27	Finalize.
32556	Pleural drainage, percutaneous, with insertion of indwelling catheter; without imaging guidance.	2.50	2.50	Finalize.
32557	Pleural drainage, percutaneous, with insertion of indwelling catheter; with imaging guidance.	3.12	3.12	Finalize.
32663	Thoracoscopy, surgical; with lobectomy (single lobe)	24.64	24.64	Finalize.
32668	Thoracoscopy, surgical; with diagnostic wedge resection followed by anatomic lung resection (list separately in addition to code for primary procedure).	3.00	3.00	Finalize.
32669	Thoracoscopy, surgical; with removal of a single lung segment (segmentectomy)	23.53	23.53	Finalize.
32670	Thoracoscopy, surgical; with removal of two lobes (bilobectomy)	28.52	28.52	Finalize.
32671	Thoracoscopy, surgical; with removal of lung (pneumonectomy)	31.92	31.92	Finalize.
32672	Thoracoscopy, surgical; with resection-plication for emphysematous lung (bullous or non-bullous) for lung volume reduction (lvrs), unilateral includes any pleural procedure, when performed.	27.00	27.00	Finalize.
32673	Thoracoscopy, surgical; with resection of thymus, unilateral or bilateral	21.13	21.13	Finalize.
32701	Thoracic target(s) delineation for stereotactic body radiation therapy (srs/sbrt), (photon or particle beam), entire course of treatment.	4.18	4.18	Finalize.
33361	Transcatheter aortic valve replacement (tavr/tavi) with prosthetic valve; percutaneous femoral artery approach.	25.13	25.13	Finalize.
33362	Transcatheter aortic valve replacement (tavr/tavi) with prosthetic valve; open femoral artery approach.	27.52	27.52	Finalize.
33363	Transcatheter aortic valve replacement (tavr/tavi) with prosthetic valve; open axillary artery approach.	28.50	28.50	Finalize.
33364	Transcatheter aortic valve replacement (tavr/tavi) with prosthetic valve; open iliac artery approach.	30.00	30.00	Finalize.
33365	Transcatheter aortic valve replacement (tavr/tavi) with prosthetic valve; transaortic approach (eg, median sternotomy, mediastinotomy).	33.12	33.12	Finalize.

TABLE 24—CODES WITH CY 2013 INTERIM FINAL WORK VALUES—Continued

HCPCS code	Long descriptor	CY 2013 work RVU	CY 2014 work RVU	CY 2014 action
33367	Transcatheter aortic valve replacement (tavr/tavi) with prosthetic valve; cardiopulmonary bypass support with percutaneous peripheral arterial and venous cannulation (eg, femoral vessels) (list separately in addition to code for primary procedure).	11.88	11.88	Finalize.
33368	Transcatheter aortic valve replacement (tavr/tavi) with prosthetic valve; cardiopulmonary bypass support with open peripheral arterial and venous cannulation (eg, femoral, iliac, axillary vessels) (list separately in addition to code for primary procedure).	14.39	14.39	Finalize.
33369	Transcatheter aortic valve replacement (tavr/tavi) with prosthetic valve; cardiopulmonary bypass support with central arterial and venous cannulation (eg, aorta, right atrium, pulmonary artery) (list separately in addition to code for primary procedure).	19.00	19.00	Finalize.
33405	Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve.	41.32	41.32	Finalize.
33430	Replacement, mitral valve, with cardiopulmonary bypass	50.93	50.93	Finalize.
33533	Coronary artery bypass, using arterial graft(s); single arterial graft	33.75	33.75	Finalize.
33990	Insertion of ventricular assist device, percutaneous including radiological supervision and interpretation; arterial access only.	8.15	8.15	Finalize.
33991	Insertion of ventricular assist device, percutaneous including radiological supervision and interpretation; both arterial and venous access, with transseptal puncture.	11.88	11.88	Finalize.
33992	Removal of percutaneous ventricular assist device at separate and distinct session from insertion.	4.00	4.00	Finalize.
33993	Repositioning of percutaneous ventricular assist device with imaging guidance at separate and distinct session from insertion.	3.51	3.51	Finalize.
35475	Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel.	5.75	6.60	Finalize.
35476	Transluminal balloon angioplasty, percutaneous; venous	4.71	5.10	Finalize.
36221	Non-selective catheter placement, thoracic aorta, with angiography of the extracranial carotid, vertebral, and/or intracranial vessels, unilateral or bilateral, and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed.	4.17	4.17	Finalize.
36222	Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral extracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed.	5.53	5.53	Finalize.
36223	Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed.	6.00	6.00	Finalize.
36224	Selective catheter placement, internal carotid artery, unilateral, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed.	6.50	6.50	Finalize.
36225	Selective catheter placement, subclavian or innominate artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed.	6.00	6.00	FInalize.
36226	Selective catheter placement, vertebral artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed.	6.50	6.50	Finalize.
36227	Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (list separately in addition to code for primary procedure).	2.09	2.09	Finalize.
36228	Selective catheter placement, each intracranial branch of the internal carotid or vertebral arteries, unilateral, with angiography of the selected vessel circulation and all associated radiological supervision and interpretation (eg, middle cerebral artery, posterior inferior cerebellar artery) (list separately in addition to code for primary procedure).	4.25	4.25	Finalize.
37197	Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter), includes radiological supervision and interpretation, and imaging guidance (ultrasound or fluoroscopy), when performed.	6.29	6.29	Finalize.
37211	Transcatheter therapy, arterial infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, initial treatment day.	8.00	8.00	Finalize.
37212	Transcatheter therapy, venous infusion for thrombolysis, any method, including radiological supervision and interpretation, initial treatment day.	7.06	7.06	Finalize.
37213	Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed.	5.00	5.00	Finalize.

TABLE 24—CODES WITH CY 2013 INTERIM FINAL WORK VALUES—Continued

HCPCS code	Long descriptor	CY 2013 work RVU	CY 2014 work RVU	CY 2014 action
37214	Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed.	2.74	2.74	Finalize.
38240	Hematopoietic progenitor cell (hpc); allogeneic transplantation per donor	3.00	4.00	Finalize.
38241	Hematopoietic progenitor cell (hpc); autologous transplantation	3.00	3.00	Finalize.
38242	Allogeneic lymphocyte infusions	2.11	2.11	Finalize.
38243	Hematopoietic progenitor cell (hpc); hpc boost	2.13	2.13	Finalize.
40490	Biopsy of lip	1.22	1.22	Finalize.
43206	Esophagoscopy, rigid or flexible; with optical endomicroscopy	C	2.39	Interim Final.
43252	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with optical endomicroscopy.	C	3.06	Interim Final.
44705	Preparation of fecal microbiota for instillation, including assessment of donor specimen.	I	I	Finalize.
45330	Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure).	0.96	0.96	Finalize.
47562	Laparoscopy, surgical; cholecystectomy	10.47	10.47	Finalize.
47563	Laparoscopy, surgical; cholecystectomy with cholangiography	11.47	11.47	Finalize.
47600	Cholecystectomy	17.48	17.48	Finalize.
47605	Cholecystectomy; with cholangiography	18.48	18.48	Finalize.
49505	Repair initial inguinal hernia, age 5 years or older; reducible	7.96	7.96	Finalize.
50590	Lithotripsy, extracorporeal shock wave	9.77	9.77	Finalize.
52214	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands.	3.50	3.50	Finalize.
52224	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of minor (less than 0.5 cm) lesion(s) with or without biopsy.,	4.05	4.05	Finalize.
52234	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; small bladder tumor(s) (0.5 up to 2.0 cm).	4.62	4.62	Finalize.
52235	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; medium bladder tumor(s) (2.0 to 5.0 cm).	5.44	5.44	Finalize.
52240	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; large bladder tumor(s).	7.50	7.50	Finalize.
52287	Cystourethroscopy, with injection(s) for chemodenervation of the bladder	3.20	3.20	Finalize.
52351	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; diagnostic	5.75	5.75	Finalize.
52352	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included).	6.75	6.75	Finalize.
52353	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included).	7.50	7.50	Finalize.
52354	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with biopsy and/or fulguration of ureteral or renal pelvic lesion.	8.00	8.00	Finalize.
52355	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with resection of ureteral or renal pelvic tumor.	9.00	9.00	Finalize.
53850	Transurethral destruction of prostate tissue; by microwave thermotherapy	10.08	10.08	Finalize.
60520	Thymectomy, partial or total; transcervical approach (separate procedure)	17.16	17.16	Finalize.
60521	Thymectomy, partial or total; sternal split or transthoracic approach, without radical mediastinal dissection (separate procedure).	19.18	19.18	Finalize.
60522	Thymectomy, partial or total; sternal split or transthoracic approach, with radical mediastinal dissection (separate procedure).	23.48	23.48	Finalize.
64450	Injection, anesthetic agent; other peripheral nerve or branch	0.75	0.75	Finalize.
64612	Chemodenervation of muscle(s); muscle(s) innervated by facial nerve, unilateral (eg, for blepharospasm, hemifacial spasm).	1.41	1.41	Finalize.
64613	Chemodenervation of muscle(s); neck muscle(s) (eg, for spasmodic torticollis, spasmodic dysphonia).	2.01	D	D.
64614	Chemodenervation of muscle(s); extremity and/or trunk muscle(s) (eg, for dystonia, cerebral palsy, multiple sclerosis).	2.20	D	D.
64615	Chemodenervation of muscle(s); muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (eg, for chronic migraine).	1.85	1.85	Finalize.
64640	Destruction by neurolytic agent; other peripheral nerve or branch	1.23	1.23	Finalize.
65222	Removal of foreign body, external eye; corneal, with slit lamp	0.84	0.84	Finalize.
65800	Paracentesis of anterior chamber of eye (separate procedure); with removal of aqueous.	1.53	1.53	Finalize.
66982	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage.	11.08	11.08	Finalize.
66984	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification).	8.52	8.52	Finalize.
67028	Intravitreal injection of a pharmacologic agent (separate procedure)	1.44	1.44	Finalize.

TABLE 24—CODES WITH CY 2013 INTERIM FINAL WORK VALUES—Continued

HCPCS code	Long descriptor	CY 2013 work RVU	CY 2014 work RVU	CY 2014 action
67810	Incisional biopsy of eyelid skin including lid margin	1.18	1.18	Finalize.
68200	Subconjunctival injection	0.49	0.49	Finalize.
69200	Removal foreign body from external auditory canal; without general anesthesia	0.77	0.77	Finalize.
69433	Tympanostomy (requiring insertion of ventilating tube), local or topical anesthesia	1.57	1.57	Finalize.
72040	Radiologic examination, spine, cervical; 3 views or less	0.22	0.22	Finalize.
72050	Radiologic examination, spine, cervical; 4 or 5 views	0.31	0.31	Finalize.
72052	Radiologic examination, spine, cervical; 6 or more views	0.36	0.36	Finalize.
72191	Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing.	1.81	1.81	Interim Final.
73221	Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s).	1.35	1.35	Finalize.
73721	Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material.	1.35	1.35	Finalize.
74170	Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections.	1.40	1.40	Finalize.
74174	Computed tomographic angiography, abdomen and pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing.	2.20	2.20	Finalize.
74175	Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing.	1.90	1.90	Finalize.
74247	Radiological examination, gastrointestinal tract, upper, air contrast, with specific high density barium, effervescent agent, with or without glucagon; with or without delayed films, with kub.	0.69	0.69	Finalize.
74280	Radiologic examination, colon; air contrast with specific high density barium, with or without glucagon.	0.99	0.99	Finalize.
74400	Urography (pyelography), intravenous, with or without kub, with or without tomography.	0.49	0.49	Finalize.
75896–26	Transcatheter therapy, infusion, other than for thrombolysis, radiological supervision and interpretation.	1.31	1.31	Interim Final.
75896–TC	Transcatheter therapy, infusion, other than for thrombolysis, radiological supervision and interpretation.	C	C	Interim Final.
75898–26	Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion, other than for thrombolysis.	1.65	1.65	Interim Final.
75898–TC	Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion, other than for thrombolysis.	C	C	Interim Final.
76830	Ultrasound, transvaginal	0.69	0.69	Finalize.
76872	Ultrasound, transrectal	0.69	0.69	Finalize.
77001	Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (list separately in addition to code for primary procedure).	0.38	0.38	Interim Final.
77002	Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device).	0.54	0.54	Interim Final.
77003	Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid).	0.60	0.60	Interim Final.
77080	Dual-energy x-ray absorptiometry (dxa), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine).	0.20	0.20	Finalize.
77082	Dual-energy x-ray absorptiometry (dxa), bone density study, 1 or more sites; vertebral fracture assessment.	0.17	0.17	Finalize.
77301	Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications.	7.99	7.99	Finalize.
78012	Thyroid uptake, single or multiple quantitative measurement(s) (including stimulation, suppression, or discharge, when performed).	0.19	0.19	Finalize.
78013	Thyroid imaging (including vascular flow, when performed)	0.37	0.37	Finalize.
78014	Thyroid imaging (including vascular flow, when performed); with single or multiple uptake(s) quantitative measurement(s) (including stimulation, suppression, or discharge, when performed).	0.50	0.50	Finalize.
78070	Parathyroid planar imaging (including subtraction, when performed)	0.80	0.80	Finalize.
78071	Parathyroid planar imaging (including subtraction, when performed); with tomographic (spect).	1.20	1.20	Finalize.
78072	Parathyroid planar imaging (including subtraction, when performed); with tomographic (spect), and concurrently acquired computed tomography (ct) for anatomical localization.	1.60	1.60	Finalize.
78278	Acute gastrointestinal blood loss imaging	0.99	0.99	Finalize.
78472	Cardiac blood pool imaging, gated equilibrium; planar, single study at rest or stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without additional quantitative processing.	0.98	0.98	Finalize.

TABLE 24—CODES WITH CY 2013 INTERIM FINAL WORK VALUES—Continued

HCPCS code	Long descriptor	CY 2013 work RVU	CY 2014 work RVU	CY 2014 action
86153	Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood); physician interpretation and report, when required.	0.69	0.69	Finalize.
88120	Cytopathology, in situ hybridization (eg, fish), urinary tract specimen with morphometric analysis, 3–5 molecular probes, each specimen; manual.	1.20	1.20	Interim Final.
88121	Cytopathology, in situ hybridization (eg, fish), urinary tract specimen with morphometric analysis, 3–5 molecular probes, each specimen; using computer-assisted technology.	1.00	1.00	Interim Final.
88312	Special stain including interpretation and report; group i for microorganisms (eg, acid fast, methenamine silver).	0.54	0.54	Finalize.
88365	In situ hybridization (eg, fish), each probe	1.20	1.20	Interim Final.
88367	Morphometric analysis, in situ hybridization (quantitative or semi-quantitative) each probe; using computer-assisted technology.	1.30	1.30	Interim Final.
88368	Morphometric analysis, in situ hybridization (quantitative or semi-quantitative) each probe; manual.	1.40	1.40	Interim Final.
88375	Optical endomicroscopic image(s), interpretation and report, real-time or referred, each endoscopic session.	C	I	Interim Final.
90785	Interactive complexity (list separately in addition to the code for primary procedure)	0.11	0.33	Interim Final.
90791	Psychiatric diagnostic evaluation	2.80	3.00	Interim Final.
90792	Psychiatric diagnostic evaluation with medical services	2.96	3.25	Interim Final.
90832	Psychotherapy, 30 minutes with patient and/or family member	1.25	1.50	Interim Final.
90833	Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service (list separately in addition to the code for primary procedure).	0.98	1.50	Interim Final.
90834	Psychotherapy, 45 minutes with patient and/or family member	1.89	2.00	Interim Final.
90836	Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service (list separately in addition to the code for primary procedure).	1.60	1.90	Interim Final.
90837	Psychotherapy, 60 minutes with patient and/or family member	2.83	3.00	Interim Final.
90838	Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management service (list separately in addition to the code for primary procedure).	2.56	2.50	Interim Final.
90839	Psychotherapy for crisis; first 60 minutes	C	3.13	Interim Final.
90840	Psychotherapy for crisis; each additional 30 minutes (list separately in addition to code for primary service).	C	1.50	Interim Final.
90845	Psychoanalysis	1.79	2.10	Interim Final.
90846	Family psychotherapy (without the patient present)	1.83	2.40	Interim Final.
90847	Family psychotherapy (conjoint psychotherapy) (with patient present)	2.21	2.50	Interim Final.
90853	Group psychotherapy (other than of a multiple-family group)	0.59	0.59	Interim Final.
90863	Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (list separately in addition to the code for primary procedure).	I	I	Interim Final.
91112	Gastrointestinal transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report.	2.10	2.10	Finalize.
92083	Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, goldmann visual fields with at least 3 isopters plotted and static determination within the central 30¡, or quantitative, automated threshold perimetry, octopus program g–1, 32 or 42, humphrey visual field analyzer full threshold programs 30–2, 24–2, or 30/60–2).	0.50	0.50	Finalize.
92100	Serial tonometry (separate procedure) with multiple measurements of intraocular pressure over an extended time period with interpretation and report, same day (eg, diurnal curve or medical treatment of acute elevation of intraocular pressure).	0.61	0.61	Finalize.
92235	Fluorescein angiography (includes multiframe imaging) with interpretation and report.	0.81	0.81	Finalize.
92286	Anterior segment imaging with interpretation and report; with specular microscopy and endothelial cell analysis.	0.40	0.40	Finalize.
92920	Percutaneous transluminal coronary angioplasty; single major coronary artery or branch.	10.10	10.10	Finalize.
92921	Percutaneous transluminal coronary angioplasty; each additional branch of a major coronary artery (list separately in addition to code for primary procedure).	B	B	Finalize.
92924	Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; single major coronary artery or branch.	11.99	11.99	Finalize.
92925	Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; each additional branch of a major coronary artery (list separately in addition to code for primary procedure).	B	B	Finalize.
92928	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch.	11.21	11.21	Finalize.
92929	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (list separately in addition to code for primary procedure).	B	B	Finalize.

TABLE 24—CODES WITH CY 2013 INTERIM FINAL WORK VALUES—Continued

HCPCS code	Long descriptor	CY 2013 work RVU	CY 2014 work RVU	CY 2014 action
92933	Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch.	12.54	12.54	Finalize.
92934	Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; each additional branch of a major coronary artery (list separately in addition to code for primary procedure).	B	B	Finalize.
92937	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel.	11.20	11.20	Finalize.
92938	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; each additional branch subtended by the bypass graft (list separately in addition to code for primary procedure).	B	B	Finalize.
92941	Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel.	12.56	12.56	Finalize.
92943	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; single vessel.	12.56	12.56	Finalize.
92944	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; each additional coronary artery, coronary artery branch, or bypass graft (list separately in addition to code for primary procedure).	B	B	Finalize.
93015	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with supervision, interpretation and report.	0.75	0.75	Finalize.
93016	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; supervision only, without interpretation and report.	0.45	0.45	Finalize.
93018	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; interpretation and report only.	0.30	0.30	Finalize.
93308	Echocardiography, transthoracic, real-time with image documentation (2d), includes m-mode recording, when performed, follow-up or limited study.	0.53	0.53	Finalize.
93653	Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with right atrial pacing and recording, right ventricular pacing and recording, his recording with intracardiac catheter ablation of arrhythmogenic focus; with treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathway, accessory atrioventricular connection, cavo-tricuspid isthmus or other single atrial focus or source of atrial re-entry.	15.00	15.00	Finalize.
93654	Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with right atrial pacing and recording, right ventricular pacing and recording, his recording with intracardiac catheter ablation of arrhythmogenic focus; with treatment of ventricular tachycardia or focus of ventricular ectopy including intracardiac electrophysiologic 3d mapping, when performed, and left ventricular pacing and recording, when performed.	20.00	20.00	Finalize.
93655	Intracardiac catheter ablation of a discrete mechanism of arrhythmia which is distinct from the primary ablated mechanism, including repeat diagnostic maneuvers, to treat a spontaneous or induced arrhythmia (list separately in addition to code for primary procedure).	7.50	7.50	Finalize.
93656	Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with atrial recording and pacing, when possible, right ventricular pacing and recording, his bundle recording with intracardiac catheter ablation of arrhythmogenic focus, with treatment of atrial fibrillation by ablation by pulmonary vein isolation.	20.02	20.02	Finalize.
93657	Additional linear or focal intracardiac catheter ablation of the left or right atrium for treatment of atrial fibrillation remaining after completion of pulmonary vein isolation (list separately in addition to code for primary procedure).	7.50	7.50	Finalize.
93925	Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study.	0.80	0.80	Finalize.
93926	Duplex scan of lower extremity arteries or arterial bypass grafts; unilateral or limited study.	0.50	0.50	Finalize.
93970	Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study.	0.70	0.70	Finalize.

TABLE 24—CODES WITH CY 2013 INTERIM FINAL WORK VALUES—Continued

HCPCS code	Long descriptor	CY 2013 work RVU	CY 2014 work RVU	CY 2014 action
93971	Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study.	0.45	0.45	Finalize.
95017	Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with venoms, immediate type reaction, including test interpretation and report, specify number of tests.	0.07	0.07	Finalize.
95018	Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with drugs or biologicals, immediate type reaction, including test interpretation and report, specify number of tests.	0.14	0.14	Finalize.
95076	Ingestion challenge test (sequential and incremental ingestion of test items, eg, food, drug or other substance); initial 120 minutes of testing.	1.50	1.50	Finalize.
95079	Ingestion challenge test (sequential and incremental ingestion of test items, eg, food, drug or other substance); each additional 60 minutes of testing (list separately in addition to code for primary procedure).	1.38	1.38	Finalize.
95782	Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, attended by a technologist.	2.60	2.60	Finalize.
95783	Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist.	2.83	2.83	Finalize.
95860	Needle electromyography; 1 extremity with or without related paraspinal areas	0.96	0.96	Finalize.
95861	Needle electromyography; 2 extremities with or without related paraspinal areas	1.54	1.54	Finalize.
95863	Needle electromyography; 3 extremities with or without related paraspinal areas	1.87	1.87	Finalize.
95864	Needle electromyography; 4 extremities with or without related paraspinal areas	1.99	1.99	Finalize.
95865	Needle electromyography; larynx	1.57	1.57	Finalize.
95866	Needle electromyography; hemidiaphragm	1.25	1.25	Finalize.
95867	Needle electromyography; cranial nerve supplied muscle(s), unilateral	0.79	0.79	Finalize.
95868	Needle electromyography; cranial nerve supplied muscles, bilateral	1.18	1.18	Finalize.
95869	Needle electromyography; thoracic paraspinal muscles (excluding t1 or t12)	0.37	0.37	Finalize.
95870	Needle electromyography; limited study of muscles in 1 extremity or non-limb (axial) muscles (unilateral or bilateral), other than thoracic paraspinal, cranial nerve supplied muscles, or sphincters.	0.37	0.37	Finalize.
95885	Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; limited (list separately in addition to code for primary procedure).	0.35	0.35	Finalize.
95886	Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; complete, five or more muscles studied, innervated by three or more nerves or four or more spinal levels (list separately in addition to code for primary procedure).	0.70	0.86	Finalize.
95887	Needle electromyography, non-extremity (cranial nerve supplied or axial) muscle(s) done with nerve conduction, amplitude and latency/velocity study (list separately in addition to code for primary procedure).	0.47	0.71	Finalize.
95905	Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study, each limb, includes f-wave study when performed, with interpretation and report.	0.05	0.05	Finalize.
95907	Nerve conduction studies; 1–2 studies	1.00	1.00	Finalize.
95908	Nerve conduction studies; 3–4 studies	1.25	1.25	Finalize.
95909	Nerve conduction studies; 5–6 studies	1.50	1.50	Finalize.
95910	Nerve conduction studies; 7–8 studies	2.00	2.00	Finalize.
95911	Nerve conduction studies; 9–10 studies	2.50	2.50	Finalize.
95912	Nerve conduction studies; 11–12 studies	3.00	3.00	Finalize.
95913	Nerve conduction studies; 13 or more studies	3.56	3.56	Finalize.
95921	Testing of autonomic nervous system function; cardiovagal innervation (parasympathetic function), including 2 or more of the following: Heart rate response to deep breathing with recorded r-r interval, valsalva ratio, and 30:15 ratio.	0.90	0.90	Finalize.
95922	Testing of autonomic nervous system function; vasomotor adrenergic innervation (sympathetic adrenergic function), including beat-to-beat blood pressure and r-r interval changes during valsalva maneuver and at least 5 minutes of passive tilt.	0.96	0.96	Finalize.
95923	Testing of autonomic nervous system function; sudomotor, including 1 or more of the following: Quantitative sudomotor axon reflex test (qsart), silastic sweat imprint, thermoregulatory sweat test, and changes in sympathetic skin potential.	0.90	0.90	Finalize.
95924	Testing of autonomic nervous system function; combined parasympathetic and sympathetic adrenergic function testing with at least 5 minutes of passive tilt.	1.73	1.73	Finalize.
95925	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs.	0.54	0.54	Finalize.
95926	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in lower limbs.	0.54	0.54	Finalize.
95928	Central motor evoked potential study (transcranial motor stimulation); upper limbs	1.50	1.50	Interim Final.
95929	Central motor evoked potential study (transcranial motor stimulation); lower limbs	1.50	1.50	Interim Final.

TABLE 24—CODES WITH CY 2013 INTERIM FINAL WORK VALUES—Continued

HCPCS code	Long descriptor	CY 2013 work RVU	CY 2014 work RVU	CY 2014 action
95938	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper and lower limbs.	0.86	0.86	Finalize.
95939	Central motor evoked potential study (transcranial motor stimulation); in upper and lower limbs.	2.25	2.25	Finalize.
95940	Continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes (list separately in addition to code for primary procedure).	0.60	0.60	Finalize.
95941	Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour (list separately in addition to code for primary procedure).	I	I	Finalize.
95943	Simultaneous, independent, quantitative measures of both parasympathetic function and sympathetic function, based on time-frequency analysis of heart rate variability concurrent with time-frequency analysis of continuous respiratory activity, with mean heart rate and blood pressure measures, during rest, paced (deep) breathing, valsalva maneuvers, and head-up postural change.	C	C	Finalize.
96920	Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm.	1.15	1.15	Finalize.
96921	Laser treatment for inflammatory skin disease (psoriasis); 250 sq cm to 500 sq cm.	1.30	1.30	Finalize.
96922	Laser treatment for inflammatory skin disease (psoriasis); over 500 sq cm	2.10	2.10	Finalize.
97150	Therapeutic procedure(s), group (2 or more individuals)	0.65	0.29	Finalize.
99485	Supervision by a control physician of interfacility transport care of the critically ill or critically injured pediatric patient, 24 months of age or younger, includes two-way communication with transport team before transport, at the referring facility and during the transport, including data interpretation and report; first 30 minutes.	B	B	Finalize.
99486	Supervision by a control physician of interfacility transport care of the critically ill or critically injured pediatric patient, 24 months of age or younger, includes two-way communication with transport team before transport, at the referring facility and during the transport, including data interpretation and report; each additional 30 minutes (list separately in addition to code for primary procedure).	B	B	Finalize.
99487	Complex chronic care coordination services; first hour of clinical staff time directed by a physician or other qualified health care professional with no face-to-face visit, per calendar month.	B	B	Finalize.
99488	Complex chronic care coordination services; first hour of clinical staff time directed by a physician or other qualified health care professional with one face-to-face visit, per calendar month.	B	B	Finalize.
99489	Complex chronic care coordination services; each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (list separately in addition to code for primary procedure).	B	B	Finalize.
99495	Transitional care management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge medical decision making of at least moderate complexity during the service period face-to-face visit, within 14 calendar days of discharge.	2.11	2.11	Finalize.
99496	Transitional care management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge medical decision making of high complexity during the service period face-to-face visit, within 7 calendar days of discharge (do not report 90951–90970, 98960–98962, 98966–98969, 99071, 99078, 99080, 99090, 99091, 99339, 99340, 99358, 99359, 99363, 99364, 99366–99368, 99374–99380, 99441–99444, 99487–99489, 99605–99607 when performed during the service time of codes 99495 or 99496).	3.05	3.05	Finalize.
G0127	Trimming of dystrophic nails, any number	0.17	0.17	Finalize.
G0416	Surgical pathology, gross and microscopic examinations for prostate needle biopsy, any method, 10–20 specimens.	3.09	3.09	Finalize.
G0452	Molecular pathology procedure; physician interpretation and report	0.37	0.37	Finalize.
G0453	Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby), per patient, (attention directed exclusively to one patient) each 15 minutes (list in addition to primary procedure).	0.5	0.6	Finalize.
G0455	Preparation with instillation of fecal microbiota by any method, including assessment of donor specimen.	0.97	1.34	Finalize.
G0456	Negative pressure wound therapy, (e.g. vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area less than or equal to 50 square centimeters.	C	C	Finalize.

TABLE 24—CODES WITH CY 2013 INTERIM FINAL WORK VALUES—Continued

HCPCS code	Long descriptor	CY 2013 work RVU	CY 2014 work RVU	CY 2014 action
G0457	Negative pressure wound therapy, (e.g. vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area greater than 50 square centimeters.	C	C	Finalize.

In the following section, we discuss all codes for which we received a comment on the CY 2013 interim final work value or time during the comment period for the CY 2013 final rule with comment period or codes for which we are modifying the work RVU or time. If a code in Table 24 is not discussed in this section, we did not receive any comments on that code and are finalizing the CY 2013 interim final value.

(1) Integumentary System: Skin, Subcutaneous, and Accessory Structures (CPT Code 10120)

As detailed in the CY 2013 final rule with comment period, CPT code 10120 had previously been identified as potentially misvalued using the Harvard-valued utilization over 30,000 screen. We assigned an interim final work RVU of 1.22 for CY 2013, which was slightly less than the AMA RUC-recommended value of 1.25. The AMA RUC recommendation was based upon survey results; however, we believed an RVU of 1.25 overstated the work of this procedure because some of the activities furnished during the postservice period of the procedure code overlapped with the E/M visit. The AMA RUC appropriately accounted for the overlap with the E/M visit in its recommendation of preservice time, but we believed the recommendation failed to account for the overlap in the postservice time. To account for this overlap, we used our standard methodology as described above. As noted in the CY 2013 final rule with comment period, we refined the time to equal 3 minutes in the postservice physician time for CPT code 10120 for CY 2013.

Comment: Commenters urged us to use the AMA RUC-recommended work value of 1.25 RVUs and postservice physician time of 5 minutes for CPT code 10120. Commenters stated that the AMA RUC conducted extensive review of Medicare claims data for services billed together and after discussing the potential overlap and explicitly determined physician time recommendations that did not include overlap with an E/M service. Since in their view, there was no overlap between the physician time and the E/M service, they recommended that we value the code as recommended by the AMA RUC.

Response: After re-review, we maintain that some of the activities conducted during the postservice time of the procedure code and the E/M visit overlap and, therefore, should not be counted twice in developing the procedure's work value. We continue to believe that the recommended postservice time should be reduced by one-third to account for this overlap. To calculate the time, we reduced the survey's median postservice time of 5 minutes by one-third, resulting in a reduction from 5 minutes to 3 minutes. As such, we also continue to believe that a work RVU of 1.22 accurately reflects the work of the service relative to similar services. Therefore, we are finalizing a work RVU of 1.22 for CPT code 10120 and the time refinement as established for CY 2014.

(2) Integumentary System: Skin, Subcutaneous, and Accessory Structures (CPT Codes 11302, 11306, 11310, 11311, 11312, and 11313)

For these codes, as we discussed in the CY 2013 final rule with comment period, we set the work RVUs at the survey's 25th percentile work RVUs as we believed this reflected the appropriate relativity of the services both within this family as well as relative to other PFS services. As noted in the CY 2013 final rule with comment period, our interim final values differed from the AMA RUC recommendation for CPT codes 11302, 11306, 11310, 11311, 11312 and11313.

Comment: Commenters expressed disappointment with our CY 2013 interim final values for CPT codes 11302, 11306, 11310, 11311, 11312, and 11313, but without providing reasons to support a higher value.

Response: We continue to believe that the survey's 25th percentile RVUs accurately reflect the work of these procedures relative to each other and relative to other procedures. Therefore, for CY 2014 we are finalizing the CY 2013 interim final work RVU values for CPT codes 11302, 11306, 11310, 11311, 11312 and 11313.

(3) Integumentary System: Repair (Closure) (CPT Codes 13132, 13150, 11351, and 13152)

For CY 2013, we received new recommendations from the AMA RUC for the complex wound repair family, including CPT codes 13132, 13150, 13151, and 13152. As we described in the CY 2013 final rule with comment period, we assigned CY 2013 interim final work RVUs consistent with AMA RUC recommendations for all the codes in this complex wound repair family, except CPT codes 13150 and 13152, as discussed below. We assigned the following CY 2013 interim final work RVUs: 4.78 for CPT code 13132, 3.58 for CPT code 13150, 4.34 for CPT code 13151 and 2.38 for CPT code 13153.

Comment: Commenters agreed with our interim final work RVUs of 4.78 for CPT code 13132 and 4.34 for CPT code 13151 and thanked us for accepting the AMA RUC-recommendations.

Response: We are finalizing work RVUs for CY 2014 of 4.78 for CPT code 13132 and 4.34 for CPT code 13151.

The AMA RUC did not provide a recommendation for CPT code 13150 for CY 2013 with the other codes in the family because it was expecting that code to be deleted for CY 2014. As we noted in the CY 2013 final rule with comment period, we believed it was appropriate to reduce the work RVU of CPT code 13150 proportionate to the reductions in work RVUs that the AMA RUC recommended and we adopted for other services in the family, so that we maintained appropriate proportionate rank order for CY 2013. For the 12 other CPT codes in the family, their CY 2012 work RVUs were reduced, on average, by 7 percent for CY 2013. Applying that reduction to the work RVU of CPT code 13150 resulted in a CY 2013 work RVU of 3.58. We believed that value appropriately reflected the work associated with the procedure and we assigned a CY 2013 interim final work RVU of 3.58 to CPT code 13150. This code will be deleted effective January 1, 2014.

As we noted in the CY 2013 final rule with comment period, after reviewing CPT code 13152, we believed that the AMA RUC-recommended work RVU of 5.34 was too high relative to similar CPT code 13132, which had an AMA RUC-recommended work RVU of 4.78, and CPT code 13151, which had an AMA RUC-recommended work RVU of 4.34. We believed that the survey's 25th percentile work RVU of 4.90 more appropriately reflected the relative work involved in furnishing the service. Therefore, we assigned a CY 2013 interim final work RVU of 4.90 for CPT code 13152.

Comment: Commenters disagreed with our relative comparison of CPT code 13152 to CPT codes 13132 and 13151. Commenters stated that the AMA RUC determined that the survey's 25th percentile work RVU of 4.90 was too low for CPT code 13152 and would cause a rank order anomaly when compared to the less intense CPT code 13132. One commenter cited the detailed rationale that they presented to the AMA RUC explaining how CPT code 13152 was more intense and complex to perform than CPT code 13132. Furthermore, commenters supported the AMA RUC-recommended direct crosswalk of CPT code 13152 to CPT code 36571, which has a work RVU of 5.34. Commenters requested that we use the AMA RUC-recommended work RVU of 5.34 for CPT code 13152.

Response: Based on comments received, we re-reviewed CPT code 13152 and agree based on the complexity and intensity of the service that CPT code 13152 is more appropriately directly crosswalked to CPT code 36571 which has a work RVU of 5.34. Therefore, we are finalizing the AMA RUC-recommended work RVU of 5.34 to CPT code 13152 for CY 2014.

(4) Arthrocentesis (CPT Code 20605)

In the CY 2013 final rule with comment period, we revised the direct PE inputs for CPT code 20605 (Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)) and valued the code on an interim final basis for CY 2013. We had revised the work RVU for this code in CY 2012. In CY 2012, when we revised the work RVU, we established a value of 0.68 (76 FR 73209). However, in CY 2013 due to a data entry error, a work RVU of 0.98 was used for CPT 20605. Subsequent to the publication of the proposed rule, a stakeholder alerted us to a work RVU discrepancy for this code. The values displayed in Addenda B and C of the CY 2013 final rule with comment period reflect this error. In this final rule with comment period we are making a technical correction to the work RVU, revising it to 0.68, which is the work value we established in CY 2012.

(5) Musculoskeletal System: Spine (Vertebral Column) (CPT Code 22586)

CPT code 22586 was created by the CPT Editorial Panel effective January 1, CY 2013. As we noted in the CY 2013 final rule with comment period, after clinical review of CPT code 22586, we believed that a work RVU of 28.12 accurately accounted for the work associated with the service and assigned this as the CY 2013 interim final value. The AMA RUC did not provide a recommendation on this service because the specialty societies that would have needed to conduct a survey as part of the AMA RUC process declined to do so. We also noted that a specialty society that does not participate in the AMA RUC conducted a survey of its members, who furnish this service, regarding the work and time associated with this procedure and submitted a work RVU recommendation to CMS.

In the CY 2013 final rule with comment period we noted that in determining the appropriate value for this new CPT code, we reviewed the survey results and recommendations submitted to us, literature on the procedure, and Medicare claims data. Ultimately, we used a building block approach to value CPT code 22586. As we stated in the CY 2013 final rule with comment period, we valued CPT 22586 using CPT code 22558 as a reference service. CPT code 22558 is a similar procedure except that it does not include additional grafting, instrumentation, and fixation that are included in CPT code 22586. To assess the appropriate relative work increase from unbundled CPT code 22558 to the new bundled CPT code 22586, we used Medicare claims data to assess which grafting, instrumentation, and fixation services were commonly billed with CPT code 22558. Using these data we created a utilization-weighted work RVU for the grafting component of CPT code 22586, the instrumentation component of the 22586, and the fixation component of 22586. Adding these work RVUs to those of CPT code 22558 created a work RVU of 28.12, which we assigned as the CY 2013 interim final work RVU for CPT code 22586.

Additionally, as detailed in the CY 2013 final rule with comment period, after reviewing the physician time and post-operative visits for similar services, we concluded that this service includes 40 minutes of preservice evaluation time, 20 minutes of preservice positioning time, 20 minutes of preservice scrub, dress and wait time, 180 minutes of intraservice time, and 30 minutes of immediate postservice time. In the post-operative period, we believed that this service typically includes 2 CPT code 99231 visits, 1 CPT code 99323 visit, 1 CPT code 99238 visit, and 4 CPT code 99213 visits.

Comment: A commenter opposed our use of the building block methodology to value CPT code 22586, noting that we had used a methodology that digressed from our current standards for valuing procedures. Additionally, the commenter disagreed with our use of data from a specialty society that does not participate in the AMA RUC.

Response: To properly value this service without an AMA RUC recommendation, we believe that our evaluation of survey results, recommendations, literature, and Medicare claims data is crucial. Additionally, as we stated in the methodology section above and in previous final rules with comment periods, we believe the building block methodology is an appropriate approach to develop RVUs. We continue to believe the methodology used to develop the CY 2013 interim final work RVU using CPT code 22588 as the base reference is suitable for this code. Furthermore, we believe that the interim final work RVU accurately reflects the work of the typical case and reflects the appropriate incremental difference in work between CPT code 22588 and new CPT code 22586. Therefore, we are finalizing a work RVU of 28.12 for CPT code 22586 for CY 2014.

(6) Elbow Implant Removal (CPT Code 24160)

As detailed in the CY 2013 final rule with comment period, we maintained the current work value for CPT code 24160 based upon the AMA RUC recommendation. We received an AMA RUC recommendation for a work RVU of 18.63 based upon a revised CPT code description for this code. We agree with the AMA RUC recommendation and are assigning a CY 2014 interim final work RVU of 18.63 to CPT code 24160.

As detailed in the CY 2013 final rule with comment period, in response to comments we received in response to the CY 2012 final rule with comment period, we referred CPT code 29581 to the CY 2012 multi-specialty refinement panel for further review. The refinement panel median work RVU for CPT code 29581 was 0.50. Typically, we finalize the work values for CPT codes after reviewing the results of the refinement

panel. However, for CY 2012 we assigned interim RVUs for CPT codes 29581, 29582, 29583, and 29584 and requested additional information, with the intention of re-reviewing the services for CY 2013 with the new information we had received, and setting interim final values at that time. After consideration of the public comments, refinement panel median value, and our clinical review, we continued to believe that a work RVU of 0.25 was appropriate for CPT code 29581. We recognized that CPT code 29581 received only editorial changes in CY 2012; however, we continued to believe the HCPAC-reviewed codes 29582, 29583, and 29584 describe similar services. While the services are performed by different specialties, they do involve similar work. Therefore, we continued to believe that crosswalking CPT code 29581 to CPT codes 29582, 29583 and 29584 was appropriate and that the resulting work RVU accurately reflected the work associated with the service. Accordingly, on an interim final basis for CY 2013, we assigned a work RVU of 0.25 to CPT code 29581; a work RVU of 0.35 to CPT code 29582; a work RVU of 0.25 to CPT code 29583; and a work RVU of 0.35 to CPT code 29584.

Comment: Commenters disagreed with our crosswalk of CPT 29581 to CPT codes 29582, 29583, and 29584. Commenters stated that it was incorrect to compare CPT code 29581 to the other codes in the family because the typical patient for CPT 29581, a patient with a recalcitrant venous ulcer, is entirely different and more complex than the typical patient for the other codes, and as a result, CPT 29581 is a more intense and time-consuming service. Therefore, commenters requested that we use the AMA RUC-recommended work RVU of 0.60 for CPT code 29581.

Response: After re-review of CPT code 29581, we maintain that a crosswalk to CPT codes 29582, 29583, and 29584 is appropriate because the services involve similar work and as such, should be valued relative to one another. Even though the typical patient for CPT code 29581 may be different than CPT codes 29582, 29583, and 29584, the work associated with the service is not necessarily different. Accordingly, we continue to believe that our recommended value accurately reflects the work of the procedure and are finalizing a work RVU of 0.25 for CPT code 29581 for CY 2014.

(8) Respiratory System: Accessory Sinuses (CPT Code 31231)

Previously, CPT code 31231 was identified for review because it was on the multispecialty points of comparison list. We assigned a CY 2013 interim final work RVU of 1.10 to CPT code 31231, which was the survey's 25th percentile value and the AMA RUC recommendation. We believed that some of the activities furnished during the preservice and postservice period of the procedure code and the E/M visit overlapped and, therefore, should not be counted twice in developing the procedure's work value. Although we believed the AMA RUC appropriately accounted for this overlap in its recommendation of preservice time, we believed they did not account for the overlap in the postservice time. To account for this overlap, we reduced the postservice time by one-third. Specifically, we reduced the postservice time from 5 minutes to 3 minutes.

Comment: Although commenters supported the use of the AMA RUC-recommended work RVU, they overwhelmingly disagreed with lowering the postservice time for CPT code 31231. Commenters stated that the AMA RUC valued CPT code 31231 through significant review of Medicare claims data for services billed together and deliberations on potential overlap, and determined physician time recommendations that did not include overlap with an E/M service. The commenters stated that none of the post-time allocated to this code overlapped with the E/M service. Therefore, commenters requested our acceptance of the AMA RUC-recommended postservice physician time of 5 minutes.

Response: After re-review, we maintain that some of the activities conducted during the postservice time of the procedure code and the E/M visit overlap and, therefore, should not be counted twice in developing the procedure's work value. To account for this overlap, we used our standard methodology as described above. Therefore, we are finalizing a refinement of postservice time and a work RVU of 1.10 for CPT code 31231 for CY 2014.

(9) Respiratory System: Trachea and Bronchi (CPT Codes 31647, 31648, 31649 and 31651)

Effective January 1, 2013, the CPT Editorial Panel created CPT codes 31647, 31648, 31649, and 31651 to replace 0250T, 0251T; and CPT codes 31660 and 31661 to replace 0276T and 0277T. As we noted in the CY 2013 final rule with comment period when we valued these codes for the first time, we assigned a work RVU of 4.40 to CPT code 31647; a work RVU of 4.20 to CPT code 31648; and a work RVU of 1.58 to CPT code 31651 on an interim final basis for CY 2013, based upon the AMA RUC recommendations for these codes.

Comment: Commenters agreed with our interim final work for these codes and thanked us for accepting the AMA RUC recommendations.

Response: We are finalizing work RVUs of 4.40 for CPT code 31647, 4.20 for CPT code 31648 and 1.58 for CPT code 31651 for CY 2014.

As we noted in the CY 2013 final rule with comment period, after clinical review, we did not agree with the AMA RUC-recommended work RVU of 2.00 for CPT code 31649. Since CPT code 31647 had a higher work RVU than CPT code 31648, we believed that to maintain the appropriate relativity between the services, the add-on code associated with CPT code 31647 (CPT code 31651) should have a higher RVU than the add-on code associated with CPT code 31648 (CPT code 31649). We believed that by valuing CPT code 31649 at the survey's 25th percentile work RVU of 1.44, the services were placed in the appropriate rank order. Therefore, we assigned a CY 2013 interim final work RVU of 1.44 to CPT code 31649.

Comment: Commenters urged us to use the AMA RUC-recommended work value of 2.00 for CPT code 31649 and requested that we refer the code to the refinement panel. They noted that proper relativity would have CPT code 31649 ranked higher than CPT code 31651 due to the fact that valve removal requires greater physician intensity and complexity compared to insertion.

Response: After evaluation of the request for refinement, we determined that the criteria for the request for refinement were not met and, as a result, we did not refer CPT code 31649 to the CY 2013 multi-specialty refinement panel for further review.

After re-review of the work RVUs for CPT code 31649 in light of the comments submitted, we maintain that our approach in valuing this procedure is appropriate. Additionally, during clinical re-review we examined in great detail the physician intensity and complexity involved in CPT code 31649 and believe that the survey's 25th percentile work RVU of 1.44 adequately captures these factors. Furthermore, we believe that the CY 2013 interim final work RVU accurately reflects the work of the typical case and reflects the appropriate incremental difference in work with CPT code 31651. Therefore, we are finalizing a work RVU of 1.44 for CPT code 31649 for CY 2014.

(10) Respiratory System: Lungs and Pleura (CPT Codes 32551 and 32557)

We assigned CPT code 32551 a CY 2013 interim final work RVU of 3.29. As we noted in the CY 2013 final rule with comment period, we did not believe that the 0.21 work RVU increase recommended by the AMA RUC based upon the survey's 25th percentile work RVU of 3.50 was warranted for this service, especially considering the substantial reduction in recommended physician time. Additionally, as we noted in the CY 2013 interim final rule with comment period, we believed that a work RVU of 3.29 placed this service in the appropriate rank order with the other similar CPT codes reviewed for CY 2013.

Comment: A commenter stated CPT code 32551 should have been assigned a higher work value than we assigned in CY 2013 and requested that we use the AMA RUC-recommended work value for the service. The commenter also pointed out that the work RVU value for 32551 was reduced a few years ago to account for the vast number of percutaneous catheter insertions billed with this code. Because the percutaneous placed catheters, which involve less work, have since been given their own code set, the commenter stated that the open chest tube insertion would be the only procedure for which CPT code 32551 could be used. As such, the commenter believed that if we accepted the idea that a "properly valued code can be split into less complex and intense (percutaneous catheter insertion) with lesser value and more complex and intense (32551, open thoracostomy) of greater value, [we] would have an appropriate rationale for accepting the RUC recommendations (25th percentile of the survey, 3.50 RVW) for 32551."

Response: After review of the comments, we continue to believe that an increase in work RVU for CPT code 32551 is inappropriate, especially considering the substantial reduction in the AMA RUC-recommended physician time. Moreover, we believe that the work RVU of 3.29 accurately reflects the work of the typical case of this service. Therefore, we are finalizing a work RVU of 3.29 for CPT code 32551 for CY 2014.

As detailed in the CY 2013 final rule with comment period, CPT code 32557 was created as part of a coding restructure for this family. This code was assigned a CY 2013 interim final work RVU of 3.12 because we believed the AMA RUC-recommended work RVU of 3.62 overstated the difference between this code and CPT code 32556, which had an AMA RUC-recommended work RVU of 2.50. The specialty societies that surveyed CPT code 32556 recommended to the AMA RUC a work RVU of 3.00 for CPT code 32556 and a work RVU of 3.62 for CPT code 32557. We believed this difference of 0.62 in work RVUs between the two codes more accurately captured the relative difference between the services. Therefore, since we assigned CPT code 32556 a CY 2013 interim final work RVU of 2.50, we believed a work RVU of 3.12 reflected the appropriate difference between CPT codes 32556 and 32557 and appropriately reflected the work of CPT code 32557.

Additionally, in CY 2013, we refined the AMA RUC-recommended preservice evaluation time from 15 minutes to 13 minutes for CPT code 32557 to match the preservice evaluation time of CPT code 32556.

Comment: Commenters stated that we did not comprehend the relationship between the base code, CPT code 32556, without imaging, and CPT code 32557, with imaging, and the significant clinical differences in providing the services. Commenters disagreed with the way we determined the work RVU for CPT 32557 and stated that a better alternative for valuing CPT code 32557 would have been to add the value of CT guidance (1.19) to the non-image guided code (CPT code 32556 at 2.50 RVUs) to achieve the AMA RUC-recommended work RVU of 3.62. Therefore, commenters requested our use of the AMA RUC-recommended work value of 3.62 for CPT code 32557 and refinement panel review of the code.

Response: After evaluation of the request for refinement, we determined that the criteria for the request for refinement were not met and, as a result, we did not refer CPT code 32557 to the CY 2013 multi-specialty refinement panel for further review.

After re-review of CPT code 32557, we maintain that our approach in valuing this procedure is appropriate since the AMA RUC-recommended work RVU of 3.62 overstates the difference between CPT codes 32556 and 32557. We continue to believe that the difference in work RVUs presented to the AMA RUC by the specialty societies that surveyed CPT code 32557 is more appropriate in order to maintain relativity among the codes. Therefore, we are finalizing the refinement to time and the work RVU of 3.12 for CPT code 32557 for CY 2014.

(11) Respiratory System: Lungs and Pleura (CPT Codes 32663, 32668, 32669, 32670, 32671, 32672, and 32673)

The CPT Editorial Panel reviewed the lung resection family of codes and deleted 8 codes, revised 5 codes, and created 18 new codes for CY 2012. As detailed in the CY 2012 final rule with comment period, during our review for the CY 2012 PFS final rule with comment period, we were concerned with the varying differentials in the AMA RUC-recommended work RVUs and times between some of the open surgery lung resection codes and their endoscopic analogs. Rather than assign alternate interim final RVUs and times in this large restructured family of codes, we accepted the AMA RUC recommendations on an interim basis for CY 2012 and requested that the AMA RUC re-review the surgical services along with their endoscopic analogs.

In the CY 2012 PFS final rule with comment period we made this request. However, there was an inadvertent typographical error in our request, in that we referred to "open heart surgery analogs" instead of just "open surgery analogs" for each code. For example, we stated, "For CPT code 32663 (Thoracoscopy, surgical; with lobectomy (single lobe)), the AMA RUC recommended a work RVU of 24.64. Upon clinical review, we have determined that it is most appropriate to accept the AMA RUC-recommended work RVU of 24.64 on a provisional basis, pending review of the open heart surgery analogs, in this case CPT code 32480. We are requesting the AMA RUC look at the incremental difference in RVUs and times between the open and laparoscopic surgeries and recommend a consistent valuation of RVUs and time for CPT code 32663 and other services within this family with this same issue. Accordingly, we are assigning a work RVU of 24.64 for CPT code 32663 on an interim basis for CY 2012" (76 FR 73195). During the comment period on the CY 2012 final rule with comment period, the affected specialty societies and the AMA RUC responded to our request noting that the codes were not open heart surgery codes.

In the CY 2013 final rule with comment period, we acknowledged that our request would have been more clear if we had referred to "open surgery codes" instead of "open heart surgery codes" and if we had written "endoscopic procedures" instead of "laparoscopic surgeries." With this clarification, we re-requested public comment on the appropriate work RVUs and time values for CPT codes 32663 and 32668–32673. For CY 2013, we maintained the following CY 2012 interim final values for these services as shown in Table 24.

Comment: A commenter stated that there was no apparent correlation

between the endoscopic and open variations of the procedures and added that no further effort was needed to determine differences between the two approaches because "any such relationship would be spurious at best." The commenter also stated that additional "exercises to establish consistent differences in work value according to surgical approach (when such relationships actually do not exist for clinical reasons)" are unnecessary.

Response: We continue to believe that our request for additional information on the relationship between open and endoscopic procedures was warranted. Because we received no additional information on this family, as requested, we are finalizing our CY 2013 interim final values for this family.

(12) Cardiovascular System: Heart and Pericardium (CPT Codes 33361, 33362, 33363, 33364, 33365, 33367, 33368, 33405, 33430, and 33533)

As detailed in the CY 2013 final rule with comment period, the CPT Editorial Panel deleted four Category III codes (0256T through 0259T) and created nine CPT codes (33361 through 33369) to report transcatheter aortic valve replacement (TAVR) procedures for CY 2012.

Like their predecessor Category III codes (0256T–0259T), the new Category I CPT codes 33361 through 33365 require the work of an interventional cardiologist and cardiothoracic surgeon to jointly participate in the intra-operative technical aspects of TAVR as co-surgeons. Claims processing instructions for the Coverage with Evidence Development (CED) (CR 7897 transmittal 2552) requires each physician to bill with modifier -62 indicating that the co-surgery payment applies. In this situation, Medicare pays each co-surgeon 62.5 percent of the fee schedule amount. The three add-on cardiopulmonary bypass support services (CPT codes 33367, 33368, and 33369) are only reported by the cardiothoracic surgeon; therefore the AMA RUC-recommended work RVUs for those services reflected only the work of one physician. The AMA RUC-recommended work RVUs for each of the co-surgery CPT codes (33361 through 33365) reflect the combined work of both physicians without any adjustment to reflect the co-surgery payment policy. As we noted in the CY 2013 final rule with comment period, we considered whether it was appropriate to continue our co-surgery payment policy at 62.5 percent of the physician fee schedule amount for each physician for these codes if the work value reflected 100 percent of the work for two physicians. Ultimately, we decided to set the work RVU values to reflect the total work of the procedures, and to continue to follow our co-surgery payment policy, which allows the services to be billed by two physicians in part because this was part of the payment policy established with the CED decision.

As we noted in the CY 2013 final rule with comment period, after clinical review of CPT code 33361, we believed that the survey's 25th percentile work RVU of 25.13 appropriately captured the total work of the service. The AMA RUC recommended the survey's median work RVU of 29.50. Regarding physician time, for CPT 33361, as well as CPT codes 33362 through 33364, we believed 45 minutes of preservice evaluation time, which was the survey median time, was more consistent with the work of this service than the AMA RUC-recommended preservice evaluation time of 50 minutes. Accordingly, we assigned a work RVU of 25.13 to CPT code 33361, with a refinement of 45 minutes of preservice evaluation time, on an interim final basis for CY 2013.

As we explained in the CY 2013 interim final rule with comment period, after clinical review of CPT code 33362, we believed that the survey's 25th percentile work RVU of 27.52 appropriately captured the total work of the service and assigned an interim final work RVU of 27.52. The AMA RUC recommended the survey median work RVU of 32.00. As with CPT code 33361, we believed 45 minutes of preservice evaluation time was more appropriate for this service than the AMA RUC recommended preservice evaluation time of 50 minutes. We therefore refined the preservice evaluation time to 45 minutes.

As we noted in the CY 2013 interim final rule with comment period, after clinical review of CPT code 33363, we believed that the survey's 25th percentile work RVU of 28.50 appropriately captured the total work of the service and assigned an interim final work RVU of 28.50. The AMA RUC recommended the survey median work RVU of 33.00. As with CPT codes 33361 and 33362, we believed 45 minutes of preservice evaluation time was more appropriate for this service than the AMA RUC recommended time of 50 minutes and we therefore refined the preservice evaluation time to 45 minutes.

As we noted in the CY 2013 final rule with comment period, after clinical review of CPT code 33364, we believed that the survey's 25th percentile work RVU of 30.00 more appropriately captured the total work of the service than the AMA RUC-recommended survey median work RVU of 34.87, and therefore, we established an interim final work RVU of 30.00. As with CPT codes 33361–33363, we also believed 45 minutes of preservice evaluation time was more appropriate for this service than the AMA RUC-recommended time of 50 minutes, and therefore, we refined the preservice evaluation time 45 minutes.

As we noted in the CY 2013 final rule with comment period, after clinical review of CPT code 33365, we believed a work RVU of 33.12 accurately reflected the work associated with this service rather than the survey's median work RVU of 37.50. We determined that the work associated with this service was similar to reference CPT code 33410, which has a work RVU of 46.41 and has a 90-day global period that includes inpatient hospital and office visits. Because CPT code 33365 had a 0-day global period that does not include post-operative visits, we calculated the value of the pre-operative and post-operative visits in the global period of CPT code 33410, which totaled 13.29 work RVUs, and subtracted that from the total work RVU of 46.41 for CPT code 33410 to determine the appropriate work RVU for CPT code 33365. With regard to time, we used the 50 minutes of preservice evaluation time because we believed that the procedure described by CPT code 33365 involves more preservice evaluation time than 33410 since it was performed by surgically opening the chest via median sternotomy. Accordingly, we assigned an interim final work RVU of 33.12 for CPT code 33365 for CY 2013.

Comment: Commenters disagreed with our use of the 25th percentile survey values for CPT codes 33361–33365 rather than the AMA RUC-recommended median survey values. Commenters stated that our valuation of CPT code 33365 was arbitrary and resulted in considerably undervalued work RVUs. They also asserted that our interim final work RVUs produced rank order anomalies, were inconsistent with the high level of intensity and complexity necessitated by the procedures, and undervalued the procedures for each physician. Additionally, commenters provided examples comparing the AMA RUC recommendations and the interim final work RVUs for CPT codes 33361–33365 to other codes that were recently valued. In providing the examples, commenters made an effort to demonstrate that, by comparing CPT codes 33361–33365 to active comparable CPT codes and through proration of the physician time, it was apparent that the work RVUs for

CPT codes 33361–33365 should be increased. Commenters therefore requested we use the AMA RUC-recommended work values of 29.50 for CPT code 33361, 32.00 for CPT code 33362, 33.00 for CPT code 33363, 34.87 for CPT code 33364 and 37.50 for CPT code 33365 and submit the code series to the refinement panel for review.

Response: After evaluation of the request for refinement, we determined that the criteria for the request for refinement were not met and, as a result, we did not refer CPT codes 33361–33365 to the CY 2013 multi-specialty refinement panel for further review.

After consideration of the comments on CPT codes 33361–33365, we maintain that our approach in valuing these procedures is appropriate. We believe that the AMA RUC-recommended work RVUs overstate the intensity and physician time in this family. We also believe that setting the work RVU values of these services to reflect the total work of the procedures is appropriate. This decision is also consistent with our co-surgery payment policy, which allows the services to be billed by two physicians. While many commenters objected to this rationale, we believe that their comparisons of CPT codes 33361–33365, services that require the work of two physicians, to codes where only one physician is performing the work are inappropriate. We continue to believe that the interim final work RVUs that we established in the CY 2013 final rule with comment period accurately reflect the work of the typical case of this service. Therefore, for CY 2014, we are finalizing the interim final work RVUs for CPT codes 33361–33365. We are also finalizing the following refinements to time for CY 2014: 45 minutes of preservice evaluation for CPT codes 33361–33364; and 50 minutes of preservice evaluation for CPT code 33365.

Comment: Commenters specifically agreed with our interim final work RVUs of 11.88 for CPT code 33367 and 14.39 to CPT code 33368 and thanked us for using the AMA RUC recommendations.

Response: We are finalizing the work RVUs of 11.88 to CPT code 33367 and 14.39 to CPT code 33368 for CY 2014.

As detailed in the CY 2013 final rule with comment period, CPT codes 33405, 33430, and 33533 were previously identified as potentially misvalued through the high expenditure procedure code screen. When reviewing the services, the specialty society utilized data from the Society of Thoracic Surgeons (STS) National Adult Cardiac Database in developing recommended times and work RVUs for CPT codes 33405, 33430 and 33533 rather than conducting a survey of work and time. After reviewing the mean procedure times for the services in the STS database alongside other information relating to the value of the services, the AMA RUC concluded that CPT codes 33405 and 33430 were appropriately valued and, accordingly, the CY 2012 RVUs of 41.32 for CPT code 33405, and 50.93 for CPT code 33430 should be maintained, and that the work associated with CPT code 33553 had increased since the service was last reviewed. The AMA RUC recommended a work RVU of 34.98 for CPT code 33533, which is a direct crosswalk to CPT code 33510.

As we noted in the CY 2013 final rule with comment period (77 FR 69049), we believed the STS database, which captures outcome data in addition to time and visit data, is a useful resource in the valuation of services. However, we remain interested in additional data from the STS database that might help provide context to the reported information. The AMA RUC recommendations on the services showed only the STS database mean time for CPT codes 33405, 33430, and 33533. We noted in the CY 2013 final rule with comment period that we were interested in seeing the distribution of times for the 25th percentile, median, and 75th percentile values, in addition to any other information STS believed would be relevant to the valuation of the services. For CY 2013, we assigned interim final work RVUs for the services, pending receipt of additional time data. Specifically, we maintained the CY 2012 work RVU values of 41.32 for CPT code 33405; 50.93 for CPT code 33430; and 33.75 for CPT code 33533.

Comment: STS requested a higher work value of CPT code 33533 and also disagreed with the AMA RUC recommendation. In its opinion, "the RUC recommendation is not consistent with the process and alters the intensity of 33533 contrary to the RUC rationale." In contrast, the AMA RUC stated that the AMA RUC work value recommendation was most appropriate and asked that we submit the code for refinement panel review.

In response to our request for additional information regarding times from the STS database, all commenters declined to provide further information, stating that sufficient time data and explanations for the methodology associated with utilization of the database were provided to both the AMA RUC and CMS. STS further expressed its disinterest in providing additional information by noting that the supplementary data that we requested, the median or 25th percentile statistical descriptors, would "systematically exclude known physician work from consideration in code valuation, and if utilized would result in undervaluation relative to the remainder of the Physician Fee Schedule."

Response: After evaluation of the request for refinement, we determined that the criteria for the request for refinement were not met and, as a result, we did not refer CPT code 33533 to the CY 2013 multi-specialty refinement panel for further review.

After re-review of CPT codes 33405, 33430 and 33533, we maintain that our approach in valuing these procedures is appropriate. In the CY 2013 final rule with comment period, we expressed our concern with the data derived from the STS database and our desire to receive additional information regarding the distribution of times and varying RVUs, for the 25th percentile, median, and 75th percentile values, in order to better value the services. We did not receive additional information from either STS or the AMA RUC regarding these procedures. In the absence of this information, we continue to believe that the CY 2013 interim final work RVUs for CPT codes 33405, 33430 and 33533 reflect the work of the typical case of these services. Therefore, we are finalizing the work RVUs of 41.32 for CPT code 33405, 50.93 for CPT code 33430 and 33.75 for CPT code 33533 for CY 2014.

(13) Cardiovascular System: Arteries and Veins (CPT Codes 35475, 35476, 36221–36227)

In the CY 2013 final rule with comment period, after clinical review of CPT code 35475, we established a work RVU of 5.75 to appropriately capture the work of the service. The AMA RUC, rather than using the survey, used a building block approach based on comparison CPT code 37224, which has a work RVU of 9.00, and recommended a work RVU of 6.60. The AMA RUC acknowledged that CPT code 35475 was typically reported with other services. We determined that the appropriate crosswalk for this code was CPT code 37220, which has a work RVU of 8.15. After accounting for overlap with other services, we determined that a work RVU of 5.75 was appropriate for the service. Accordingly, we assigned a work RVU of 5.75 to CPT code 35475 on an interim final basis for CY 2013.

After clinical review of CPT code 35476, we assigned a work RVU of 4.71 to the service in the CY 2013 final rule with comment period. The AMA RUC

had recommended a work RVU of 5.10, based on the survey's 25th percentile value. We determined that the work associated with CPT code 35476 was similar in terms of physician time and intensity to CPT code 37191, which had a work RVU of 4.71. We believed the work RVU of 4.71 appropriately captured the relative difference between the service and CPT code 35475. Therefore, we assigned a work RVU of 4.71 for CPT code 35476 on an interim final basis for CY 2013.

Comment: Commenters universally disagreed with our reference codes for CPT codes 35475 and 35476. They stated that our comparison of CPT code 35475 to CPT code 37224 did not fully consider intensity or complexity of CPT code 35475, such as the need for a physician to perform catheter manipulation or traverse multiple vessels. They also stated that our comparison of CPT code 35476 to CPT code 37220 was inappropriate because the latter procedure was related to a service in a lower flow vein and, thus, using this crosswalk did not account for the service's work intensity or complexity, including the risk associated with angioplasty. Commenters believed that the comparison codes utilized by the AMA RUC in its recommended valuation, CPT codes 37224 and 37220, had a more comparable level of difficulty to CPT codes 35475 and 35476, respectively, than the codes we used. Additionally, commenters were concerned on a broader policy basis that the interim final values would compromise both the vascular access care provided to chronic kidney disease patients and specialty programs. For those reasons, commenters requested our use of the AMA RUC-recommended work RVUs of 6.60 for CPT code 35475 and 5.10 for CPT code 35476 and refinement panel review of the codes.

Response: We referred CPT codes 35475 and 35476 to the CY 2013 multi-specialty refinement panel for further consideration because the requirements for refinement panel review were met. The refinement panel median work RVU for CPT codes 35475 and 35476 were 6.60 and 5.10, respectively. After reevaluation, we are finalizing work RVUs of 6.60 for CPT code 35475 and 5.10 for CPT code 35476, based upon the refinement panel median.

In the CY 2013 final rule with comment period we assigned CPT code 36221 an interim final work RVU of 4.17 and refined the postservice to 30 minutes. The AMA RUC recommended a work RVU of 4.51 and a postservice time of 40 minutes using a direct crosswalk to the two component codes being bundled, CPT code 32600, which has a work RVU of 3.02, and CPT code 75650, which has a work RVU of 1.49. As we noted in the CY 2013 final rule with comment period, we believed that that there were efficiencies gained when services were bundled and that crosswalking to the work RVU of CPT code 32550, which had a work RVU of 4.17, appropriately accounted for the physician time and intensity with CPT code 36221. Additionally, we believed that the survey's postservice time of 30 minutes more accurately accounted for the time involved in furnishing the service than the AMA RUC-recommended postservice time of 40 minutes.

In the CY 2013 final rule with comment period we noted that after clinical review of CPT code 36222, we believed the survey 25th percentile work RVU of 5.53 appropriately captured the work of the service, particularly the efficiencies when two services were bundled together. The AMA RUC recommended the survey median work RVU of 6.00. Like CPT code 36221, we believed the survey's postservice time of 30 minutes was more appropriate than the AMA RUC-recommended postservice time of 40 minutes. We assigned a work RVU of 5.53 with refinement to time for CPT code 36222 as interim final for CY 2013.

In the CY 2013 final rule, we noted that after clinical review of CPT code 36223, we assigned an interim final work RVU value of 6.00, the survey's 25th percentile value, because we believed it appropriately captured the work of the service, particularly efficiencies when two services were bundled together. The AMA RUC reviewed the survey results, and after a comparison to similar CPT codes, recommended a work RVU of 6.50. Like many other codes in the family, we believed the survey's postservice time of 30 minutes was more appropriate than the AMA RUC-recommended time of 40 minutes and refined the time accordingly.

In the CY 2013 final rule, we noted that after clinical review of CPT code 36224, we believed a work RVU of 6.50, the survey's 25th percentile value, appropriately captured the work of the service, particularly, efficiencies when two services were bundled together. We believed 30 minutes of postservice time more appropriately accounted for the work of the service. The AMA RUC reviewed the survey results, and after a comparison to similar CPT codes, recommended a value of 7.55 and a postservice time of 40 minutes for CPT code 36224. Accordingly, we assigned a work RVU of 6.50 with refinement to time for CPT code 36224 as interim final for CY 2013.

In the CY 2013 final rule, we noted that after clinical review of CPT code 36225, we believed it should be valued the same as the CPT code 36223, which was assigned an interim final work RVU of 6.00. Comparable to CPT code 36223, we also believed 30 minutes of postservice time more appropriately accounted for the work of the service and refined the time accordingly. The AMA RUC reviewed the survey results and recommended the survey's median work RVU of 6.50 and a postservice time of 40 minutes for CPT code 36225.

In the CY 2013 final rule (77 FR 69051), we noted that after clinical review of CPT code 36226, we believed it should be valued the same as CPT code 36224, which was assigned work RVU of 6.50. Comparable to CPT code 36224, we believed 30 minutes of postservice time more appropriately accounted for the work of the service. The AMA RUC reviewed the survey results, and after a comparison to similar CPT codes, recommended a value of 7.55 and a postservice time of 40 minutes for CPT code 36226. We assigned a work RVU of 6.50 with refinement to time for CPT code 36226 as interim final for CY 2013.

In the CY 2013 final rule, we noted that after clinical review of CPT code 36227, we determined that efficiencies were gained when services were bundled, and identified a work RVU of 2.09 for the service. A 2.09 work RVU reflected the application of a very conservative estimate of 10 percent for the work efficiencies that we expected to occur when multiple component codes were bundled together to the sum of the work RVUs for the component codes. The AMA RUC reviewed the survey results, and after a comparison to similar CPT codes, recommended a value of 2.32 for CPT code 36227. The AMA RUC used a direct crosswalk to the two component codes being bundled, CPT code 36218, which has a work RVU of 1.01, and CPT code 75660, which has a work RVU of 1.31. We assigned a CY 2013 interim final work RVU of 2.09.

Comment: Commenters stated that the AMA RUC-recommended work RVUs captured all of the efficiencies that were achieved by bundling the services and that our conclusion that these codes values should further be lowered was unsupported and would produce rank order anomalies among intervention services. Some stated that for CPT codes 36222, 36223, 36224, 36225 and 36226, the AMA RUC-recommended values represented a considerable savings to the Medicare system. Commenters

acknowledged that it may be true that efficiencies occur when surgical codes are bundled with other surgical codes or radiologic supervision and interpretation (S&I) codes are bundled with other S&I codes. However, commenters stated that CPT codes 36221 and 36227 reflects the bundling of surgical codes with S&I codes and, that since the activities of surgical codes and S&I codes are, by definition, separate, they disagreed that efficiencies should be assumed. Furthermore, commenters stated that it was incorrect for us to directly crosswalk to other procedures, such as CPT codes 32550, 36251 and 36253, which are easier in nature and entail less risk and less image interpretation, when more parallel crosswalks existed. As such, commenters supported the direct crosswalks and the following recommended work RVUs provided by the AMA RUC: 4.51 for CPT code 36221, 6.00 for CPT code 36222, 6.50 for CPT code 36223, 7.55 for CPT code 36224, 6.50 for CPT code 36225, 7.55 for CPT code 36226 and 2.32 for CPT code 36227 and requested refinement panel review of the codes.

Response: After evaluation of the request for refinement, we determined that the criteria for the request for refinement were not met and, as a result, we did not refer the codes to the CY 2013 multi-specialty refinement panel for further review.

After re-review of CPT codes 36221–36227, we maintain that the recommended direct crosswalks for these services are appropriate because the codes involve similar work and, as such, should be valued relative to one another. We also disagree with the commenters that efficiencies do not occur when surgical codes and S&I codes are bundled. Therefore, we are finalizing the CY 2013 interim final values for CY 2014 for CPT codes 36221–36227. We are also finalizing the postservice time refinement of 30 minutes to CPT codes 36221–36226 for CY 2014.

(14) Cardiovascular System: Arteries and Veins (CPT Codes 37197 and 37214)

As we noted in the CY 2013 final rule with comment period, we crosswalked the physician time and intensity of CPT code 36247 to CPT code 37197, resulting in a CY 2013 interim final work RVU of 6.29 for CPT code 37197. The AMA RUC had recommended a work RVU of 6.72 for CPT code 37197.

For the CY 2013 final rule with comment period, we assigned an interim final work RVU of 2.74 to CPT code 37214. In making its recommendation, the AMA RUC reviewed the survey results, and after a comparison to similar CPT codes, recommended a work RVU of 3.04 to CPT code 37214. After clinical review, we determined that there were efficiencies gained when services were bundled and ultimately used a very conservative estimate of 10 percent for the work efficiencies we expected to occur when multiple component codes were bundled. Specifically, we decreased the AMA RUC-recommended work RVU value of 3.04 by 10 percent to produce the work RVU value of 2.74, which we assigned as the CY 2103 an interim final work RVU for CPT code 37214.

Comment: Commenters disagreed with these interim final values and suggested that we finalize the AMA RUC-recommended work RVUs of 6.72 for CPT code 37197 and 3.04 for CPT code 37214 because the services are more intense and complex than accounted for by the CY 2013 interim final values. Additionally, several commenters alerted us to our oversight in not providing a written rationale for our work RVU values for CPT codes 37197 and 37214 and as result, requested a technical correction.

Response: The commenters are correct that we did not include a rationale to explain how we reached the interim final work values for these codes in the CY 2013 final rule with comment period. However, Table 30 "Work RVUs for CY 2013 New, Revised and Potentially Misvalued Codes" in the CY 2013 final rule with comment period clearly identified the interim final values being assigned to these codes. It also included the AMA RUC recommendations, denoted whether we agreed with the AMA RUC recommendations, and indicated whether we refined the times recommended by the AMA RUC.

Based upon the comments received, we re-reviewed CPT codes 37197 and 37214. Based upon our review, we believe that directly crosswalking CPT code 37197 to CPT code 36247 and reducing CPT code 37214 by a conservative 10 percent to account for efficiencies gained when services are bundled are appropriate to establish values for these services and produce RVUs that fully reflect the typical work and intensity of the procedures. Therefore, we are finalizing the work RVU of 6.29 for CPT code 37197 and 2.74 for CPT code 37214 for CY 2014.

(15) Hemic and Lymphatic System: General (CPT Codes 38240 and 38241)

In the CY 2013 final rule, we noted that after review, we believed CPT code 38240 should have the same work RVU as CPT code 38241 because the two services involved the same amount of work. The AMA RUC recommended a work RVU of 4.00 for CPT code 38240 and 3.00 for CPT code 38241. On an interim final basis for CY 2013 we assigned CPT code 38240 a work RVU of 3.00 and agreed with the AMA RUC recommendation of 3.00 for CPT code 38241.

Comment: Commenters specifically opposed our comparison of work for CPT code 38240 to CPT code 38241, stating that CPT code 38240 was much more complicated, intense and time consuming than CPT code 38241 and, as a result, should have a higher work RVU. Commenters also indicated that CPT 38240 has become more difficult to perform in recent years. Therefore, commenters requested that we use the AMA RUC-recommended work RVU of 4.00 for CPT code 38240 and maintain the interim final value of RVU of 3.00 for CPT code 38241. Commenters asked that both codes be referred to the refinement panel.

Response: After evaluation of the request for refinement, we determined that the criteria for the request for refinement were not met and, as a result, we did not refer CPT codes 38240 and 38241 to the CY 2013 multi-specialty refinement panel for further review.

Based on comments received, we re-reviewed the codes and agree that CPT code 38240 is a more involved and intense procedure than CPT code 38241 and as a result, should have a higher RVU valuation for work than the CY 2013 interim final work RVU. Therefore, we are finalizing the AMA RUC-recommended work RVU for 4.00 to CPT code 38240 and 3.00 for CPT code 38241 for CY 2014.

(16) Digestive System: Lips (CPT Code 40490)

As detailed in the CY 2013 final rule with comment period, we assigned an interim final work RVU of 1.22 to CPT code 40490, as recommended by the AMA RUC.

Comment: Commenters agreed and expressed appreciation with our use of the AMA RUC-recommended value.

Response: We are finalizing a work RVU of 1.22 for CPT code 40490 for CY 2014.

(17) Gastrointestinal (GI) Endoscopy (CPT Codes 43206 and 43252)

As detailed in the CY 2013 final rule with comment period, CPT codes 43206 and 43252 were contractor priced on an interim final basis. As part of its review of all gastrointestinal endoscopy codes, we received recommendations from the

AMA RUC for a work RVU of 2.39 for CPT code 43206 and 3.06 for CPT code 43252. Based upon these recommendations we have the data necessary to establish RVUs and so are assigning CY 2014 interim final work RVUs of 2.39 for CPT code 43206 and 3.06 for CPT code 43252.

As detailed in the CY 2013 final rule with comment period, we assigned an interim final work RVU of 3.20 to CPT code 52287 as recommended by the AMA RUC.

Comment: A specialty association disagreed with our use of the AMA RUC work RVU recommendation for CPT code 52287. The commenter supported the survey's use of CPT code 51715 as the key reference code for this service, but stated that CPT code 52287 should have, at a minimum, the same RVU as CPT code 51715 because CPT code 52287 requires more injections and, as a result, a higher level of technical skill and more time. Therefore, the commenter requested that we accept a work RVU recommendation of 3.79 for CPT code 52287.

Response: After re-review of CPT code 52287, we maintain that our interim final value based upon the AMA RUC recommendation is appropriate. We note that the key reference service CPT code 51715 has more intraservice time (45 minutes) than CPT code 52287 (21 minutes), contrary to the commenter's assertion. We continue to believe that a RVU of 3.20 accurately and fully captures the work required for this service. Therefore, we are finalizing a work RVU of 3.20 for CPT code 52287 for CY 2014.

(19) Urinary System: Bladder (CPT Code 52353)

We assigned a CY 2013 interim final work RVU of 7.50 for CPT code 52353. As detailed in the CY 2013 final rule with comment period, after clinical review, we determined that the survey's 25th percentile work RVU represented a more appropriate incremental difference over the base code, CPT code 52351, than the AMA RUC-recommended work RVU of 7.88. Additionally, we believed the survey 25th percentile work RVU more appropriately accounted for the significant reduction in intraservice time from the current value.

Comment: Commenters objected to our reduction in the work RVU from the CY 2012 value and stated that we should use the AMA RUC-recommended work RVU of 7.88. Commenters said that the skills, effort, and time of CPT 52353 were more intense than those of CPT code 52351 and our value did not provide the fully warranted differential between the two codes. Additionally, commenters initially requested refinement panel review of CPT code 52353, but later withdrew their request.

Response: Based on comments received, we re-reviewed CPT code 52353 and continue to believe that our interim final work value is appropriate. We maintain that the survey's 25th percentile work RVU appropriately accounts for the work of this service, especially given the significant reduction in intraservice time and the lack of evidence that the intensity of this procedure has increased. We also believe that the interim final work value appropriately provides an incremental difference over the base CPT code 52351. For these reasons, we are finalizing a work RVU of 7.50 to CPT code 52353 for CY 2014.

(20) Nervous System: Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System (CPT Code 64615)

The CPT Editorial Panel created CPT code 64615 effective January 1, 2013. The AMA RUC recommended a work RVU of 1.85 and we agreed with the recommendation.

The AMA RUC also requested a decrease in the global period from 10 days to 0 days. As we noted in the CY 2013 final rule, we assigned CPT 64615 a global period of 10 days to maintain consistency within the family of codes.

Comment: Commenters stated that the assigned 10-day global period was not appropriate because there are no E/M post-operative visits related to the service, and accordingly, a 0-day global period would correctly reflect the work involved in, and valuation of, the service. Additionally, commenters noted that the 10-day global period was inconsistent with the 0-day global period we adopted for other services within the family. Commenters requested that we accept the AMA RUC-recommended global period of 0 days.

Response: Based on comments received, we re-reviewed CPT code 64615 and continue to believe that a 10-day global period is appropriate. Given that most of the other services within this family of CPT codes also have 10-day global periods, we continue to believe that a 10-day global period is appropriate for CPT code 64615. Furthermore, while there are other chemodenerveration codes in other areas of the body that do have 0-day global periods, we continue to believe that a 10-day global period for CPT code 64615 is appropriate in this anatomical region. Therefore, we are finalizing the work RVU of 1.85 for CPT code 64615, with a 10-day global period, for CY 2014.

(21) Eye and Ocular Adnexa: Eyeball (CPT Code 65222)

CPT code 65222 was identified as potentially misvalued under the Harvard-valued utilization over 30,000 screen. As we noted in the CY 2013 final rule with comment period, we assigned a work RVU of 0.84 to CPT code 65222, as well as a refinement to the AMA RUC-recommended time. Medicare claims data from 2011 indicated that CPT code 65222 was typically furnished to the beneficiary on the same day as an E/M visit. We believed that some of the activities furnished during the preservice and postservice period overlapped with the E/M visit. We did not believe that the AMA RUC appropriately accounted for this overlap in its recommendation of preservice and postservice time. To account for this overlap, we reduced the AMA RUC-recommended preservice evaluation time by one-third, from 7 minutes to 5 minutes, and the AMA RUC-recommended postservice time by one-third, from 5 minutes to 3 minutes. We believed that 5 minutes of preservice evaluation time and 3 minutes of postservice time accurately reflected the time involved in furnishing the preservice and postservice work of the procedure, and that those times were well-aligned with similar services.

Comment: Commenters disagreed with our work RVU and time refinement for CPT code 65222, stating that they were arbitrary in nature and based on an incorrect assumption that the overlap between the E/M visit and the preservice and postservice periods were not properly accounted for in the AMA RUC recommendation. Commenters stated that the AMA RUC did take the overlap into consideration and correctly accounted for it through a decrease in the preservice time from the specialty society survey determined time of 13 minutes to 7 minutes. Therefore, commenters requested that we accept the AMA RUC recommendation of a 0.93 work RVU with 7 minutes of preservice time and 5 minutes of postservice time.

Response: Based on comments received, we re-reviewed CPT code 65222 and continue to believe that our interim final work RVU of 0.84 is appropriate. We maintain that the AMA RUC did not fully account for the fact that some of the activities furnished during the preservice and postservice period of the procedure code overlap with those for the E/M visit, making the preservice time reductions recommended by the AMA RUC

insufficient. As such, we continue to believe that 5 minutes of preservice evaluation time and 3 minutes of postservice time accurately reflect the physician time involved in furnishing the preservice and postservice work of this procedure, and that these times are well-aligned with similar services. Therefore, we are finalizing a work RVU of 0.84 to CPT code 65222 with 5 minutes of preservice evaluation time and 3 minutes of postservice, for CY 2014.

(22) Eye and Ocular Adnexa: Ocular Adnexa (CPT Code 67810)

CPT code 67810 was identified as potentially misvalued under the Harvard-valued utilization over 30,000 screen. On an interim final basis for CY 2013, we assigned the AMA RUC-recommended work RVU of 1.18 to CPT code 67810, with a refinement to the AMA RUC-recommended time. As we noted in the CY 2013 final rule with comment period, Medicare claims data from CY 2011 indicated that CPT code 67810 was typically furnished to the beneficiary on the same day as an E/M visit. We noted that that some of the activities furnished during the preservice and postservice period of the procedure code and the E/M visit overlapped and that although the AMA RUC appropriately accounted for this overlap in its recommendation of preservice time, its recommendation for postservice time was high relative to similar services performed on the same day as an E/M service. To better account for the overlap in the postservice period, and to value the service relative to similar services, we reduced the AMA RUC-recommended postservice time for this procedure by one-third, from 5 minutes to 3 minutes.

Comment: Commenters believed that our time refinement for CPT code 67810 was unsubstantiated and that we were incorrect in assuming that the overlap between the E/M visit and the postservice period was not appropriately accounted for in the AMA RUC recommendation. Commenters suggested that the AMA RUC did take the overlap into consideration and appropriately accounted for it by lowering the time recommendations by nearly 50 percent. Therefore, commenters requested that we accept the AMA RUC-recommended postservice time of 5 minutes for CPT code 67810.

Response: Based on comments received, we re-reviewed CPT code 67810 and continue to believe that our interim final work RVU of 1.18 and our time refinement is appropriate. We maintain that the AMA RUC did not fully account for the fact that some of the activities furnished during the postservice period of the procedure code overlap with the E/M visit and that the AMA RUC's time refinements were insufficient. As such, we continue to believe that 3 minutes of postservice time accurately reflects the physician time involved in furnishing the postservice work of this procedure, and that this time is well-aligned with that for similar services. Therefore, we are finalizing a work RVU of 1.18 to CPT code 67810 with 3 minutes of postservice time for CY 2014.

(23) Eye and Ocular Adnexa: Conjunctiva (CPT Code 68200)

CPT code 68200 was identified as potentially misvalued under the Harvard-valued utilization over 30,000 screen. On an interim final basis for CY 2013, we assigned a work RVU of 0.49 to CPT code 68200, with a refinement to the AMA RUC-recommended time. As we noted in the CY 2013 final rule with comment period, Medicare claims data from CY 2011 indicated that CPT code 68200 was typically furnished to the beneficiary on the same day as an E/M visit. We believed that some of the activities furnished during the preservice and postservice period of the procedure code overlapped with the E/M visit. We believed that the AMA RUC appropriately accounted for this overlap in its recommendation of preservice time, but did not adequately account for the overlap in the postservice time. To better account for the overlap in postservice time, we reduced the AMA RUC-recommended postservice time for this procedure by one-third, from 5 minutes to 3 minutes. After reviewing CPT code 68200 and assessing the overlap in time and work, we agreed with the AMA RUC-recommended work RVU of 0.49 for CY 2013.

Comment: Commenters believed that our time refinement for CPT code 68200 was unsupported and that we assumed incorrectly that the overlap between the E/M visit and the postservice period was not appropriately accounted for in the AMA RUC recommendation. Commenters suggested that the AMA RUC did take the overlap into consideration and completely accounted for it by lowering the preservice time recommendation. Therefore, commenters request that we accept the AMA RUC-recommended postservice time of 5 minutes postservice for CPT code 68200.

Response: After reviewing the comments, we continue to believe that our refinement of the recommended time is appropriate. We maintain that the AMA RUC did not fully account for the fact that some of the activities furnished during the postservice period of the procedure code overlap with the E/M visit and that the AMA RUC-recommended time refinements were insufficient. As such, we continue to believe that 3 minutes of postservice time accurately reflects the time involved in furnishing the postservice work of this procedure, and that this time is well-aligned with similar services. Therefore, we are finalizing a work RVU of 0.49 for CPT code 68200 with 3 minutes of postservice time, for CY 2014.

(24) Eye and Ocular Adnexa: Conjunctiva (CPT Code 69200)

CPT code 69200 was identified as potentially misvalued under the Harvard-valued utilization over 30,000 screen. On an interim final basis for CY 2013, we assigned a work RVU of 0.77 to CPT code 69200, as well as refining to the AMA RUC-recommended time. In the CY 2013 final rule, we noted that Medicare claims data from 2011 indicated that CPT code 69200 was typically furnished to the beneficiary on the same day as an E/M visit and that some of the activities furnished during the preservice and postservice period of the procedure code overlapped with the E/M visit. To account for this overlap, we removed one-third of the preservice evaluation time from the preservice time package, reducing the preservice evaluation time from 7 minutes to 5 minutes. Additionally, we reduced the AMA RUC-recommended postservice time for this procedure by one-third, from 5 minutes to 3 minutes. After reviewing CPT code 69200 and assessing the overlap in time and work, we agreed with the AMA RUC-recommended work RVU of 0.77 for CY 2013.

Comment: A commenter thanked us for our acceptance of the AMA RUC-recommended work for CPT code 69200.

Response: For CY 2014, we are finalizing the interim final work RVU and time for this code.

(25) Eye and Ocular Adnexa: Conjunctiva (CPT Code 69433)

As detailed in the CY 2013 final rule with comment period, we assigned an interim final work RVU of 1.57 to CPT code 69433; which the AMA RUC had recommended.

Comment: A commenter thanked us for our acceptance of the AMA RUC recommendation.

Response: We are finalizing our interim final work RVU for CY 2014.

(26) Computed Tomographic (CT) Angiography (CPT Code 72191)

As detailed in the CY 2013 final rule with comment period, CPT code 72191 was assigned a CY 2013 interim final work RVU of 1.81, consistent with the AMA RUC recommendation.

As detailed in this final rule with comment period, based upon the AMA RUC recommendations, we are establishing interim final values for codes within the CT angiography family. To allow for contemporaneous public comment on this entire family of codes, we are maintaining the CY 2013 work value for CPT code 72191 as interim final for CY 2014.

(27) Radiologic Guidance: Fluoroscopic Guidance (CPT Codes 77001, 77002 and 77003)

As detailed in the CY 2013 final rule with comment period, CPT codes 77001, 77002 and 77003 were assigned CY 2013 interim final work RVUs of 0.38, 0.54 and 0.60, respectively, based upon AMA RUC recommendations. We received AMA RUC recommendations for work RVUs of 0.38 for CPT code 77001, 0.54 for CPT code 77002 and 0.60 for CPT code 77003.

We agree with the AMA RUC-recommended values but are concerned that the recommended intraservice times for all three codes are generally higher than the procedure codes with which they are typically billed. For example, CPT code 77002 has 15 minutes of intraservice time and CPT code 20610 (Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa)) has an intraservice time of only 5 minutes. We are requesting additional public comment and input from the AMA RUC and other stakeholders regarding the appropriate relationship between the intraservice time associated with fluoroscopic guidance and the intraservice time of the procedure codes with which they are typically billed. Therefore, for CY 2014 we are assigning CY 2014 interim final work RVUs of 0.38 to CPT code 77001, 0.54 to CPT code 77002 and 0.60 to CPT code 77003.

(28) Radiology (CPT Codes 75896 and 75898)

CPT code 75896 was identified as potentially misvalued through the codes reported together 75 percent or more screen. As we noted in the CY 2013 final rule with comment period, the AMA RUC intended to survey and review CPT codes 75896 and 75898 for CY 2014 as part of their work on bundling thrombolysis codes. The AMA RUC recommended contractor pricing these two services for CY 2014. However, since we had established a national payment rate for the professional component of these services and only the technical component of the services was contractor priced at that time, we maintained the national price on the professional component and continued contractor pricing for the technical component for these codes on an interim final basis for CY 2013.

We did not receive any comments on these codes nor did we receive any recommendations from the AMA RUC. As we anticipate receiving AMA RUC recommendations for these codes, we are maintaining the current pricing on an interim final basis for CY 2014.

(29) Pathology (CPT Codes 88120, 88121, 88365, 88367, and 88368)

The CPT Editorial Panel created CPT 88120 and 88121 effective for CY 2011. In the CY 2012 PFS final rule with comment period, we assigned interim final work RVUs of 1.20 and 1.00 to CPT codes 88120 and 88121, respectively. We maintained the 2012 work RVUs for 88120 and 88121 as interim final for CY 2013. Additionally, we expressed concern about potential payment disparities between these codes and similar codes, CPT codes 88365, 88367 and 88368, and asked the AMA RUC to review the work and PE for these codes to ensure the appropriate relativity between the two sets of services. Since the AMA RUC is reviewing CPT codes 88365, 88367, and 88368, we are establishing CY 2014 interim final work RVUs of 1.20 for CPT code 88365, 1.30 for CPT code 88367, and 1.40 for CPT code 88368 for CY 2014.

Comment: A commenter stated that it was appropriate to reaffirm the values for 88120 and 88121.

Response: For the reasons stated above, we are assigning CY 2014 interim final work RVUs of 1.20 and 1.00 to CPT codes 88120 and 88121, respectively.

(30) Optical Endomicroscopy (CPT Code 88375)

As detailed in the CY 2013 final rule with comment period, CPT code 88375 was assigned an interim final PFS procedure status of C (Contractors price the code. Contractors establish RVUs and payment amounts for these services.). We received a recommendation from the AMA RUC for a work RVU of 1.08 for CPT code 88375.

CPT code 88375 provides a code for reporting the pathology service when one is required to assist in the procedure. The AMA RUC recommended an intraservice time of 25 minutes and a work RVU of 1.08 for CPT code 88375. Based on our analysis of this recommendation, we believe that the typical optical endomicroscopy case will involve only the endoscopist, and CPT codes 43206 and 43253 are valued to reflect this. Accordingly, we believe a separate payment for CPT code 88375 would result in double payment for a portion of the overall optical endomicroscopy service. Therefore, we are assigning a PFS procedure status of I (Not valid for Medicare purposes. Medicare uses another code for the reporting of and the payment for these services) to CPT code 88375. In the unusual situation that a pathologist is requested to assist an endoscopist in optical endomicroscopy, we would expect the pathologist to report other codes more appropriate to the service (e.g. CPT code 88392 Pathology consultation during surgery).

(31) Psychiatry (CPT Codes 90785, 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90846, 90847, 90853 and 90863)

For CY 2013, the CPT Editorial Panel restructured the psychiatry/psychotherapy CPT codes allowing for separate reporting of E/M codes, eliminating the site-of-service differential, creating codes for crisis, and creating a series of add-on psychotherapy codes to describe interactive complexity and medication management. The AMA RUC recommended values for all of the codes in this family except CPT codes 90785 (add-on for interactive complexity), 90839 (psychotherapy for crisis, first 60 minutes), 90840 (each additional 30 minutes) and 90863 (pharmacologic management, when performed with psychotherapy) which were the AMA RUC recommended to be contractor priced. In establishing CY 2013 values for the psychitry codes, our general approach was to maintain the CY 2012 values for the services or adopt values that approximated the CY 2012 values after adjusting for differences in code structure between CY 2012 and 2013, for all psychiatry/psychotherapy services on an interim final basis. We noted in the CY 2013 final rule with comment period that we intended to review the values for all the codes in the family once the survey process was complete and we had recommendations for all the codes. This would allow for a comprehensive review of the values for the full code set that would ensure more accurate valuation and proper relativity. The CY 2013 interim values for this family can be found in Table 24.

We have now received AMA RUC recommendations for all of the codes in the family and are establishing CY 2014

interim final work RVUs based on these recommendations. The CY 2014 interim work values displayed in Table 24 correspond with the AMA RUC recommended values, with the exception of CPT code 90863, which has been assigned a PFS procedure status of I (Not valid for Medicare purposes. Medicare uses another code for the reporting of and the payment for these services). These recommendations, which are now complete, have provided us with a comprehensive set of information regarding revisions to the overall relative resource costs for these services. This is consistent with the approach we described in the CY 2013 PFS final rule with comment period (77 FR 69060–69063). Because of the changes for this relativity new code set, we are establishing these values on an interim final basis.

Comment: Several commenters urged CMS to use the AMA RUC-recommended values for CY 2013 and questioned why CMS chose instead to adopt a general approach of maintaining the CY 2012 values for the services. These commenters noted that CMS has previously adopted interim final values for only a portion of new codes in a family, pending subsequent valuation of other codes in the family. Other commenters questioned the logic of maintaining preexisting values for these services since the new set of codes resulted from the identification of these services as potentially misvalued several years ago. Other commenters pointed out that the general approach to valuing the codes resulted in anomalous values. Several other commenters suggested alternative work values for the codes with and without corresponding AMA RUC recommendations.

Response: We appreciate commenters' concerns regarding the appropriate valuation of this family of codes. We also acknowledge that commenters accurately point out that, in some cases, we have previously established new interim values for new codes when related codes have not been simultaneously reviewed. However, as we explained in the CY 2013 final rule with comment period (77 FR 69060), the CY 2013 changes for this family of codes consisted of a new structure that allowed for the separate reporting of E/M codes, the elimination of the site-of-service differential, the establishment of CPT codes for crisis, and the creation of a series of add-on CPT codes to psychotherapy to describe interactive complexity and medication management. We believed that the unusual complexity of these coding changes and the magnitude of their impacts among the affected specialties that furnish these services necessitated a comprehensive review of the potential impact of the changes prior to adopting significant changes in overall value. We also acknowledge that maintaining overall value for services between calendar years with coding changes presents extensive challenges that often result in anomalous values between individual codes. Since we are establishing new interim final work RVUs for the codes in this family for CY 2014 based on the recommendations of the AMA RUC, we believe that commenters' concerns regarding our approach to CY 2013 have been largely been mitigated for CY 2014. We note that the interim final CY 2014 work RVUs for all of these services are open for comment and we will respond to comments regarding these values in the CY 2015 PFS final rule with comment period.

Comment: Several commenters stated that it was difficult for health care professionals that furnish these services to implement use of the new CPT codes for Medicare payment with only a few months' notice given the technology involved in claims systems. Other commenters suggested that CMS should revise CPT code descriptors for codes to conform to Medicare policies.

Response: We appreciate the concern regarding insufficient time to adopt new codes. Although we would prefer for the new, revised and deleted codes to be released in time to appear in PFS proposed rulemaking, the timing of the annual release of the new codes set is completely under the control of the CPT Editorial Panel. We note that CMS does not have the authority to alter CPT code descriptors.

Comment: Several commenters supported CMS's decision to assign CPT code 90863 with a PFS procedure status indicator of I (Not valid for Medicare purposes. Medicare uses another code for the reporting of and the payment for these services) for CY 2013 and encouraged CMS to maintain that status for CY 2014.

Response: We appreciate commenters' support for this assignment. We understand from our past meetings with stakeholders that the ability to prescribe medicine is predicated upon first providing evaluation and management (E/M) services. Although clinical psychologists have been granted prescriptive privileges in Louisiana and New Mexico, we do not believe that they are n authorized under their state scope of practice to furnish the full range of traditional E/M services. As a result, we believe that clinical psychologists continue to be precluded from billing Medicare for pharmacologic management services under CPT code 90863 because pharmacologic management services require some knowledge and ability to furnish E/M services, as some stakeholders have indicated. Even though clinical psychologists in Louisiana and New Mexico have been granted prescriptive privileges, clinical psychologists overall remain unlicensed and unauthorized by their state to furnish E/M services. Accordingly, on an interim final basis for CY 2014, for CPT code 90863, we are maintaining a PFS procedure status indicator of I (Not valid for Medicare purposes. Medicare uses another code for the reporting of and the payment for these services.).

(32) Cardiovascular: Therapeutic Services and Procedures (CPT Codes 92920, 92921, 92924, 92925, 92928, and 92929)

The CPT Editorial Panel created 13 new percutaneous coronary intervention (PCI) CPT codes for CY 2013 (92920, 92921, 92924, 92925, 92928, 92929, 92933, 92934, 92937, 92938, 92941, 92943, and 92944) to replace the 6 existing codes, which resulted in a greater level of granularity.

As detailed in the CY 2013 final rule with comment period, we believed that the CPT-established unbundling of the placement of branch-level stents may encourage increased placement of stents. To eliminate that incentive, on an interim final basis for CY 2013, we rebundled the work associated with the placement of a stent in an arterial branch into the base code for the placement of a stent in an artery. Accordingly, for CY 2013 we bundled each new add-on code into its base code. Specifically, we bundled the work of CPT code 92921 into CPT code 92920, the work of CPT code 92925 into CPT code 92924, the work of CPT code 92929 into CPT code 92928, the work of CPT code 92934 into CPT code 92933, the work of CPT code 92938 into CPT code 92937; and the work of CPT code 92944 into CPT code 92943.

In the CY 2013 final rule with comment period we explained how we established the work RVUs for the new bundled codes. For each code, we used the AMA RUC-recommended utilization crosswalk to determine what percentage of the base code utilization would be billed with the add-on code, and added that percentage of the AMA RUC-recommended work RVU for the add-on code to the AMA RUC-recommended work RVU for the base code. Based on this methodology, we assigned the following CY 2013 interim final work RVUs: 10.10 to CPT code 92920, 11.99

to CPT code 92924, 11.21 to CPT code 92928, 12.54 to CPT code 92933, 11.20 to CPT code 92937, and 12.56 to CPT code 92943.

On an interim final basis for CY 2013, add-on CPT codes 92921, 92925, 92929, 92934, 92938, and 92944 were assigned a PFS procedure status indicator of B (Bundled code. Payments for covered services are always bundled into payment for other services, which are not specified. If RVUs are shown, they are not used for Medicare payment. If these services are covered, payment for them is subsumed by the payment for the services to which they are bundled.) Therefore, these codes were not separately payable.

As detailed in the CY 2013 final rule with comment period, we did not use this methodology to establish a work RVU for CPT code 92941, which did not have a specific corresponding add-on code. After reviewing the service alongside the other services in the family, we believed CPT code 92941 had the same work as CPT code 92943. As we stated above, we assigned a work RVU of 12.56 to CPT code 92943. Therefore, on an interim final basis for CY 2013 we assigned a work RVU of 12.56 to CPT code 92941 with the AMA RUC-recommended intraservice time of 70 minutes.

Comment: Commenters disagreed with our bundling of codes into their respective base codes. Commenters stated that we negated the work of the CPT Editorial Panel, specialty societies, and the AMA RUC by further bundling already bundled codes for PCI services. They indicated that the additional bundling of payment for these codes generated a substantial disconnect between the coding guidelines detailed in the CPT manual and the use of the codes under the Medicare system, causing great uncertainty and confusion. Additionally, commenters stated that the decreases in PCI were of serious concern because it would drive physicians from private practice. Therefore, commenters requested we adopt the CPT Editorial Panel coding construct and the AMA RUC-recommended values for all of the PCI codes. Furthermore, commenters requested that we publish the values for the bundled codes, even though they were not recognized for separate payment by Medicare, so that third-party carriers who depend on the PFS to determine payment rates can develop payment policies that conform to the CPT Editorial Panel's coding decisions.

Response: After re-review, we maintain that our valuation and bundling of codes into their respective base codes is appropriate. We continue to believe that the revised CPT coding structure represents a trend toward creating greater granularity in codes that describe the most intense and difficult work. Specifically for this code family, we continue to believe that making separate Medicare payment for unbundled codes that describe the placement of branch-level stents may encourage increased placement of stents in a fee-for-service system. To eliminate that incentive while maintaining an appropriate reflection of the resources involved in furnishing these services, we continue to believe that rebundling the work associated with the placement of a stent in an arterial branch into the base code for the placement of a stent in an artery is appropriate and consistent with the prior coding structure.

Therefore, we are finalizing work RVU values of 10.10 for CPT code 92920, 11.99 for CPT code 92924 and 11.21 for CPT 92928 and a PFS procedure status indicator of B (Bundled code. Payments for covered services are always bundled into payment for other services, which are not specified. If RVUs are shown, they are not used for Medicare payment. If these services are covered, payment for them is subsumed by the payment for the services to which they are bundled for CPT codes 92921, 92925 and 92929 for CY 2014. We are also finalizing for CY 2014 a work RVU of 12.56 for CPT code 92941, with the AMA RUC-recommended intraservice time of 70 minutes.

(33) Cardiovascular: Intracardiac Electrophysiological Procedures/Studies (CPT Codes 93655 and 93657)

Previously, CPT codes 93651 and 93652 were identified as potentially misvalued through the codes reported together 75 percent or more screen. Upon reviewing these codes, the CPT Editorial Panel deleted CPT codes 93651 and 93652 and and replaced them with new CPT codes 93653 through 93657 effective January 1, 2013.

As detailed in CY 2013 final rule with comment period, we believed these codes had a similar level of intensity to CPT codes 93653, 93654, and 93656, which were all valued at 5.00 RVUs per 1 hour of intraservice time. Therefore, for CY 2013 we assigned a work RVU of 7.50 to CPT codes 93655 and 93657, which have 90 minutes of intraservice time. The AMA RUC recommended a work RVU of 9.00 for CPT code 93655 and a work RVU of 10.00 for CPT code 93657.

Comment: Commenters disagreed with the incremental value methodology for CPT codes 93655 and 93657, stating that our approach did not accurately account for the intensity of these services. They stated that CPT codes 93655 and 93657 are more intense and complex procedures than CPT codes 93653, 93654, and 93656 because patients who require the services have widespread refractory disease, requiring additional technical skill and time. Therefore, commenters requested we use the AMA RUC-recommended work RVUs of 9.0 for CPT code 93655 and 10.0 for CPT code 93657. In addition, one commenter requested that we refer these codes to the refinement panel.

Response: After reviewing the request for refinement, we agreed that CPT codes 93655 and 93657 met the requirements for refinement and referred the codes to the CY 2013 multi-specialty refinement panel for further review. The refinement panel median work RVU for CPT codes 93655 and 93657 are 9.00, and 10.00 respectively. Following the refinement panel meeting, we again reviewed the work involved in this code and continue to believe that the two services involve a very similar level of intensity to CPT codes 93653, 93654, and 93656, which are all valued at 5.00 RVUs per 1 hour of intraservice time. We continue to believe that this is the appropriate value for CPT codes 93655 and 93657 because we believe these services contain the same amount of work as the base codes, CPT codes 93653, 93654, and 93656. Therefore, we are finalizing a work RVU of 7.50 for CPT codes 93655 and 93657 for CY 2014.

(34) Noninvasive Vascular Diagnostic Studies: Extremity Arterial Studies (Including Digits) (CPT Codes 93925 and 93926)

Previously, CPT codes 93925 and 93926 were identified by the AMA RUC as potentially misvalued and we received AMA RUC recommendations for CY 2013.

After reviewing CPT codes 93925 and 93926, we believed that the survey's 25th percentile work RVUs of 0.80 for CPT code 93925 and 0.50 for CPT code 93926 accurately accounted for the work involved in furnishing the services and appropriately captured the increase in work since the services were last valued and assigned these as interim final work RVUs for CY 2013. As we noted in the CY 2013 final rule with comment period, we believed that the AMA RUC-recommended survey median work RVUs of 0.90 for CPT code 93925 and 0.70 for CPT code 93926 overstated the increase in work for the services and that the RVUs were too high relative to similar services. Regarding physician time, we refined the AMA RUC-

recommended preservice and postservice times from 5 minutes to 3 minutes to align with similar services, specifically CPT codes 93922 and 93923.

Comment: All commenters disagreed with our work valuation and some commenters also disagreed with our time refinements for CPT codes 93925 and 93926. One commenter stated that the work RVUs for CPT codes 93925 and 93926 should be increased because the work associated with the services has changed and also argued that our valuations were arbitrary in nature and unsupported. Two commenters noted that the AMA RUC-recommended work RVUs of 0.90 for CPT code 93925 and 0.70 for CPT code 93926 were supported by relativity comparisons to CPT codes 93306, 73700, 76776 and 76817 and according the CY 2013 interim final work RVU values were too low. Additionally, two commenters disagreed with our time refinements for CPT codes 93925 and 93926 from the survey's median to the survey's 25th percentile values. One commenter specifically disagreed with our use of CPT codes 93922 and 93923 as reference codes for time refinements because they stated "physiologic studies do not require artery-by-artery inch-by-inch assessment of femoral and tibial arteries, as do the duplex exams" and as such, are not appropriate codes for comparison. They added that CPT codes 93925 and 93926 require more time for proper performance of the exam and interpretation of results. All commenters suggested acceptance of the AMA RUC recommendations. One commenter also requested refinement panel review of the codes.

Response: After evaluation of the request for refinement, we determined that the criteria for the request for refinement were not met and, as a result, we did not refer CPT codes 93925 and 93926 to the CY 2013 multi-specialty refinement panel for further review.

After reviewing the comments, we maintain that our valuation is appropriate. We continue to believe that that the survey's 25th percentile work RVUs of 0.80 for CPT code 93925, and 0.50 for CPT code 93926 accurately account for the work involved in furnishing these services and appropriately captures the increase in work since these services were last valued. Additionally, we continue to believe that a refinement to the AMA RUC-recommended time is appropriate to align the times with those associated with CPT codes 93922 and 93923 that describe similar services. Therefore, we are finalizing a work RVU of 0.80 to CPT code 93925 and a work RVU of 0.50 to CPT code 93926, with 3 minutes of preservice and postservice time for CY 2014.

(35) Neurology and Neuromuscular Procedures: Sleep Medicine Testing (CPT Codes 95782 and 95783)

The CPT Editorial Panel created new CPT codes 95782 and 95783, effective January 1, 2013, to describe the work involved in pediatric polysomnography for children 5 years of age or younger. For CY 2013, we assigned an interim final work RVU of 2.60 to CPT code 95782 and a work RVU of 2.83 to CPT code 95783. As we noted in the CY 2013 final rule with comment period, we assigned these values after we reviewed CPT codes 95782 and 95783 and determined that the survey's 25th percentile work RVUs of 2.60 for CPT code 95782 and 2.83 for CPT code 95783 appropriately reflected the work involved in furnishing the services. The AMA RUC recommended the survey's median work RVUs of 3.00 for CPT code 95782 and 3.20 for CPT code 95783.

Comment: Commenters disagreed with our valuation of CPT codes 95782 and 95783, stating that the services should have received a greater valuation explaining that it is more difficult to perform sleep studies on children than adults, and more work is required to obtain an accurate polysomnogram due to children's greater need for attention and, in some cases, even mild sedation. Additionally, commenters noted that the work involved in the interpretation of data supported a higher work RVU. Therefore, commenters requested that we use the AMA RUC-recommended work RVU of 3.00 for CPT code 95782 and 3.20 for CPT code 95783.

Response: After consideration of comments and re-reviewing of CPT codes 95782 and 95783, we maintain that our valuation is appropriate. We continue to believe that that the survey's 25th percentile work RVUs of 2.60 for CPT code 95782 and 2.83 for CPT code 95783 accurately accounts for the work involved in furnishing these services. Therefore, we are finalizing a work RVU of 2.60 for CPT code 95782 and 2.83 for CPT code 95783, for CY 2014.

(36) Neurology and Neuromuscular Procedures: Electromyography and Nerve Conduction Tests (CPT Codes 95885, 95886, and 95887)

CPT codes 95860, 95861, 95863, and 95864 were previously identified as potentially misvalued through the codes reported together 75 percent or more screen. The relevant specialty societies submitted a code change proposal to the CPT Editorial Panel to bundle the services commonly reported together. In response, the CPT created three add-on codes (CPT codes 95885, 95886, and 95887) and seven new codes (CPT codes 95907 through 95913) that bundled the work of multiple nerve conduction studies into each individual code.

We agreed with the AMA RUC recommendation for CPT code 95885 and assigned a CY 2013 interim final work RVU of 0.35. After review, we determined that CPT codes 95886 and 95887 involved the same level of work intensity as CPT code 95885. To determine the appropriate RVU for CPT codes 95886 and 95887, we increased the work RVUs of CPT codes 95886 and 95887 proportionate to the differences in times from CPT code 95885. Therefore, we assigned an interim final work RVU of 0.70 to CPT code 95886 and of 0.47 to CPT code 95887 for CY 2013 as compared to the AMA RUC-recommended 0.92 and 0.73, respectively.

Comment: Commenters indicated that we utilized a flawed building block approach in valuing CPT codes 95886 and 95887 because the methodology did not take into account precise distinctions within each service and inaccurately assumed that the codes had identical intensity and complexity. Commenters supported the AMA RUC-recommended values developed using magnitude estimation saying that the methodology was more precise due to its use of data derived from multiple factors like physician time, intensity and work value estimates. Additionally, commenters noted that we failed to distinguish the increasing intensity and complexity involved as additional nerve conductions were performed. Therefore, commenters requested our use of the AMA RUC-recommended work RVU of 0.92 for CPT code 95886 and 0.73 for CPT code 95887 and refinement panel review of the codes.

Response: After reviewing the request for refinement, we agreed that CPT codes 95886 and 95887 met the requirements for refinement and referred the codes to the CY 2013 multi-specialty refinement panel for further review. The refinement panel median work RVUs for CPT codes 95886 and 95887 were respectively, 0.92 and 0.73. Following the refinement panel meeting, we again reviewed the work involved in these codes and agreed with the panel that these codes were more intense and complex than reflected in the CY 2013 interim final values and, as such, warranted a higher work RVU. While we agree that work RVUs for CPT codes 95886 and 95887 should be increased, based on our clinical review, we conclude that the refinement panel's

suggested values overstate the work involved in these procedures.

We believe that the work for CPT code 95886 is similar to the work performed when five or more muscles are examined in one extremity, as described by CPT code 95860, which has a work RVU of 0.96. However, CPT code 95886 is an add-on code to nerve conduction studies. Therefore, as we have previously valued services that overlap with another CPT code, we applied a 10% reduction to the work RVU of CPT code 95860 to determine a work RVU of 0.86 for CPT code 95886. Similarly, in our valuation of CPT code 95887, we believe that the work for the code is similar to the work performed when cranial nerve supplied muscles are examined, as described by CPT code 95867, which has a work RVU of 0.79. However, CPT code 95887 is an add-on code to nerve conduction studies. Therefore, as we have previously valued services that overlap with another code, we applied a 10 percent reduction to the work RVU of CPT code 95867 to determine a work RVU of 0.79 for CPT code 95887. For CY 2014, we are finalizing a work RVU of 0.86 for CPT code 95886 and 0.71 for CPT code 95887.

(37) Neurology and Neuromuscular Procedures: Electromyography and Nerve Conduction Tests (CPT Codes 95908, 95909, 95910, 95911, 95912, and 95913)

In our CY 2013 review, we did not accept the AMA RUC-recommended values for CPT codes 95908, 95909, 95910, 95911, 95912, and 95913. For those codes, we found that the progression of the survey's 25th percentile work RVUs and survey's median times appropriately reflected the relativity of the services and valued the codes accordingly. CPT code 95908 was an exception to this, as we believed the survey's 25th percentile work RVU was too low relative to other fee schedule services. Therefore, we assigned the following work RVUs for CY 2013: 1.00 to CPT code 95907, 1.25 to CPT code 95908, 1.50 to CPT code 95909, 2.00 to CPT code 95910, 2.50 to CPT code 95911, 3.00 to CPT code 95912, and 3.56 to CPT code 95913.

Additionally, we refined the AMA RUC-recommended intraservice time for CPT code 95908 from 25 minutes to the survey's median time of 22 minutes and for CPT code 95909 from 35 minutes to the survey's median time of 30 minutes, so that all the CPT codes in the series were valued using the survey's median intraservice time.

Comment: Commenters disagreed with our valuation of CPT codes 95908, 95909, 95910, 95911, 95912, and 95913. Commenters opposed the interim final values for the codes because they believed the intensity and complexity of the procedures increased as more nerve conductions were performed and as a result, believed that the valuations should be higher. Additionally, commenters believe that because no significant changes in the efficiencies of the test had occurred, in terms of time and cost related to performance, that our changes in the valuations were unjustified. Therefore, commenters requested that we accept the AMA RUC-recommended work RVUs for all of these codes and requested refinement panel review. Lastly, commenters also suggested that if the interim final values were to be finalized, that their implementation be staggered to limit the adverse impacts that the values would have on health care access.

Response: After reviewing the request for refinement, we agreed that CPT codes 95908, 95909, 95910, 95911, 95912, and 95913 met the requirements for refinement and referred the codes to the CY 2013 multi-specialty refinement panel for further review. The refinement panel median work RVUs were: 1.37 for CPT code 95908, 1.77 for CPT code 95909, 2.80 for CPT code 95910, 3.34 for CPT code 95911, 4.00 for CPT code 95912, and 4.20 for CPT code 95913. Following the refinement panel meeting, we again reviewed the work involved in these codes and continue to believe that the progression of the survey's 25th percentile work RVUs and survey median times for these codes appropriately reflect the relativity of these codes. CPT code 95908 was an exception to this approach because we believe that the survey's 25th percentile work RVU is too low relative to other fee schedule services. We also note that we do not believe that the results of the survey support the notion that the intensity and complexity of the procedures increases as more nerve conductions are performed. Instead, we believe that the incremental differences reflected in the survey correspond with the incremental differences in our CY 2013 interim final values. Therefore, we are finalizing the CY 2013 interim final work RVUs and time refinements for CPT codes 95908, 95909, 95910, 95911, 95912, and 95913 for CY 2014. With regard to the comment that our rates would impede access to these critical services, we are unaware of data that shows that access has declined.

(38) Evoked Potentials (CPT Codes 95928 and 95929)

As detailed in the CY 2013 final rule with comment period, CPT codes 95928 and 95929 were each assigned a CY 2013 interim final work RVU of 1.50. Subsequently, the AMA RUC recommended intraservice time for these codes based on only 19 of the 28 survey responses. As a result, the AMA RUC recommendations included an intraservice time of 40 minutes with which we do not agree. When based on all 28 survey responses, the intraservice time is 33 minutes. We agree with the AMA RUC recommended preservice and postservice times because they are consistent across all 28 survey responses. Therefore, for CY 2014, we are refining the preservice time, intraservice and postservice times for CPT codes 95928 and 95929 to 15 minutes, 33 minutes and 10 minutes, respectively. We are assigning CY 2014 interim final work RVUs of 1.50 to CPT codes 95928 and 95929, based upon the AMA RUC recommendations, and are seeking public input on the time of the codes.

(39) Neurology and Neuromuscular Procedures: Intraoperative Neurophysiology (CPT Codes 95940 and 95941 and HCPCS Code G0453)

Effective January 1, 2013, the CPT Editorial Panel deleted CPT code 95920 and replaced it with CPT codes 95940 for continuous intraoperative neurophysiology monitoring in the operating room requiring personal attendance and 95941 for continuous intraoperative neurophysiology monitoring from outside the operating room (remote or nearby). Prior to CY 2013, the Medicare PFS paid for remote monitoring billed under CPT code 95920, which was used for both in-person and remote monitoring. For CY 2013, we created HCPCS code G0453 to be used for Medicare purposes instead of CPT code 95941. Unlike CPT code 95941, HCPCS code G0453 can be billed only for undivided attention by the monitoring physician to a single beneficiary, not for the monitoring of multiple beneficiaries simultaneously. Since G0453 was used for remote monitoring of Medicare beneficiaries, CPT code 95941 was assigned a PFS procedure status indicator of I (Not valid for Medicare purposes. Medicare uses another code for the reporting of and the payment for these services.

As detailed in the CY 2013 final rule with comment period, after reviewing CPT code 95940, we agreed with the AMA RUC that a work RVU of 0.60 accurately accounted for the work involved in furnishing the procedure. Also, we agreed with the AMA RUC that a work RVU of 2.00 accurately accounted for the work involved in furnishing 60 minutes of continuous

intraoperative neurophysiology monitoring from outside the operating room. Accordingly, we assigned a work RVU of 0.50 to HCPCS code G0453, which described 15 minutes of monitoring from outside the operating room, on an interim final basis for CY 2013.

Comment: Commenters disagreed with our valuation of CPT codes 95940, 95941 and G0453. Commenters opposed the one-on-one patient to physician model that our recommendations proposed. Commenters stated the following: G0453 was contradictory to current provider models; the accessibility of IONM services would be lowered; surgeons would be deprived of advantageous services; qualified level of professional supervision would be reduced; hospitals would suffer increased overheard costs; and GO453 inappropriately assessed the services. Therefore, commenters requested we withdraw HCPCS code G0453 and validate CPT codes 95940 and 95941 together, through acceptance of the AMA RUC-recommended work RVUs of 0.60 for CPT code 95940 and 2.00 for CPT code 95941.

Another commenter suggested we value CPT code 95941 at 0.5 of CPT 95940 although a rationale for that valuation was not provided. Several other commenters requested we increase the work value of G0453 so that it was equal to the work RVU assigned to CPT code 95940 because they believed the physician time and effort for both services was the same. The majority of commenters suggested we value the concurrent monitoring of up to 4 patients by a neurologist with the creation of additional G codes for the remote monitoring of 2, 3 or 4 patients.

Response: Based on comments received, we re-reviewed CPT codes 95940, 95941 and HCPCS code G0453 and agree that based on the comparable nature of the work between CPT code 95940 and HCPCS code G0453, that G0453 should be valued equally to CPT code 95940.

Therefore, we are finalizing a work RVU of 0.60 to CPT code 95940 and 0.60 to HCPCS code G0453 for CY 2014. We are also finalizing a PFS procedure status indicator of I (Not valid for Medicare purposes. Medicare uses another code for the reporting of and the payment for these services) to CPT code 95941 for CY 2014, because for Medicare purposes, HCPCS code G0453 will continue to be used instead of CPT code 95941. Although we considered commenters' suggestions to value concurrent monitoring of up to 3 or 4 patients by a neurologist with the creation of additional G-codes for the remote monitoring of 2, 3 or 4 patients, creation of these G codes would allow billing for more than 60 minutes of work during a 60 minute time period. We continue to believe that HCPCS code G0453 adequately accounts for the relative resources involved when the physician monitors a Medicare beneficiary, while it precludes inaccurate payment in cases where multiple patients are being monitored simultaneously. Therefore, we will maintain the current code descriptor for HCPCS code G0453.

Comment: Some commenters suggested we create mechanisms for practitioners to report the professional and technical components separately for CPT codes 95940 and HCPCS code G0453. One of these commenters suggested that creating separate technical component payment for the PFS would allow hospitals to approximate the relative resource costs associated with the technical component of the service.

Response: It is our understanding that these services are nearly always furnished to beneficiaries in facility settings. Therefore, Medicare would not make payments through the PFS that account for the clinical labor, disposable supplies, or medical equipment involved in furnishing the service. Instead, these resource costs would be included in the payment Medicare makes to the facility through other payment mechanisms. Therefore, we do not believe it would be appropriate to create separate payment rates for the professional and technical component of these services.

(40) Neurology System: Autonomic Function Tests (CPT Code 95943)

As detailed in the CY 2013 final rule with comment period, we assigned a PFS procedure status of C to CPT code 95943, pursuant to the AMA RUC recommendation. (Contractors price the code. Contractors establish RVUs and payment amounts for these services.) The AMA RUC believes that a PFS procedure status of "C" was appropriate because they did not have sufficient information for making a specific work RVU recommendation.

Comment: Commenters opposed contractor pricing of CPT code 95943 because the other autonomic nervous system testing codes have national work RVUs and payment rates. Commenters suggested we crosswalk CPT code 95943 to CPT code 95924 due to the procedures' similarity in total work.

Response: We continue to believe that a PFS procedure status of C (Contractors price the code. Contractors establish RVUs and payment amounts for these services.) is appropriate for CPT code 95943. We do not believe that the commenters provided sufficient data to value the service. Therefore, we are finalizing a Contractor Pricing procedure status to CPT code 95943 for CY 2014.

(41) Inpatient Neonatal Intensive Care Services and Pediatric and Neonatal Critical Care Services: Pediatric Critical Care Patient Transport (CPT Codes 99485 and 99486)

For CY 2013, he CPT editorial panel created CPT codes 99485 and 99486, to describe the non-face-to-face services provided by physician to supervise interfacility care of critically ill or critically injured pediatric patients.

As detailed in the CY 2013 final rule with comment period, we reviewed CPT codes 99485 and 99486 and believed the services should be bundled into other services and not be separately payable. We believed the services were similar to CPT code 99288, which is also bundled on the PFS. The AMA RUC recommended a work RVU of 1.50 for CPT code 99485 and a work RVU of 1.30 for CPT code 99486. On an interim final basis for CY 2013, we assigned CPT codes 99485 and 99486 a PFS procedure status indicator of B (Payments for covered services are always bundled into payment for other services, which are not specified. If RVUs are shown, they are not used for Medicare payment. If these services are covered, payment for them is subsumed by the payment for the services to which they are bundled).

Comment: Commenters disagreed with our assignment of CPT codes 99485 and 99486 as bundled codes. They stated that that classification puts pediatric physicians at a disadvantage since the majority of non-Medicare payers will commonly bundle the codes as well. Commenters strongly recommended that we adopt status indicator A (Active) or, at the very least, status indicator N (Noncovered Service) for CPT codes 99485 and 99486.

Response: We continue to believe that CPT codes 99485 and 99486 are similar to CPT code 99288 and, like CPT code 99288, involve work that is already considered in the valuation of other services. Therefore, we do not believe that these services should be separately payable. Therefore, we are finalizing a PFS procedure status of B (Payments for covered services are always bundled into payment for other services, which are not specified. If RVUs are shown, they are not used for Medicare payment. If these services are covered, payment for them is subsumed by the payment for the services to which they are

bundled) to CPT codes 99485 and 99486 for CY 2014.

(42) Molecular Pathology (HCPCS Code G0452)

As detailed in the CY 2013 final rule with comment period, one of the molecular pathology CPT codes that was deleted by CPT for CY 2012 was payable on the PFS: CPT code 83912–26. To replace this CPT code, we created HCPCS code G0452 to describe medically necessary interpretation and written report of a molecular pathology test, above and beyond the report of laboratory results. We reviewed the work associated with this procedure and we believed it was appropriate to directly crosswalk the work RVUs and times of CPT code 83912–26 to HCPCS code G0452, because we did not believe the coding change reflected a change in the service or in the resources involved in furnishing the service. Accordingly, we assigned a work RVU of 0.37, with 5 minutes of preservice time, 10 minutes of intraservice time, and 5 minutes of postservice time to HCPCS code G0452 on an interim final basis for CY 2013.

Comment: Commenters disagreed with our valuation of HCPCS code G0452. Commenters expressed concern about the creation of a single HCPCS G-code to distinguish work related to a considerable number of procedures with changing relative values recommended by the AMA RUC.

Response: The decision to pay for molecular pathology codes under the CLFS required the creation of a new code for the interpretation and reporting services by pathologists on the PFS. We continue to believe that the creation of HCPCS code G0452 was appropriate to describe medically necessary interpretation and written report of a molecular pathology test, above and beyond the report of laboratory results. We also believe that this single HCPCS code is sufficient to capture the work involved in any of the numerous molecular pathology codes. Additionally, the professional component-only HCPCS G-code is a "clinical laboratory interpretation service," which is one of the current categories of PFS pathology services under the definition of physician pathology services at § 415.130(b)(4). Therefore, we are finalizing a work RVU of 0.37 to HCPCS code G0452.

(43) Digestive System: Intestines (Except Rectum) (CPT Code G0455)

For CY 2013, we created HCPCS code G0455 to be used for Medicare purposes instead of CPT code 44705. HCPCS code G0455 will be used to bundle the preparation and instillation of microbiota. CPT code 44705 was assigned a PFS procedure status indicator of I (Not valid for Medicare purposes).

After reviewing the preparation and instillation work associated with this procedure, we believed that CPT code 99213 was an appropriate crosswalk for the work and time of HCPCS code G0455. Therefore, on an interim final basis for CY 2013, we assigned a work RVU of 0.97 to HCPCS code G0455.

Comment: Commenters disagreed with our valuation of HCPCS code G0455. Commenters opposed the interim final work RVU because they believed extensive work was required for the preparation of the microbiota, to determine if a patient was an appropriate candidate for fecal donation. Commenters believed that our work RVU valuation failed to distinguish between varying clinical circumstances for the use of this code. Commenters also suggested that we should consider coverage of more than one donor specimen screening when clinically suitable.

Response: After review, we agree with the commenters that the interim final work RVU of 0.97 undervalues this service. We believe that bundling the work RVU and physician time of CPT code 80500, a lab pathology consultation, with CPT code 99213 more appropriately values this work. Therefore, we are finalizing a work RVU of 1.34 and an intraservice time of 28 minutes for HCPCS code G0455.

b. Finalizing CY 2013 Interim Direct PE Inputs

(i) Background and Methodology

On an annual basis, the AMA RUC provides CMS with recommendations regarding direct PE inputs, including clinical labor, disposable supplies, and medical equipment, for new, revised, and potentially misvalued codes. We review the AMA RUC-recommended direct PE inputs on a code-by-code basis. When we determine that the AMA RUC recommendations appropriately estimate the direct PE inputs required for the typical service and reflect our payment policies, we use those direct PE inputs to value a service. If not, we refine the PE inputs to better reflect our estimate of the PE resources required for the service. We also confirm whether CPT codes should have facility and/or nonfacility direct PE inputs and refine the inputs accordingly.

In the CY 2013 PFS final rule with comment period (77 FR 69072), we addressed the general nature of some of our common refinements to the AMA RUC-recommended direct PE inputs as well as the reasons for refinements to particular inputs. In the following subsections, we respond to the comments we received regarding common refinements we made based on established principles or policies. Following those discussions, we summarize and respond to comments received regarding other refinements to particular codes.

We note that the interim final direct PE inputs for CY 2013 that are being finalized for CY 2014 are displayed in the final CY 2014 direct PE input database, available on the CMS Web site under the downloads for the CY 2014 PFS final rule at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html*. The inputs displayed there have also been used in developing the CY 2014 PE RVUs as displayed in Addendum B of this final rule with comment period.

(ii) Common Refinements

(1) Equipment Time

Prior to CY 2010, the AMA RUC did not generally provide CMS with recommendations regarding equipment time inputs. In CY 2010, in the interest of ensuring the greatest possible degree of accuracy in allocating equipment minutes, we requested that the AMA RUC provide equipment times along with the other direct PE recommendations, and we provided the AMA RUC with general guidelines regarding appropriate equipment time inputs. We continue to appreciate the AMA RUC's willingness to provide us with these additional inputs as part of its direct PE recommendations.

In general, the equipment time inputs correspond to the service period portion of the clinical labor times. We have clarified this principle, indicating that we consider equipment time as the times within the intraservice period when a clinician is using the piece of equipment plus any additional time that the piece of equipment is not available for use for another patient due to its use during the designated procedure. For services in which we allocate cleaning time to portable equipment items, we do not include that time for the remaining equipment items as they are available for use for other patients during that time. In addition, when a piece of equipment is typically used during any additional visits included in a service's global period, the equipment time would also reflect that use.

We believe that certain highly technical pieces of equipment and equipment rooms are less likely to be

used during all of the preservice or postservice tasks performed by clinical labor staff on the day of the procedure (the clinical labor service period) and are typically available for other patients even when one member of clinical staff may be occupied with a preservice or postservice task related to the procedure.

Some commenters have repeatedly objected to our rationale for refinement of equipment minutes on this basis. We acknowledge the comments we received that reiterate those objections to this rationale and refer readers to our extensive discussion regarding those objections in the CY 2012 PFS final rule with comment period (76 FR 73182). In the following paragraphs we address new comments on this policy.

Comment: Several commenters pointed out that technician time is independent of physician time for some procedures so that equipment time should not be altered based on changes in physician intraservice time.

Response: The estimated time it takes for a practitioner or clinical staff to furnish a procedure is an important factor used in determining the appropriate direct PE input values used in developing nonfacility PE RVUs. For many services, the physician intraservice time serves as the basis for allocating the appropriate number of minutes within the service period to account for the time used in furnishing the service to the patient. In the case of many services, the number of physician intraservice minutes, or occasionally a particular proportion thereof, is allocated to both the clinical staff that assist the practitioner in furnishing the service and to the equipment used by either the practitioner or the staff in furnishing the service. This allocation reflects only the time the beneficiary receives treatment and does not include resources used immediately prior to or following the service. Additional minutes are often allocated to both clinical labor and equipment resources to account for the time used for necessary preparatory tasks immediately preceding the procedure or tasks typically performed immediately following it. For these services, we routinely adjust the minutes assigned to the direct PE inputs so that they correspond with the procedure time assumptions displayed in the physician time file that are used in determining work RVUs and allocating indirect PE values.

The commenters accurately point out that for a significant number of services, especially diagnostic tests, the procedure time assumptions used in determining direct PE inputs are distinct from, and therefore not dependent on, physician intraservice time assumptions. For these services, we do not make refinements to the direct PE inputs based on changes to estimated physician intraservice times.

Comment: Several commenters asked that CMS identify what constitutes a highly technical piece of equipment.

Response: During our review of all recommended direct PE inputs, we consider whether or not particular equipment items would typically be used in the most efficient manner possible. In making this determination, we consider such items as the degree of specificity of a piece of equipment, which may influence whether the equipment item is likely to be stored in the same room in which the clinical staff greets and gowns, obtains vitals, or provides education to a patient prior to the procedure itself. We also consider the level of portability (including the level of difficulty involved in cleaning the equipment item) to determine whether an item could be easily transferred between rooms before or after a given procedure. We also examine the prices for the particular equipment items to determine whether the equipment is likely to be located in the same room used for all the tasks undertaken by clinical staff prior to and following the procedure. For each service, on a case-by-case basis, we look at the description provided in the AMA RUC recommendation and consider the overlap of the equipment item's level of specificity, portability, and cost; and, consistent with the review of other recommended direct PE inputs, make the determination of whether the recommended equipment items are highly technical.

(2) Standard Tasks and Minutes for Clinical Labor Tasks

In general, the preservice, service period, and postservice clinical labor minutes associated with clinical labor inputs in the direct PE input database reflect the sum of particular tasks described in the information that accompanies the recommended direct PE inputs, "PE worksheets." For most of these described tasks, there are a standardized number of minutes, depending on the type of procedure, its typical setting, its global period, and the other procedures with which it is typically reported. At times, the AMA RUC recommends a number of minutes either greater than or less than the time typically allotted for certain tasks. In those cases, CMS clinical staff reviews the deviations from the standards to determine their clinical appropriateness. Where the AMA RUC-recommended exceptions are not accepted, we refine the interim final direct PE inputs to match the standard times for those tasks. In addition, in cases when a service is typically billed with an E/M, we remove the preservice clinical labor tasks so that the inputs are not duplicative and reflect the resource costs of furnishing the typical service.

In general, clinical labor tasks fall into one of the categories on the PE worksheets. In cases where tasks cannot be attributed to an existing category, the tasks are labeled "other clinical activity." In these instances, CMS clinical staff reviews these tasks to determine whether they are similar to tasks delineated for other services under the PFS. For those tasks that do not meet this criterion, we do not accept those clinical labor tasks as direct inputs.

Comment: Several commenters objected to CMS's refinement to recommended clinical labor minutes to meet these standards in cases where the recommendation included information suggesting that the service requires specialized clinical labor tasks, especially relating to quality assurance documentation, that are not typically included on the PE worksheets.

Response: Although we appreciate the importance of quality assurance and other tasks, we note that the nonfacility direct PE inputs include an estimated number of clinical labor minutes for most codes developed based on an extensive, standard list of clinical labor tasks such as "prepare equipment," and "prepare and position patient." We believe that quality assurance documentation tasks for services across the PFS are already accounted for in the overall estimate of clinical labor time. We do not believe that it would serve the relativity of the direct PE input database were additional minutes added for each clinical task that could be discretely described for every code and thus are not making any changes based upon this comment.

(3) Equipment Minutes for Film Equipment Inputs

In general, the equipment time allocated to film equipment, such as "film processor, dry, laser" (ED024), "film processor, wet" (ED025), and "film alternator (motorized film viewbox)" (ER029), corresponds to the clinical labor task "hang and process film."

Comment: Several commenters argued that the film equipment should be allocated for the entire service period.

Response: We believe that the film equipment, when used, is typically only used during the time associated with

certain clinical labor tasks, and is otherwise generally available for use in furnishing services to other patients. In reviewing these equipment inputs in the direct PE input database, we note that this equipment is generally not allocated for the full number of minutes of the clinical labor service period. Because we do not believe that this equipment would be in use during periods other than during particular clinical labor tasks, and to maintain relativity, we are finalizing the CY 2013 direct PE inputs based on this general principle.

(4) Film Inputs as a Proxy for Digital Imaging Inputs

Comment: A few commenters objected to our refinement of certain film inputs including eliminating VHS video system and tapes, and reducing the number of films for several procedures. Commenters also stated that the film processor was a necessary input for several procedures from which it was removed.

Response: As stated in the CY 2013 PFS final rule with comment period (77 FR 69029), a variety of imaging services across the PFS include direct PE inputs that reflect film-based technology instead of digital technology. We believe that for imaging services, digital technology is more typical than film technology. However, stakeholders, including the AMA RUC, have recommended that we continue to use film technology inputs as a proxy for digital until digital inputs for all imaging services can be considered. In response to these recommendations, we have maintained inputs for film-based technology as proxy inputs while this review occurs. In the case of new, revised, and potentially misvalued codes, we have accepted the recommended proxy inputs to the extent that the recommended proxy inputs are those that are usually associated with imaging codes. However, we have not accepted recommended inputs that are not usually included in other imaging services. We have reviewed the recommended inclusion of the film processor and, upon additional review, noted that the item is routinely included in other imaging codes. Therefore, we are including that item in the direct PE input database. We anticipate updating all of the associated inputs in future rulemaking. After consideration of comments received, we are finalizing the direct PE inputs in accordance with this general principle with the additional refinement of inserting the film processor for relevant codes.

(iii) Code-Specific Direct PE Inputs

We note that we received many comments objecting to refinements made based on CMS clinical review (including our determination that certain recommended items were duplicative of others already included with the service), statutory requirements, or established principles and policies under the PFS. We note that for many of our refinements, the medical specialty societies that represent the practitioners who furnish the service objected to most of these refinements for the general reasons described above or for the reasons we respond to in the "background and methodology" portion of this section. Below, we respond to comments in which commenters address specific CPT/HCPCS codes and provide rationale for their objections to our refinements in the form of new information supporting the inclusion of the items and/or times requested. When discussing these refinements, rather than listing all refinements made for each service, we discuss only the specific refinements that meet these criteria. We indicate the presence of other refinements by noting "among other refinements" after delineating the specific refinements for a particular service or group of services. For those comments that stated that an item was "necessary for the service" and no additional rationale or evidence was provided, we conducted further review to determine whether the inputs as refined were appropriate and concluded that the inputs as refined were indeed appropriate.

Further, in the CY 2013 PFS correction notice (78 FR 48996), we addressed several technical and typographical errors that respond to comments received. We do not repeat those comments nor provide our responses for those items here.

(1) Cross-Family Comments

Comment: We received comments regarding refinements to equipment times for many procedures, in which commenters indicated that the equipment time for the procedure should include the time that the equipment is unavailable for other patients, including while preparing equipment, positioning the patient, assisting the physician, and cleaning the room.

Response: As stated above, we agree with commenters that the equipment time should include the times within the intraservice period when a clinician is using the piece of equipment plus any additional time the piece of equipment is not available for use for another patient due to its use during the designated procedure. We believe that some of these commenters are suggesting that we should allocate the full number of clinical labor minutes included in the service period to the equipment items. However, as we have explained, the clinical labor service period includes minutes based on some clinical labor tasks associated with preservice and postservice activities that we do not believe typically preclude equipment items from being used in furnishing services to other patients because these activities typically occur in other rooms.

The equipment times allocated to the CPT codes in Table 25 already include the full intraservice time the equipment is typically used in furnishing the service, plus additional minutes to reflect time that the equipment is unavailable for use in furnishing services to other patients.

TABLE 25—EQUIPMENT INPUTS THAT INCLUDE APPROPRIATE CLINICAL LABOR TASKS ABOUT WHICH COMMENTS WERE RECEIVED

CPT code	Equipment items
50590	EQ175.
52214	all items.
52224	all items.
72040	EL012.
72050	EL012.
72052	EL012.
72192	EL007.
72193	EL007.
72194	EL007.
73221	EL008.
73721	EL008.
74150	EL007.
74160	EL007.
74170	EL007.
74175	EL007.
74177	EL007.
74178	EL007.
77301	ER005.
78012	ER063.
78013	ER032.
78014	EF010, ER063.
78070	ER032.
78071	ER032.
93925	EL016.
93926	EL016.
93970	EL016.

Comment: Some commenters stated that selected items added to various CPT codes during clinical review by CMS were not typical. In Table 26, we list those services and items identified by commenters as atypical for the service. For each of these items, we note whether we maintained our refinement or removed the input based on commenter recommendation. In general,

we have accepted the comments to remove the items, except when we believed that doing so would deviate from our standard policies. Specifically, as we discuss above, we are maintaining standard times for clinical labor tasks; these include 10 minutes for "clean surgical instrument package" for CPT codes 11301–11313, the time for "Assist physician in performing procedure" to conform to physician time for CPT code 13150, and the equipment minutes used exclusively for the patient for "lane, screening (oph)" (EL006) for CPT codes 92081, 92082, and 92083.

TABLE 26—ITEMS IDENTIFIED AS NOT TYPICAL BY COMMENTERS

CPT code/ code range	CMS code	CMS code description	Labor activity (if applicable)	AMA RUC recommendation	CMS refinement	Commenter recommendation	CMS decision/ rationale
11301–11313	L037D	RN/LPN/MTA	Clean Surgical Instrument Package.	1	10	1	Maintain refinement/Standard Time.
13150	L037D	RN/LPN/MTA	Assist physician in performing procedure.	20	26	20	Maintain refinement/Standard Time.
32554	SA067	tray, shave prep		0	1	0	Removed.
	SB001	cap, surgical		0	2	0	Removed.
	SB039	shoe covers, surgical.		0	2	0	Removed.
32556	SA044	pack, moderate sedation.		0	1	0	Removed.
	SA067	tray, shave prep		0	1	0	Removed.
	SB001	cap, surgical		0	2	0	Removed.
	SB039	shoe covers, surgical.		0	2	0	Removed.
	SC010	closed flush system, angiography.		0	1	0	Removed.
	SH065	sodium chloride 0.9% flush syringe.		0	1	0	Removed.
	SH069	sodium chloride 0.9% irrigation (500–1000 ml uou).		0	1	0	Removed.
32557	SB027	gown, staff, impervious.		0	1	0	Removed.
	SG078	tape, surgical occlusive 1 in (Blenderm).		0	25	0	Removed.
67810	SB011	drape, sterile, fenestrated 16 in × 29 in.		0	1	0	Removed.
72192	SK076	slide sleeve (photo slides).		0	1	0	Removed.
	SK098	film, x-ray, laser print.		0	8	4	Removed.
72193	SH065	sodium chloride 0.9% flush syringe.		0	15	1	Removed.
	SK076	slide sleeve (photo slides).		0	1	0	Removed.
74150	SK076	slide sleeve (photo slides).		0	1	0	Removed.
	SK098	film, x-ray, laser print.		0	8	4	Removed.
74160	SH065	sodium chloride 0.9% flush syringe.		0	15	1	Removed.
74170	SH065	sodium chloride 0.9% flush syringe.		0	15	1	Removed.
92081	EL006	lane, screening (oph).		12	17	12	Maintain refinement/Standard Time.
92082	EL006	lane, screening (oph).		22	27	22	Maintain refinement/Standard Time.
92083	EL006	lane, screening (oph).		32	37	32	Maintain refinement/Standard Time.

TABLE 26—ITEMS IDENTIFIED AS NOT TYPICAL BY COMMENTERS—Continued

CPT code/ code range	CMS code	CMS code description	Labor activity (if applicable)	AMA RUC recommendation	CMS refinement	Commenter recommendation	CMS decision/ rationale
93017	L051A	RN	Complete diagnostic forms, lab & X-ray requisitions.	0	4	0	Removed.

(2) Integumentary System: Skin, Subcutaneous, and Accessory Structures (CPT Codes 11300, 11301, 11302, 11303, 11305, 11306, 11307, 11308, 11310, 11311, 11312, 11313)

In establishing interim final direct PE inputs for CY 2013, CMS refined the AMA RUC's recommendation for CPT codes 11300 (Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.5 cm or less), 11301 (Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.6 to 1.0 cm), 11302 (Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 1.1 to 2.0 cm), 11303 (Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter over 2.0 cm), 11305 (Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less), 11306 (Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm), 11307 (Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm), 11308 (Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter over 2.0 cm), 11310 (Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less), 11311 (Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm), 11312 (Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm), and 11313 (Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 2.0 cm) by removing "electrocautery-hyfrecator, up to 45 watts" (EQ110), and "cover, probe (cryosurgery)" (SB003), among other refinements.

Comment: Commenters noted that there is an "inherent and persistent risk of bleeding" during these procedures, and that the electrocautery-hyfrecator needs to be readily available to prevent excessive blood loss and is typically included in the surgical field. These commenters explained that the item, "cover, probe (cryosurgery)" is the generic sterile sheath that covers the electrocautery-hyfrecator pen-handle and cable, and therefore required to be used with the electrocautery-hyfrecator.

Response: In our clinical review, we reviewed the work vignettes for these procedures, which did not include the use of the electrocautery-hyfrecator as a part of the procedure. Although we acknowledge that the electrocautery-hyfrecator needs to be readily available during the procedure, we note that "standby" equipment, or items that are not used in the typical case, are considered indirect costs. For further discussion of this issue, we refer readers to our discussion of "standby" equipment in the CY 2001 PFS proposed rule (65 FR 44187). With regard to the "cover, probe (cryosurgery)", this item is a disposable supply that would only be used with each patient if the electrocautery-hyfrecator is in the sterile field during all procedures. We do not have information to suggest that the electrocautery-hyfrecator is typically in the sterile field, so we are not including the supply item "cover, probe (cryosurgery)" in the direct PE database for this service. After consideration of the comments received, we are finalizing the CY 2013 interim final direct PE inputs for 11300–11313 as established.

(3) Integumentary System: Repair (Closure) (CPT Codes 13100, 13101, 13102, 13120, 13121, 13122, 13131, 13132, 13133, 13152, and 13153)

In establishing interim final direct PE inputs for CY 2013, CMS refined the AMA RUC's recommendations for CPT codes 13100 (Repair, complex, trunk; 1.1 cm to 2.5 cm), 13101 (Repair, complex, trunk; 2.6 cm to 7.5 cm), 13102 (Repair, complex, trunk; each additional 5 cm or less (list separately in addition to code for primary procedure)), 13120 (Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm), 13121 (Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm), 13122 (Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less (list separately in addition to code for primary procedure)), 13131 (Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm), 13132 (Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm), 13133 (Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less (list separately in addition to code for primary procedure)), 13150 (Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less), 13151 (Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm), 13152 (Repair, complex, eyelids, nose, ears and/or lips; 2.6 cm to 7.5 cm), and 13153 (Repair, complex, eyelids, nose, ears and/or lips; each additional 5 cm or less (list separately in addition to code for primary procedure)) by removing duplicative items, among other refinements.

Comment: A few commenters argued that the majority of procedures reported using CPT codes 13100, 13101, 13120, 13121, 13131, 13132, 13150, 13151, and 13153 are furnished under local anesthesia, delivered by subcutaneous injection, and therefore typically require "needle, 18–27g" (SC029). Commenters also pointed out that the second "gown, staff, impervious" (SB027) and "mask, surgical" (SB033) are not duplicative, but required, because an assistant at surgery is allowed for these surgeries in some cases, and OSHA requirements mandate that health care workers be protected from blood exposure. Commenters stated that they did not believe these procedures could be furnished without these inputs.

Response: Based on the rationale provided by commenters, we agree that the needle should be included as a direct PE input for this family of codes. However, we continue to believe that a second gown and mask are not typical because our claims data show that an assistant at surgery is rarely, if ever, used for these services.

After consideration of the comments received, we are finalizing the CY 2013 interim final direct PE inputs for 13100–13153 with the additional refinement of incorporating the "needle, 18–27g"

(SC029) as recommended by commenters.

(4) Integumentary System: Nails (CPT Code 11719)

In establishing interim final direct PE inputs for CY 2013, we refined the AMA RUC recommendation for CPT code 11719 by adjusting the times allocated for clinical labor tasks as follows: "Provide preservice education/obtain consent" from 2 minutes to 1 minute, "Greet patient, provide gowning, assure appropriate medical records are available" from 3 minutes to 1 minute, "Prepare room, equipment, supplies" from 2 minutes to 1 minute, and "Clean room/equipment by physician staff" from 3 minutes to 1 minute, among other refinements.

Comment: A commenter objected to our refinements to this clinical labor task, and argued that one minute of "provide preservice education/obtain consent" is inadequate to review the advanced beneficiary notice (ABN) and answer patient questions. This commenter also objected to our decreasing the number of minutes associated with the other clinical labor activities to below the AMA–RUC recommended standard minutes.

Response: We believe that the time assigned to "provide preservice education/obtain consent" appropriately reflects the resources required in furnishing the typical procedure and thus are not making the change requested, particularly since five minutes of preservice physician time are also included for the service. We also would not expect an ABN to be provided in the typical case. We agree with commenters that we should allocate the standard number of minutes for the remaining clinical labor activities and have adjusted the direct PE database accordingly.

Comment: One commenter suggested that it was typical to position a patient in a power table/chair in lieu of an exam table when furnishing this service.

Response: CMS clinical staff reviewed CPT code 11719 in the context of this comment. We do not believe that it is typical that a power table/chair would be used for these procedures. After considering the comments received, we are finalizing the CY 2013 interim final direct PE inputs for CPT code 11719 as established, with the exception of increasing the minutes assigned to clinical labor activities to the standard number of minutes.

(5) Arthrocentesis (CPT Codes 20600, 20605, 20610)

In establishing direct PE inputs for CY 2013, we refined the AMA RUC's recommendations for CPT codes 20600 (Arthrocentesis, aspiration and/or injection; small joint or bursa (eg, fingers, toes), 20605 (Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)), and 20610 (Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa)) by removing the minutes associated with the clinical labor activity "discharge day management" and replacing these minutes with "conduct phone calls/call in prescriptions" in the facility setting.

Comment: Commenters requested clarification as to whether the time allocated for "conduct phone calls/call in prescriptions" is limited to the facility setting or is also included in the non-facility setting.

Response: The AMA RUC recommendation included "conduct phone calls/call in prescriptions" in the nonfacility setting and we did not refine this recommendation. Therefore, this activity is included in the inputs for the nonfacility setting as well.

Comment: One commenter suggested it was typical for a physician to position a patient in a power table/chair in lieu of an exam table when furnishing 20600 and 20605.

Response: Our clinical staff reviewed CPT codes 20600 and 20605 in the context of this comment. We do not believe that it is typical that a power table/chair would be used for these procedures. After considering the comments received, we are finalizing the CY 2013 interim final direct PE inputs for CPT codes 20600, 20605, and 20610 as established.

(6) Respiratory System: Accessory Sinuses (CPT Code 31231)

In establishing interim final direct PE inputs for CY 2013, we refined the AMA RUC's recommendation for CPT code 31231 (Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)) by removing the second "endoscope, rigid, sinoscopy" (ES013) from the inputs for the service, refining the equipment time to reflect typical use exclusive to the patient, and removing the time allocated to preservice clinical labor tasks, among other refinements.

Comment: A commenter disagreed with our removal of the second endoscope, arguing that the second scope is medically necessary because the first scope (zero degree rigid scope) does not allow visualizing above or behind all the normal structures of the nasal vault such as superior turbinate and the frontal recess. The second scope (for example, a 30, 45 or 70 degree scope) is used more than 51 percent of the time.

Response: We agree with the commenter that the second scope is used in the typical case, and based on this comment; we are adding the second scope to the direct PE inputs for the service.

Comment: A commenter disagreed with our refinements to the equipment time for this service, and stated that the entire clinical labor service period time of 63 minutes, and at a minimum, 43 minutes, should be allocated to all equipment used in this procedure.

Response: In general, for equipment that we do not consider to be highly technical, we allocate the entire service period time, with the exception of the time allocated for cleaning of other, portable pieces of equipment. Therefore, we agree with the commenter that the equipment times should be modified, but do not agree with the commenter that 63 minutes should be allocated. Instead, we are modifying the time allocated for the equipment in this procedure by assigning 53 minutes to the instrument pack to reflect the intraservice time other than cleaning of the scopes, 48 minutes to the scopes to reflect the intraservice time other than the cleaning of the instrument pack, and 38 minutes to the remaining equipment items, which reflects the entire intraservice clinical labor time except for the time allocated for cleaning the portable equipment items instrument pack and scope.

Comment: Commenters argued that the preservice clinical labor tasks included in the RUC recommendation should have been maintained in this procedure.

Response: This procedure is typically billed with an E/M service, and the preservice tasks are already included as direct PE inputs for the E/M services. Therefore, we believe that including these items again in CPT 31231 would be duplicative.

After consideration of public comments, we are finalizing the CY 2013 interim final direct PE inputs for 31231 as established with the additional refinements of adding in the second scope as an equipment item and adjusting the equipment times as discussed above.

(7) Respiratory System: Lungs and Pleura (CPT Codes 32554, 32555, and 32557)

In establishing interim final direct PE inputs for CY 2013, we refined the AMA RUC's recommendation for CPT codes 32554 (Removal of fluid from chest cavity), 32555 (Removal of fluid from

chest cavity with imaging guidance), and 32557 (Removal of fluid from chest cavity with insertion of indwelling catheter and imaging guidance), by inserting supply item "kit, pleural catheter insertion" (SA077) and refining the equipment times to reflect the typical use exclusive to the patient.

Comment: Commenters indicated that a tunneled catheter is not used during this procedure, so that the pleural catheter insertion kit is not an accurate supply item to use as the thoracentesis kit (SA113). The commenter also pointed out that the price of the thoracentesis kit that appears in the direct PE input database appeared to be inaccurately priced at $260.59. The commenter pointed out that the price listed in the database reflects an invoice that includes ten units, so that the accurate price for the items is $26.06.

Response: Based on the information provided by commenters, we agree that supply item "Kit, thoracentesis" (SA113) would be more appropriate than "kit, pleural catheter insertion" (SA077) and we agree that the correct price for the item is $26.06. We have updated this price in the direct PE input database accordingly.

Comment: Commenters stated that the time allocated to equipment items "room, ultrasound, general" (EL015) and "room, CT" (EL007), as well as "light, exam" (EQ168) should reflect the time for tasks during which the room is not available to other patients; specifically, for CPT code 32555, 33 minutes should be assigned to EL015, and for CPT code 32557, 45 minutes should be assigned to EL007 and EQ168.

Response: We agree with commenters that it is consistent with our stated policy to allocate time for highly technical equipment for preparing the room, positioning the patient, acquiring images, and cleaning the room. Therefore, for CPT code 32555, we are assigning 33 minutes to "room, ultrasound, general" (EL015), and for CPT code 32557, we are assigning 45 minutes to "room, CT" (EL007) and "light, exam" (EQ168).

After reviewing the public comments received, we are finalizing the CY 2013 interim final direct PE inputs for CPT codes 32554, 32555, and 32557 as established with the additional refinements of including and updating the price of the "kit, thoracentesis" (SA113) supply item and adjusting the equipment times as commenters recommended.

(8) Cardiovascular System: Heart and Pericardium (CPT Codes 33361, 33362, 33363, 33364, 33365, and 33405)

In establishing interim final direct PE inputs for CY 2013, we refined the AMA RUC's recommendation for CPT codes 33361, 33362, 33363, 33364, and 33365 by refining the time allocated to clinical labor tasks in the preservice and postservice periods to be consistent with the standards for adjusted 000-day global services.

Comment: Commenters stated that these services are furnished in a facility setting, requiring a fully equipped operating room or hybrid suite. The commenter detailed the various clinical labor tasks that are needed for these procedures, and noted that the requirements are similar to those of 90-day global procedures.

Response: We agree with commenters that it would be appropriate to allocate the standard 90-day global clinical labor inputs for these services. After consideration of public comments, we are finalizing the CY 2013 interim final direct PE inputs for CPT codes 33361–33365 as established, with the additional refinement of replacing the current times for clinical labor tasks with those of the standard 90-day global inputs.

We also refined the direct PE inputs for CPT code 33405 by removing the clinical labor activity, "Additional coordination between multiple specialties for complex procedures (tests, meds, scheduling, etc.) prior to patient arrival at site of service."

Comment: A commenter stated that inclusion of the time allocated for this additional coordination activity is consistent with other major surgical procedures, and that removing it would create an anomaly with other cardiac procedures.

Response: We do not agree that it is appropriate to include these "additional coordination" tasks as inputs to this procedure. We thank the commenter for bringing to our attention the potential anomaly created by having this activity included in other procedures and will consider any relativity issues regarding clinical labor preservice minutes allocated for other procedures in future rulemaking. After consideration of the comments received, we are finalizing the CY 2013 direct PE inputs for CPT code 33405 as established.

(9) Cardiovascular System: Arteries and Veins (CPT Codes 36221, 36222, 36223, 36224, 36225, 36226, 36227, 36228, and 37197)

In establishing interim final direct PE inputs for CY 2013, we refined the AMA RUC's recommendation for CPT codes 36221 (Insertion of catheter into chest aorta for diagnosis or treatment), 36222 (Insertion of catheter into neck artery for diagnosis or treatment), 36223 (Insertion of catheter into neck artery for diagnosis or treatment), 36224 (Insertion of catheter into neck artery for diagnosis or treatment), 36225 (Insertion of catheter into chest artery for diagnosis or treatment), 36226 (Insertion of catheter into chest artery for diagnosis or treatment), and 36227 (Insertion of catheter into neck artery for diagnosis or treatment) by substituting equipment item "table, instrument, mobile" (EF027) for equipment item "Stretcher" (EF018), refining equipment time to reflect typical use exclusive to the patient for equipment items "room, angiography" (EL011), "contrast media warmer" (EQ088), and "film alternator (motorized film viewbox)" (ER029), and removing the recommended minutes based on the clinical labor task described as "image post processing" from CPT code 36221, among other refinements.

Comment: Commenters stated that they believed that the removal of the stretcher was an error because a stretcher is necessary for these cerebral angiography codes and requested that the stretcher be included as an input for these procedures.

Response: We do not agree with commenters that it is appropriate to include a stretcher for this family of codes. The inclusion of a stretcher is not consistent with the AMA RUC-recommended standardized nonfacility direct PE inputs that account for moderate sedation as typically furnished as a part of such service, which we used as the basis for proposing and finalizing a standard package of direct PE inputs for moderate sedation during CY 2012 rulemaking. For further discussion of this issue, we refer readers to the CY 2012 PFS rule (76 FR 73044).

Comment: Commenters stated the CMS refinement for equipment minutes was inappropriate, and that the equipment time for "room, angiography" (EL011), "contrast media warmer" (EQ088), and "film alternator (motorized film viewbox)" (ER029) should include the clinical labor tasks of "prepare room," "prepare and position patient," "sedate patient," "assist physician/acquire images," and "clean room." Specifically, commenters requested that we adjust the time for all equipment items as follows: 49 minutes for CPT code 36221, 59 minutes for CPT code 36222, 64 minutes for CPT code 36223, 69 minutes for CPT code 36224,

64 minutes for CPT code 36225, and 69 minutes for CPT code 36226.

Response: We agree with commenters that the time allocated to the equipment should account for these tasks. We are adjusting the equipment times for "room, angiography" (EL011), "contrast media warmer" (EQ088), and "film alternator (motorized film viewbox)" (ER029) to those identified by the commenters and described above.

Comment: A commenter noted that "image post processing" often appears as a clinical labor task activity on the PE worksheet and that the task is integral to patient care for the services described by these codes. Commenters requested that we include these clinical labor tasks for these procedures.

Response: Upon further review of similar codes, we agree with the commenter that it is consistent with other services in this family to include clinical labor minutes based on the "image post processing" task. After consideration of public comments, we are finalizing the CY 2013 interim final direct PE inputs for CPT codes 36221–36227 as established with the additional refinements of the adjusted equipment and clinical labor times noted above.

We also refined the AMA RUC's recommendation for direct PE inputs for CPT code 36228 (Insertion of catheter into neck artery for diagnosis or treatment) by removing 1 minute of clinical labor time, based on the task called "prepare room, equipment, and supplies," and 1 minute for "assisting with fluoroscopy/image acquisition." We also refined the recommendation by not including the supply item "syringe, 5–6 ml" (SC075).

Comment: Commenters stated that the additional minute for "prepare room, equipment, and supplies" is necessary for this add-on code. They also requested that we adjust the time for acquiring images as well. Commenters also stated that the syringe is necessary to safely inject micro-catheters and should be included.

Response: We do not agree with commenters that an additional minute should be added to the clinical labor time for this add-on code to account for additional time to "prepare the room, equipment, and supplies." As we stated in the CY 2013 PFS final rule with comment period (77 FR 68933), we believe that preparing the room would not typically be duplicated when furnishing a subsequent procedure to the same patient on the same day, and we believe that the standard number of minutes allocated on the basis of the clinical labor task accounts for the typical amount time spent preparing the items for the primary procedure, regardless of whether or not a separate code is reported for some cases. However, based on the commenters' explanation, we agree that an additional minute for image acquisition is typical when the add-on code is reported. We also agree that the syringe is necessary for this procedure.

After reviewing public comments received, we are finalizing the CY 2013 direct PE inputs for CPT code 36228 as established with the additional refinements to the clinical labor and supply items noted above.

In establishing interim final direct PE inputs for CY 2013, we refined the AMA RUC's recommendation for CPT code 37197 (Retrieval of intravascular foreign body) by removing equipment items "ultrasound unit, portable" (EQ250) and "contrast media warmer" (EQ088), and supply items "sheath-cover, sterile, 96in x 6in (transducer)" (SB048), "catheter, (Glide)" (SD147), "guidewire, Amplatz wire 260 cm" (SD252), and "sodium chloride 0.9% flush syringe" (SH065).

Comment: Commenters indicated that the portable ultrasound unit is necessary to gain vascular access, the contrast media warmer is necessary for the procedure, and the supply items we refined from the AMA RUC recommendation are also required for the procedures since the foreign body cannot be removed without these items.

Response: We do not agree that the portable ultrasound unit should be included as a direct PE input for this procedure. The CPT description of this code states that either fluoroscopy or ultrasound is used; the angiography room accounts for the resources associated with fluoroscopy. When fluoroscopy is used, these resources are appropriately accounted for. In the event that a portable ultrasound unit is used in place of fluoroscopy, the resource costs would be significantly overestimated, since a portable ultrasound unit is far less expensive than the angiography room. Therefore, we continue to believe that the PE inputs adequately account for the resource costs used for imaging in this procedure. We also continue to believe that the supply items we refined from the AMA RUC recommendation are duplicative since the inputs for this service already include supply items that are used for removing the foreign body during the procedure. We agree with commenters that the contrast media warmer should be included in the procedure, and are including this equipment item as a direct PE input for this service.

After consideration of these comments, we are finalizing the CY 2013 interim final direct PE inputs for CPT code 37197 as established with the additional refinement of adding the equipment item "contrast media warmer" (EQ088), as noted above.

(10) Digestive System: Intestines (Except Rectum) (CPT Code 44705 and HCPCS Code G0455)

In establishing interim final direct PE inputs for CY 2013, CMS crosswalked the inputs from 44705 (Prepare fecal microbiota for instillation, including assessment of donor specimen) to G0455 (Preparation with instillation of fecal microbiota by any method, including assessment of donor specimen), and incorporated a minimum multi-specialty visit pack (SA048) and an additional 17 minutes of clinical labor time in the service period based on the amount of time allocated for clinical labor tasks in the direct PE inputs for E/M services. In the CY 2013 final rule with comment period, we noted that Medicare would only pay for the preparation of the donor specimen if the specimen is ultimately used for the treatment of a beneficiary. Accordingly, we bundled preparation and instillation into a HCPCS code, G0455, to be used for Medicare beneficiaries instead of the new CPT code 44705 (Preparation of fecal microbiota for instillation, including assessment of donor specimen), which we assigned a PFS procedure status indicator of I (Not valid for Medicare purposes). G0455 includes both the work of preparation and instillation of the microbiota.

Comment: A commenter asserted that CMS listed G0455 as having a PE RVU of 2.48 without explaining how this value was derived.

Response: In the CY 2013 PFS final rule with comment period (77 FR 69073), we described how we established the direct PE inputs for G0455. Specifically, we stated that we used the AMA RUC-recommended nonfacility PE inputs for CPT code 44705, in addition to 17 minutes of clinical labor time and a "minimum multi-specialty visit pack" (SA048), to account for both the preparation and instillation. The PE RVU of 2.48 results from the standard methodology outlined in PFS rules in the section entitled "Resource-Based Practice Expense (PE) Relative Value Units (RVUs)" (see, for example, 77 FR 68899). After consideration of the public comment, we are finalizing the interim final direct PE inputs for HCPCS code G0455 as established.

(11) Digestive System: Biliary Tract (CPT Codes 47600 and 47605)

In establishing interim final direct PE inputs for CY 2013, we refined the AMA

RUC's recommendation for CPT codes 47600 (Removal of gallbladder) and 47605 (Removal of gallbladder with X-ray study of bile ducts) by replacing the supply item "pack, post-op incision care (suture & staple)" (SA053) with supply item "pack, post-op incision care (suture)" (SA054).

Comment: Commenters stated that although sutures and staples are sometimes both used, at a minimum, staples are used in this procedure. Therefore, commenters requested that, as a minimum, we include the staple removal pack.

Response: We agree with the commenters that the staple removal pack (SA052) should be included instead of the suture pack. After consideration of these comments, we are finalizing the CY 2013 interim final direct PE inputs for CPT codes 47600 and 47605 as established, with the additional refinement of substituting the staple removal pack (SA052) for the suture removal pack (SA054).

(12) Urinary System: Bladder (CPT Codes 52214, 52224, and 52287)

In establishing the interim final direct practice expense inputs for CY 2013 for CPT code 52214, we refined the AMA RUC recommendation to remove supply items "drape-towel, sterile, 18in × 26in" (SB019)," "lidocaine 1%–2% inj (Xylocaine)" (SH047), and "penis clamp."

Comment: Commenters indicated that the supply item "drape-towel, sterile, 18in x 26in," is used on the instrument table and that the supply item "lidocaine 1%–2% inj (Xylocaine)" (SH047), is used to instill into the bladder as a numbing agent. Commenters also indicated that the item "penis clamp" is required to keep the lidocaine in the penile urethra.

Response: We agree with commenters that the drape towel and lidocaine should be included in this procedure. However, we do not agree that the reusable penis clamp, even when typically used, should be included in the direct PE input database for this procedure. Since the item is reusable, the resource cost associated with the item is not considered to be a direct PE supply input. Given the price associated with the item, the cost per minute over several years of useful life becomes negligible relative to the other costs accounted for in the PE methodology. We refer readers to a discussion of equipment items under $500 in the NPRM for CY 2005 (69 FR 47494). We note that including such items as equipment in the direct PE input database would not impact the PE RVU values.

In establishing the interim final direct practice expense inputs for CY 2013, we refined the AMA RUC recommendation for CPT code 52224 by adjusting the equipment time for "fiberscope, flexible, cystoscopy" (ES018) to 94 minutes, adjusting the clinical labor activity "prepare biopsy specimen" to 2 minutes, and adjusting the quantity of the supply item "gloves, sterile" (SB024) to 1 pair, and "cup, biopsy-specimen sterile 4oz" (SL036) to 3, among other refinements.

Comment: Commenters stated that the time for this equipment item should include all standard tasks, in addition to the cleaning of the scope. Commenters also noted that, depending upon the number of biopsies, the preparation of the specimen can take more than 2 minutes, that a minimum of 3 pairs of gloves are required, and that biopsy specimens are submitted in several containers.

Response: We re-examined the time for the fiberscope and agree with commenters that the time should include all time associated with standard tasks and cleaning the scope. We are therefore adjusting the time for this equipment item to 97 minutes. We continue to believe that 2 minutes represents the typical time required to prepare the specimen and are not adjusting the time. We agree with commenters that more than 1 pair of gloves may be required; however, since a biopsy is not required in all cases, we believe that 2 pairs of gloves accounts for the resources used in furnishing the typical service. Finally, we continue to believe that 3 containers represent the typical resources used in furnishing this procedure given the small size of the lesions. After considering the comments received, we are finalizing the CY 2013 interim final direct PE inputs for CPT code 52224 as established with the additional refinement of adjusting the equipment time to account for cleaning the scope, and adding one pair of gloves, as noted above.

In establishing interim final direct PE inputs for CY 2013, we refined the AMA RUC's recommendation for CPT code 52287 by adjusting the time for the clinical labor activity "assist physician in performing procedure" from 20 minutes to 21 minutes to conform to the physician intraservice time, and refining the equipment time to reflect the typical use exclusive to the patient.

Comment: The AMA RUC stated that its original submission to CMS contained 21 minutes for this clinical labor activity. Another commenter noted that the times allocated to preservice clinical labor tasks were missing in the nonfacility setting. Another commenter stated that the equipment time should include the time for all of the standard clinical labor tasks.

Response: We note that the AMA RUC and CMS agree on the appropriate number of minutes to assign to the clinical labor service period to account for "assist physician." Regarding the preservice clinical labor tasks, we note that the AMA RUC did not recommend preservice clinical labor time for these tasks in the nonfacility setting, and that such inputs are not standard for 000-day global services. With respect to equipment time, we agree with commenters that the equipment time for all equipment in this procedure should include time for all of the standard clinical labor tasks, with the exception of the time allocated for cleaning of the scope. The times for the equipment items included in CPT code 52287 already include all of these tasks, with the exception of "fiberscope, flexible, cystoscopy" (ES018). We are adjusting time for the scope from 76 to 78 minutes to align the equipment time with that of the standard clinical labor tasks.

After considering the comments received, we are finalizing the CY 2013 interim final direct PE inputs for CPT code 52287 as established with the additional refinement of adjusting the equipment time as noted above.

(13) Transurethral Destruction of Prostate Tissue (CPT Code 53850)

In establishing interim final direct PE inputs for CY 2013, we refined the AMA RUC's recommendation for CPT code 53850 by refining equipment time to reflect typical use exclusive to the patient.

Comment: A commenter stated that the equipment time should include the time for all of the standard clinical labor tasks.

Response: We agree with the commenter that the equipment time for all equipment in this procedure should include time for all of the standard clinical labor tasks, and we are allocating the entire service period of 99 minutes for "stretcher, endoscopy" (EF020), "table, instrument, mobile" (EF027), "TUMT system control unit" (EQ037), and "ultrasound unit, portable" (EQ250), which are used during the service period only. In addition, we are allocating 169 minutes for items used during both the service period and postservice period, which are "table, power" (EF031) and "light, exam" (EQ168), to account for both the service period and postservice period.

We also refined the AMA recommendation for this code by not assigning additional clinical labor

minutes for non-standard clinical labor tasks described as "setup ultrasound probe," "setup TUMT machine," and "clean TUMT machine."

Comment: The same commenter also stated that the clinical labor tasks were necessary because extra time was required.

Response: We do not agree that the time for these clinical labor tasks is reflective of typical resource costs involved in furnishing the service. For this procedure the assigned clinical labor time already includes the standard number of minutes for set-up and clean-up, and the commenter provided no information justifying a deviation from these standard times for this procedure.

Comment: A commenter stated that there is no preservice clinical staff time assigned for the nonfacility, and that the clinical labor time should account for tasks such as "setting up the room," "greeting patient," and "position patient prior to the procedure."

Response: The clinical labor tasks referred to by the commenter are tasks generally included in service period activities; the preservice clinical staff time that is included when the procedure is done in the facility includes scheduling and coordination services that are unique to procedures furnished in facility settings. The service period time for this procedure includes minutes allocated for clinical labor tasks such as "greet patient," "provide gowning," "ensure appropriate medical records are available," and "prepare and position patient." Therefore, we are not making a change at this time and are finalizing the CY 2013 interim final direct PE inputs for CPT code 53850, including the clinical labor tasks, as established.

(14) Nervous System: Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System (CPT Code 64615)

In establishing interim final direct PE inputs for CY 2013, we accepted the AMA RUC's recommendation for CPT code 64615 (Injection of chemical for destruction of facial and neck nerve muscles).

Comment: A commenter questioned why this service had only 3 minutes of postservice clinical labor time, while other codes in the family have 27 or 30 minutes.

Response: The apparent discrepancy between CPT code 64615 and the other codes in the family results because CPT 64615 does not have any post-operative visits in the global period while the other codes in the family have post-operative visits. Specifically, the 30 minutes of postservice clinical labor time in 64612 are allocated specifically for the post-operative visits. After consideration of public comment, we are finalizing the CY 2013 interim final direct PE inputs for CPT code 64615 as established.

(15) Diagnostic Radiology: Abdomen and Pelvis (CPT Codes 72191, 72192, 72193, 72194, 74150, 74160, 74170, 74175, 74176, 74177, 74178)

In establishing interim final direct PE inputs for CY 2013, we reviewed the direct PE inputs for all of the abdomen, pelvis, and abdomen/pelvis combined CT codes. For each set of codes, we established a common set of disposable supplies and medical equipment. We established clinical labor minutes that reflect the fundamental assumption that the component codes should include a base number of minutes for particular tasks, and that the number of minutes in the combined codes should reflect efficiencies that occur when the regions are examined together. Among other refinements, we adjusted the intraservice time for CPT codes 72194, 74160, and 74177 by 2 minutes, 4 minutes, and 6 minutes respectively.

Comment: Commenters stated that more information was required about from where CMS decreased the minutes from the service period for CPT codes 72194, 74160, and 74177.

Response: We refined the minutes in the service period such that the aggregate number of clinical labor minutes reflected in the direct PE input database and used to develop PE RVUs was consistent within this family of codes. We believe that the aggregate clinical labor time in each clinical service period (preservice period, service period, and postservice period) or aggregate number of minutes for particular equipment items that reflects the total typical resource use is more important than the minutes associated with each clinical labor task, which are a tool used by the AMA RUC to develop their recommendations. We hope that in reviewing future services, commenters consider the aggregate clinical labor time as well, recognizing that it is the aggregate time that ultimately has implications for payment. Finally, we welcome comments that address the appropriateness of the number of clinical labor minutes in each service period and the number of equipment minutes for each service.

In this refinement process, we also removed supply item "needle, 18–27g" (SC029) and replaced it with "needle, 14–20g, biopsy" (SC025) for CPT codes 72193, 72194, 74160, and 74170.

Comment: Commenters stated that the biopsy needle (SC025) was not appropriate for these services, and that supply item "needle, 18–27g" (SC029) would be more appropriate. In addition, commenters noted that the "film processor" (ED024) is in use during a portion of the service.

Response: We agree with commenters that the "needle, 18–28g" (SC029) is more appropriate for these services, and that the film processor should be included for these codes. We are adjusting the direct PE inputs to include the needle and film processor in CPT codes 72193, 72194, 74160, and 74170.

In refining the direct PE inputs, we also substituted a radiologic technologist for a CT technologist for CPT codes 72191 and 74175, and removed the clinical labor time for "Retrieve prior appropriate imaging exams and hang for MD review, verify orders, review the chart to incorporate relevant clinical information" from 72191, 74170, and 74175.

Comment: Commenters stated that a CT technologist was the typical clinical labor type for these CT procedures. Commenters also objected to the removal of recommended minutes based on the clinical labor activity "Retrieve prior appropriate imaging exams and hang for MD review, verify orders, review the chart to incorporate relevant clinical information" from CPT codes 72191, 74170, and 74175, and to the reduction of preservice and intraservice clinical labor time in this family of codes.

Response: Based on the information provided by commenters, we agree that CPT codes 72191 and 74175 should include a CT technologist rather than a radiologic technologist for CPT codes 72191 and 74175 because the CT technologist is typical. However, we do not agree that the clinical labor time should be changed per the commenters' request, as we continue to believe that these tasks are already captured in the preservice clinical labor time. We refer readers to the CY 2013 PFS final rule with comment period (77 FR 69073) for a discussion of the development of a standard allocation of inputs for these families of codes.

For CPT code 72191, we refined the time for equipment item "room, CT" (EL007) to 40 minutes.

Comment: Commenters stated that the CT room time for should be at least 43 minutes to include time for cleaning the room.

Response: We agree with commenters that the time for the CT room should be 43 minutes to include the standard clinical labor tasks for highly technical equipment, including cleaning the room.

After considering the comments received, we are finalizing the CY 2013 interim final direct PE inputs for CPT codes 72193, 72194, 73221, 73721, 74150, 74160, 74170, 74175, 74176, and 74177 as established with the additional refinements of the supply item, changes to clinical labor staff type, and equipment time noted above.

(16) Diagnostic Ultrasound: Transvaginal and Transrectal Ultrasound (CPT Codes 76830 and 76872)

In establishing interim final direct PE inputs for CY 2013, we refined the AMA RUC's recommendation for CPT code 76830 by removing the equipment item "room, ultrasound, general" (EL015) and replacing it with individual items including a portable ultrasound unit.

Comment: A commenter noted that a panel of obstetrician/gynecologists, a specialty that frequently furnishes this service, indicated that a dedicated ultrasound room was used.

Response: Based on the comments we received, we agree that it would be more appropriate to allocate a general ultrasound room for this procedure rather than a portable ultrasound unit and accompanying items. We are including the ultrasound room as a direct PE input for CPT code 76830.

In refining the inputs for CPT code 76830, we also removed "film alternator (motorized film viewbox)" (ER029), "Surgilube lubricating jelly" (SJ033), and "film processor, dry, laser" (ED024).

Comment: Another commenter stated that the film alternator and Surgilube lubricating jelly are required; however, the specialty that most frequently furnishes the service stated that they did not use either of these items.

Response: We continue to believe that neither the film alternator nor the lubricating jelly should be included for this service as, and after considering the comments from the specialty that most frequently furnishes the service, we agree that these are not used in the typical case.

After considering the comments received, we are finalizing the CY 2013 interim final direct PE inputs for CPT code 76830 as established with the additional refinement of allocating a general ultrasound room and removing individual inputs related to a portable ultrasound unit.

In establishing interim final direct PE inputs for CY 2013, we refined the AMA RUC's recommendation for CPT code 76872 by adjusting the equipment time to reflect the typical use exclusive to the patient, and removing clinical labor tasks, "obtain vital signs," and "prepare ultrasound probe" from the preservice period; removing "obtain vital signs" from the service period; and removing supply items "drape, sterile, for Mayo stand" (SB012), "iv tubing (extension)" (SC019), "lidocaine 2% jelly, topical (Xylocaine)" (SH048), "alcohol isopropyl 70%" (SJ001), "lubricating jelly (K-Y) (5gm uou)" (SJ032), "glutaraldehyde 3.4% (Cidex, Maxicide, Wavicide)" (SM018), "glutaraldehyde test strips (Cidex, Metrex)" (SM019), and "sanitizing cloth-wipe (surface, instruments, equipment)" (SM022).

Comment: Commenters indicated that the equipment time allocated for this procedure should be 68 minutes to reflect the time that the equipment is unavailable for other patients.

Response: We agree with commenters that the equipment time for all equipment in this procedure should include time for all of the standard clinical labor tasks in the service period, so we are allocating 42 minutes for those equipment items.

Comment: Commenters noted that it is necessary to obtain vital signs prior to the service, and that the supplies were necessary for a variety of purposes outlined in the comment.

Response: We do not agree that it is necessary to obtain vital signs in the preservice period in order to determine if the patient becomes hypotensive during the service period, but agree that obtaining vital signs in the service period is necessary. We note that we have standard setup times for equipment and do not generally allocate separate time for preparing individual pieces of equipment. After considering the information provided by the commenters, we are persuaded that the supplies that were removed are necessary for the procedure. Therefore, we are including 3 additional minutes in the service period and reinstating the supplies that we removed from the procedure in establishing interim final direct PE inputs.

After considering comments received, we are finalizing the CY 2013 interim final direct PE inputs for CPT code 76872 as established with the additional refinement of adjusting equipment time and incorporating supply items as noted above.

(17) Radiation Oncology: Medical Radiation Physics, Dosimetry, Treatment Devices, and Special Services (CPT Code 77301)

In establishing interim final direct PE inputs for CY 2013, we refined the AMA RUC's recommendation for CPT code 77301 by removing equipment item "computer system, record and verify" from the service, adjusting the equipment time for "treatment planning system, IMRT (Corvus w-Peregrine 3D Monte Carlo)" from 376 to 330, among other refinements previously discussed in the context of our discussion of general refinements.

Comment: Commenters indicated that the minutes used for the computer system are not captured elsewhere and should be included in the service, and that there is physician time independent of clinical staff time for the treatment planning system.

Response: The computer system was not previously an input for this service, and the commenter did not provide sufficient information or evidence for us to conclude that there should be a change. We also note that this service has both a technical and professional component; the professional component has no inputs, and the equipment time associated with the physician time is not appropriately placed in the technical component. Thus, the equipment time is allocated for the technical component only.

After considering public comments, we are finalizing the CY 2013 interim final direct PE inputs for CPT code 77301 as established.

(18) Nuclear Medicine: Diagnostic (CPT Code 78072)

In establishing interim final direct PE inputs for CY 2013, we were unable to price the new equipment item "gamma camera system, single-dual head SPECT/CT" for CPT code 78072 (Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT), and concurrently acquired computed tomography (CT) for anatomical localization)) since we did not receive any paid invoices. Because the cost of the item that we were unable to price is disproportionately large relative to the costs reflected by remainder of the recommended direct PE inputs, we contractor priced the technical component of the code for CY 2013, on an interim basis, until the newly recommended equipment item could be appropriately priced.

Comment: A commenter indicated that it would provide necessary documentation so that CMS can establish a price for the new SPECT/CT equipment item associated with CPT code 78072. We received 4 paid invoices for the SPECT/CT equipment.

Response: Out of the four invoices we received, we were only able to use one of them to price the equipment because the other three included training and other costs as part of the overall equipment price. Since training and these other costs are not considered part of the price of the equipment in the

current PE methodology, we are unable to use invoices when these items are not separately priced on the invoice. Based on the invoice that met our criteria, this equipment is priced at $600,272. We are assigning 92 minutes based on our standard allocation for highly technical equipment, to include "prepare room, prepare and position patient, administer radiopharmaceutical, acquire images, complete diagnostic forms, and clean room." After reviewing the comments received, we are establishing interim final direct PE inputs for CPT code 78082 and, rather than contractor price the code as we did in 2013, we are pricing this code under the PFS on an interim final basis for CY 2014.

(19) Pathology and Laboratory: Chemistry (CPT Code 86153)

In establishing interim final direct PE inputs for CY 2013, we refined the AMA RUC's recommendation for CPT code 86153 (Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood)) by valuing the service without direct practice expense inputs.

Comment: Commenters requested that we include direct PE inputs for CPT code 86153, explaining that in the majority of cases, CPT code 86152 is submitted without an accompanying 86153 code. Commenters noted that there are clinical labor tasks furnished by a laboratory technician for this service.

Response: CPT code 86153 is a professional component-only CPT code that is a "clinical laboratory interpretation service," which is one of the current categories of PFS physician pathology services. For this category of services, only services billed with a "26" modifier may be paid under the PFS; the technical component of these services is paid under the Clinical Lab Fee Schedule (CLFS). Generally, under the PFS, RVUs for services billed with a "26" modifier do not include direct PE inputs, since the development of the RVUs for such codes incorporate all associated direct PE inputs in the RVUs for the technical component of the service. When the corresponding laboratory service is billed under the CLFS, the payment accounts for the resource costs involved in furnishing the laboratory service, including the kinds of costs described by the items in the direct PE input database. In addition, we do not believe that it would serve appropriate relativity to include direct PE inputs for professional component services only when the corresponding technical component payment is made through a different Medicare payment system. After consideration of public comment, we are finalizing our CY 2013 interim final valuation of this service as established.

(20) Pathology and Laboratory: Surgical Pathology (CPT Codes 88300, 88302, 88304, 88305, 88307, 88309)

In establishing interim final direct PE inputs for CY 2013, we refined the AMA RUC's recommendation for CPT codes 88300, 88302, 88304, 88305, 88307, and 88309 (Surgical Pathology, Levels I through VI), by not including new supply items "specimen, solvent, and formalin disposal cost," and "courier transportation costs" and new equipment items called "equipment maintenance cost," "Copath System with maintenance contract," and "Copath software." We stated in the CY 2013 final rule with comment period that we would consider additional information from commenters regarding whether the Copath computer system and associated software should be considered a direct cost as medical equipment associated with furnishing the technical component of these surgical pathology services. We stated that we were especially interested in understanding the clinical functionality of the equipment in relation to the services being furnished. We also sought additional public comment regarding the appropriate assumptions regarding the direct PE inputs for these services, as well as independent evidence regarding the appropriate number of blocks to assume as typical for each of these services. We requested public comment regarding the appropriate number of blocks and urged the AMA RUC and interested medical specialty societies to provide corroborating, independent evidence that the number of blocks assumed in the current direct PE input recommendations is typical prior to finalizing the direct PE inputs for these services.

Comment: Commenters generally rejected the notion that the items CMS did not accept for this family of codes are indirect costs and asked for a basis for CMS's statement that disposal costs are accounted for in the indirect PE allocation. A commenter asserted that it is extremely rare for CMS to not accept direct PE inputs recommended by the AMA RUC.

Response: As we noted above and in the CY 2014 PFS proposed rule (78 FR 43292), within the PE methodology all costs other than clinical labor, disposable supplies, and medical equipment are considered indirect costs. We note that we frequently refine direct PE recommendations from the AMA RUC and address these refinements through rulemaking. Below, we respond to the specific statements by commenters regarding particular items not accepted as direct inputs.

Comment: Commenters stated that specimen, solvent, and formalin disposal costs are variable costs that can be allocated to individual specimens, and noted that these costs are not captured in surveys of indirect costs used for the PFS. Commenters asserted that these costs are proportional to the number of specimens processed each day, and are directly attributable to each case by specimen size and the number of tissue blocks associated with that specimen. Commenters pointed to several items in the direct PE database that they believed were anomalous to the specimen, solvent, and formalin disposal costs that we did not accept.

Response: In the CY 2014 PFS proposed rule (78 FR 43293), we addressed the items in the direct PE database brought to our attention by the commenters. There, we clarified that we believe that a disposable supply is one that is attributable, in its entirety, to an individual patient for a particular service. We clarified that we believe that supply costs related to specimen disposal attributable to individual services may be appropriately categorized as disposable supplies, but that specimen disposal costs related to an allocated portion of service contracts that cannot be attributed to individual services should not be incorporated into the direct PE input database as disposable supplies. As we address in section II.B. of this final rule, all costs other than clinical labor, disposable supplies, and medical equipment should be considered indirect costs in order to maintain relativity within the PE methodology. We believe that there are a wide range of costs allocable to individual services that are appropriately considered part of indirect cost categories for purposes of the PE methodology.

Comment: Commenters argued that courier transportation costs are directly allocable to individual beneficiary specimens, and represent a significant practice expense. One commenter stated, "Although more than one specimen may be included in a courier run, still there is a cost per specimen" and asserted that the indirect PE costs allocated to CPT code 88305 do not adequately account for the sizeable expense of couriers.

Response: Again, we maintain that all costs other than clinical labor, disposable supplies, and medical equipment should be considered indirect costs to maintain relativity within the PE methodology. In addition

to not meeting that criterion to be considered direct PE, the commenter pointed out that more than one specimen may be included in a courier run, so that the cost of courier services does not meet the additional criterion of being "attributable, in its entirety, to an individual patient for a particular service." We acknowledge the commenters' concern that the indirect costs allocated to CPT code 88305 may not equate to the indirect costs associated for every instance a service described by that code is furnished. However, we note that the practice expense methodology is applied consistently throughout the fee schedule, and that the nature of indirect costs is such that the costs allocated to an individual procedure are an estimate of the relative costs associated with the typical procedure reported with a particular code, and are not intended to account for those costs on a line item basis for each instance the code is reported.

Comment: Commenters argued that the maintenance costs are in fact variable costs in that the costs are proportional to specimen volume. Commenters acknowledged the 5% equipment maintenance factor that is figured into the costs of equipment inputs to the PE methodology, but argued that pathology laboratories have several equipment items that require more frequent maintenance (in the range of 10%–12%). Commenters requested that we establish specialty-specific maintenance factors.

Response: We believe that the nature of many equipment items across the fee schedule is such that the required maintenance would relate, at least in part, to the volume of procedures furnished using the equipment. We note that the established PE methodology does not generally account for either additional costs incurred or efficiencies gained when services are furnished in atypical volumes. The equipment maintenance factor is intended to represent the typical cost per minute associated with a particular piece of equipment. At this time, our PE methodology does not accommodate equipment maintenance factors that vary by specialty.

Comment: Commenters provided descriptions of the CoPath system, indicating that the system provides procedure support that assists labs with specimen management and tracking, report generation, record storage, workflow automation, management reporting and quality assurance functions and support. Commenters stated that the CoPath system is a stand-alone system that must be interfaced with the main electronic health care record system, and is unique to pathology and only used by pathology. The CoPath system is required for labs to assign each specimen its unique identifier and associate it with other specimens from the same patient, as well as track the course of the entire process.

Commenters also explained that the CoPath system is an advanced pathology information management system for storing and reporting pathology information and accommodates clinical disciplines including surgical pathology, cytology, histology, and autopsy. CoPath manages the integrity of specimen accession and processing, and provides patient history review, pathology text entry, support for diagnostic coding using the CAP SNOMED database, report generation, case review and sign out, and retrieval for subsequent purposes. It also assists in inputting blocks and interfaces with cassette and slide labelers, querying database for cases, patient histories, and reducing workload. Commenters compared the Picture Archiving and Communication System (PACS) system for radiologists to the CoPath or equivalent system for pathology.

One commenter argued that the clerical and administrative functionality support by a laboratory information system is immaterial to the direct costs associated with its more prominent utility as the clinical information infrastructure for anatomic pathology laboratories.

Response: We asked for comments to help with our understanding of the clinical functionality of the equipment in relation to the services being furnished. We appreciate the explanations provided, as well as the comparison to the PACS system for radiologists. Based on our review of the comments received, we understand that this information management system is used for a variety of administrative and clerical functions, as well as clinical support functions. Tools that facilitate the similar functionality for other services, such as the cognitive work involved in the professional component, are considered indirect costs under the PFS. For instance, across services furnished by a range of physician specialties, many items that support clinical decision-making are considered indirect costs, irrespective of their utility and are not included in the PE methodology as direct costs. Instead, they are part of the indirect category of resource costs. As a general principle, for this reason, we do not believe that information management systems are appropriately characterized as direct costs.

Furthermore, we believe that the relativity within the PE methodology would be undermined by including these kinds of items as medical equipment only for particular kinds of services. We believe that, were we to reconsider the categorization of clinical information systems for this particular kind of service, it would be necessary to reconsider the categorization of resource costs of other clinical information systems used across PFS services. Therefore, we continue to believe that the CoPath system is best characterized as an indirect cost that is captured in the indirect cost allocation.

Comment: One commenter suggested that the labor cost of the histotechnologist is closer to 50 cents per minute, rather than the 37 cents per minute used in the PE direct inputs database.

Response: We did not change the labor cost for histotechnologists in the CY 2013 final rule with comment period. We note, however, that the prices associated with the labor codes derive from data from the Bureau of Labor Statistics, and we will consider the appropriate time to update all labor category costs in the PE direct inputs database for future rulemaking.

Comment: Commenters disputed the assertion that there is a "typical" case for CPT code 88305, given that there are wide variations in the types of tissues being biopsied.

Response: Under the PFS, services are priced based on the typical case. We continue to seek the best information regarding the inputs involved in furnishing the typical case.

Comment: Commenters expressed concern that CMS asked the AMA RUC to review CPT code 88305 based on the assertion of a single stakeholder that the clinical vignette used to identify the PE inputs was not typical.

Response: As indicated in section II.C.2 of this final rule with comment period, we note that we generally do not identify a code as potentially misvalued solely on the basis of individual assertions. On the contrary, when stakeholders bring information to our attention, it is subject to internal review to determine whether the code would appropriately be proposed as a potentially misvalued code, and we offer the public the opportunity to comment prior to finalizing a code as potentially misvalued. We followed our standard process in evaluating CPT code 88305 as potentially misvalued and reached the conclusion that it was appropriate the refer the service to the AMA RUC. Therefore, we do not agree

with commenters that we asked the AMA RUC to review this service based solely on information provided by a single stakeholder.

Comment: Some commenters provided information regarding the number of blocks that is typical for 88305. An association representing pathologists argued that there is no typical case for 88305, and provided several vignettes to illustrate the variation based on the type of tissue being biopsied. The association also presented findings from one data collection effort involving several specialty societies that suggested that the typical number of blocks may be as high as four. However, the association supported the AMA RUC's recommendation of two blocks as most likely to represent the typical case. Other commenters indicated that a review of hundreds of cases from multiple institutions indicated that the typical, or average, case of 88305 requires one block, not two, and that 92% of cases including pathology, skin pathology, surgical pathology, urologic pathology, cell blocks, and bone marrow cases required one block. Another medical specialty indicated that more than two slide-blocks are routinely required, and requested the use of a modifier for 88305 for those services that routinely require more than two slide-blocks. Another commenter requested that we stratify payment based on the number of blocks. Another commenter suggested that the AMA RUC's recommended number of clinical labor minutes for 88305 underestimates the amount of clinical labor time associated with the typical service described by the code.

Response: Based on the wide range of views expressed in comments, it is difficult to determine the appropriate number of blocks to use in establishing direct PE inputs for CPT code 88305. At this time, because we do not have strong evidence to conclude that a change should be made, are maintaining these values. However, we will continue to seek better information to permit consideration of the appropriate number of blocks, and the appropriate direct PE inputs for this code. We are not establishing a modifier to differentiate the number of blocks since there is not a current billing mechanism to make adjustments based on the number of blocks used when a code is reported.

Comment: One commenter argued that the practice expense RVU for CPT code 88305 is insufficient for a tissue exam with two blocks and certainly insufficient for those exams that require more than the two blocks and slides than are accounted for in the AMA RUC's vignette. The commenter argued that even though many tissue biopsies may use an average of two blocks, the valuation of this service does not account for the many kinds of biopsies that use more than two blocks. Another commenter argued that the payment will no longer allow "profits" for 1–2 block specimens to offset the "losses" from specimens that require a larger number of blocks.

Response: We acknowledge the commenter's concern that the valuation of this service is based on two blocks when some services require a greater number of blocks. However, this circumstance is not inconsistent with the established PE methodology, which accounts for the relative resources involved in furnishing a typical case for a particular HCPCS code. We acknowledge that there are cases that use higher than typical resources, and that there are also cases that use lower than typical resources. As a general principle, we do not believe that the direct inputs associated with a particular PFS service should be established or maintained to result in payment rates that might offset outlier cases for that service or support practice expenses for practitioners who furnish lower-paid services.

Furthermore, we note that we continue to receive feedback regarding the appropriate coding and code descriptors for surgical pathology for the prostate needle biopsy services. We believe that revising the code descriptors to ensure that all prostate needle biopsy services with 10 or more specimens are described by the G-codes may facilitate broader consensus regarding the typical resource costs for 88305. Therefore, for clarity, we are revising the CY 2014 descriptors for these HCPCS codes to include the phrase "any method" following "sampling."

The revised HCPCS code descriptors for microscopic examination for prostate biopsy are as follows: G0416 (Surgical pathology, gross and microscopic examination for prostate needle biopsies, any method; 10–20 specimens), G0417 (Surgical pathology, gross and microscopic examination for prostate needle biopsies, any method; 21–40 specimens), G0418 (Surgical pathology, gross and microscopic examination for prostate needle biopsies, any method; 41–60 specimens) and G0419 (Surgical pathology, gross and microscopic examination for prostate needle biopsies, any method; greater than 60 specimens).

After consideration of public comments received, we are finalizing the CY 2013 interim final direct PE inputs for CPT codes 88300–88309 as established.

(21) Pathology and Laboratory: Cytopathology (CPT Codes 88120 and 88121)

In the PFS final rule with comment period, we addressed comments from stakeholders who suggested that CMS increase the price of the supply "UroVysion test kit" (SA105) by building in an "efficiency factor" to account for the kits that are purchased by practitioners and used in tests that fail. The stakeholders provided documentation suggesting that a certain failure rate is inherent in the procedure.

We indicated that the prices associated with supply inputs in the direct PE input database reflect the price per unit of each supply. Since the current PE methodology relies on the inputs for each service reflecting the typical direct practice expense costs for each service, and the supply costs for the failed tests are not used in furnishing PFS services, we do not believe that the methodology accommodates a failure rate in allocating the cost of disposable medical supplies. Therefore, we did not adjust the price input for "UroVysion test kit" (SA105) in the direct PE input database.

Comment: Commenters disagreed with our decision, stating that these are valid expenses and that the inherent failure rate is commonly due to factors beyond the control of the laboratory or quality of equipment. Further, commenters pointed out that these costs are not reflected in overhead costs, and should therefore be included in direct practice expense inputs.

Response: Because the current PE methodology relies on the inputs used in furnishing each service, reflecting the typical direct practice expense costs for each service, we continue to believe that the price of the supply kit should not reflect any failure rate. After consideration of public comment, we are finalizing the CY 2013 interim final direct PE inputs for CPT codes 88120 and 88121 as established.

(22) Immunotherapy Injections (CPT Codes 95115 and 95117)

In establishing interim final direct PE inputs for CPT codes 95115 and 95117, we refined the AMA RUC's recommendation by removing equipment item "refrigerator, vaccine, commercial grade, w-alarm lock."

Comment: Commenters indicated that injectable materials need to be refrigerated, and thus the refrigerator should be included for this service.

Response: As previously noted, equipment that is used for multiple

procedures at once is considered an indirect cost. In future rulemaking, we anticipate reviewing our files for consistency across practice expense inputs in this regard. After consideration of comments received, we are finalizing the CY 2013 interim final direct practice expense inputs for CPT codes 95115 and 95117 as established.

(23) Neurology and Neuromuscular Procedures: Intraoperative Neurophysiology (CPT Codes 95940, 95941 and HCPCS Code G0453)

In establishing payment for intraoperative neurophysiology (95940 and G0453) for CY 2013, we did not accept the AMA RUC direct PE input recommendations, since we do not believe that these services are furnished to patients outside of facility settings.

Comment: A commenter noted that hospitals previously owned all of the equipment and supplies and employed the technicians for intraoperative monitoring. The commenter asserted that, currently, hospitals often use "mobile services" to furnish these monitoring procedures, and thus there should be technical component RVUs for these services.

Response: The structure of monitoring businesses and the arrangements made with hospitals are not a factor in determining the inputs typical to a particular service. Since this service is furnished in a facility, we have not included direct PE inputs for this service. We continue to believe that this service should be priced without direct PE inputs because when a service is furnished in the facility setting, the equipment, supplies, and labor costs of the service are considered in the calculation of Medicare payments made to the facility through other Medicare payment systems. After consideration of comments received, we are finalizing the CY 2013 interim final direct PE inputs for 95940 and G0453 as established.

(24) Neurology and Neuromuscular Procedures: Sleep Medicine Testing (CPT Codes 95782, 95783)

In establishing interim final direct PE inputs for CY 2013, we refined the AMA RUC's recommendation for CPT codes 95782 (Polysomnography, younger than 6 years, 4 or more) and 95783 (Polysomnography, younger than 6 years, w/cpap) by reducing time associated with "Measure and mark head and face. Apply and secure electrodes to head and face. Check impedances. Reapply electrodes as needed" and "apply recording devices" and removing equipment item "crib" for use in these services. We stated that we did not believe a crib would typically be used in this service, and we incorporated the bedroom furniture including a hospital bed and a reclining chair as typical equipment for this service.

Comment: Commenters disagreed, stating that it takes additional time to perform these clinical labor tasks for a child, and that we should assign 30 minutes to the "measure and mark head and face" task and 25 minutes to the "apply recording devices" task. Commenters also indicated that the crib is used in the typical case, while the parent uses the hospital bed to remain close to the child. We also received a paid invoice for the equipment item "crib."

Response: After additional clinical review, we agree with commenters' explanation that the additional clinical labor minutes are required when furnishing these services to children. Therefore, we are allocating an additional 5 minutes for each of these tasks, so that 25 minutes are allocated based on the clinical labor task called "Measure and mark head and face. Apply and secure electrodes to head and face. Check impedances. Reapply electrodes as needed" and 20 minutes are allocated for the task "apply recording devices." Based on the information provided by commenters, we agree that the equipment item "crib" should be included for CPT codes 95782 and 95783. We are pricing the equipment item "crib" at $3,900 based on the invoice received. After consideration of the comments received, we are finalizing the CY 2013 interim final direct PE inputs for 95782 and 95783 as established with the additional refinement of adjusting the clinical labor time and incorporating the "crib" discussed above.

(25) Neurology and Neuromuscular Procedures: Electromyography and Nerve Conduction Tests (CPT Codes 95907, 95908, 95909, 95910, 95911, 95912, 95913, and 95861)

In establishing interim final direct PE inputs for CY 2013, we refined the AMA RUC's recommendation for CPT code 95861 by adjusting the time for the clinical labor activity "assist physician in performing procedure" from 19 minutes to 29 minutes to conform to physician time.

Comment: Commenters brought to our attention that this refinement was inaccurate, in that the AMA RUC recommendation included 29 minutes for this labor activity.

Response: We agree with commenters that this refinement was inaccurate and acknowledge the administrative discrepancy in the refinement table. We note that this had no impact on payment rates, since there was no corresponding discrepancy in the direct PE input database. After considering comments received, we are finalizing the CY 2013 interim final direct PE inputs for CPT code 95861 as established.

We also refined the AMA RUC's recommendation for CPT codes 95907, 95908, 95909, 95910, 95911, 95912, and 95913 by substituting non-sterile gauze for sterile gauze, and removing surgical tape and electrode gel.

Comment: Commenters indicated that sterile gauze is required because the skin is cleansed before the procedure with vigorous scrubbing that often can produce minor bleeding, and that tape is required because the electrodes may not stick well when testing patients who have used lotions or creams prior to testing. Finally, the electrode gel is required to maximize conductivity, especially in patients who have used lotions or creams prior to testing.

Response: We agree with commenters that the sterile gauze and tape should be included for this service. However, since the disposable electrode pack includes pre-gelled electrodes, we do not believe it is typical that electrode gel is also used in this procedure. After consideration of public comments, we are finalizing the CY 2013 interim final direct practice expense inputs for CPT codes 95907—95913 as established, with the additional refinement of including the sterile gauze and tape.

(26) Neurology and Neuromuscular Procedures: Autonomic Function Testing (CPT Codes 95921, 95922, 95923, and 95924)

In establishing interim final direct PE inputs for CY 2013, we refined the AMA RUC's recommendation for CPT codes 95921 and 95922 by removing the preservice clinical labor tasks, and adjusting the monitoring time following the procedure from 5 to 2 minutes for 95921, 95922, 95923, and 95924.

Comment: Commenters stated that the patient requires assistance following the tests; therefore, additional time for monitoring the patient is necessary and should be added to the number of clinical labor minutes in the service period.

Response: CMS clinical staff reviewed the information presented by commenters and found no evidence that 2 minutes did not represent the typical resources involved in furnishing the service for CPT codes 95921, 95922, 95923, and 95924.

In refining CPT codes 95921, 95922, 95923, and 95924, we refined the

equipment time to reflect the typical use exclusive to the patient.

Comment: Commenters stated that extra time was required for the equipment so that the patient can lie still after the procedure to ensure that there are not negative side effects due to fluctuations in blood pressure.

Response: We agree with commenters' justification for allocating additional equipment minutes to account for the time that the patient is laying still after the procedure.

In refining CPT code 95923, we refined the clinical labor activity "assist physician" to 45 minutes.

Comment: Commenters stated that an additional 10 minutes of "assist physician" time was needed to assist the patient out of the machine and into the shower, since patients are extremely sweaty after the procedure.

Response: Assisting patients following the procedure is not part of the "assist physician" labor activity. Since this clinical labor activity was not specified in the AMA RUC recommendation, we do not believe this activity typically takes additional time over that already allotted to the procedure. After considering public comments received, we are finalizing the CY 2013 interim final direct practice expense inputs for CPT codes 95921—95924 as established.

(27) Special Dermatological Procedures (CPT Codes 96920, 96921, 96922)

In establishing interim final direct PE inputs for CY 2013, we refined the AMA RUC's recommendation for CPT codes 96920, 96921, and 96922 by decreasing the time allocated to clinical labor activity "monitor patient following service/check tubes, monitors, drains" from 3 minutes to 1 minutes, and clinical labor activity "clean room/equipment by physician staff" from 3 minutes to 2 minutes.

Comment: Commenters objected to CMS's refinement of clinical labor tasks below the standard number of minutes allocated for these tasks.

Response: We agree with commenters that the standard number of AMA RUC-recommended minutes should be allocated for these tasks. After considering public comments received, we are finalizing the CY 2013 interim final direct practice expense inputs for CPT codes 96920, 96921, and 96922 with the additional refinement of adjusting the times allocated for the clinical labor activities noted above.

(28) Psychiatry (CPT Codes 90791, 90832, 90834, and 90837)

As we addressed in the CY 2013 PFS final rule (77 FR 69075), the AMA RUC submitted direct PE input recommendations in the revised set of codes that describe psychotherapy services. These recommendations included significant reductions to the direct PE inputs associated with the predecessor codes. For most of the new codes, we accepted these recommended reductions in direct practice expense. This was consistent with our general approach of maintaining the existing values for these services given that many practitioners who furnished these services prior to CY 2013 would report concurrent medical evaluation and management services (which have practice expense values that will offset the differences in total PE values between the new and old psychotherapy codes). However, for practitioners who do not furnish medical E/M services, there were no corresponding PE value increases to offset the recommended reductions. Therefore, instead of accepting the recommended direct PE inputs for the new CPT codes that describe services primarily furnished by practitioners who do not also report medical E/M services, for CY 2013, we crosswalked the 2012 PE RVUs from the predecessor codes. This crosswalk used the CY 2012 year fully-implemented PE RVUs established for CPT codes 90791 (Psychiatric diagnostic evaluation), 90832 (Psychotherapy, 30 minutes with patient and/or family member), 90834 (Psychotherapy, 45 minutes with patient and/or family member), and 90837 (Psychotherapy, 60 minutes with patient and/or family member).

Comment: Several commenters pointed out that by crosswalking the PE RVUs from predecessor codes, CMS created a rank order anomaly for CPT codes 90791 (Psychiatric diagnostic evaluation) and 90792 (Psychiatric diagnostic evaluation with medical services). These commenters urged CMS to issue a technical correction for CY 2013 and accept the AMA–RUC recommended inputs in developing PE RVUs for these services for CY 2014.

Response: We appreciate the commenters' concerns regarding rank order anomalies for these services. However, as we explained in establishing the interim final values for CY 2013; we believed that it was important to maintain approximate overall value for the family of services for the specialties involved, pending valuation of the whole set of codes for CY 2014. Now that we have considered the full family of codes for CY 2014 including the additional work RVUs, we agree with the commenters and believe that the AMA RUC-recommended direct PE inputs for the whole family of codes can be implemented. Given the significant change in PE RVUs and in the context of the whole family of services, the direct PE inputs for these services will be interim final and subject to comment for CY 2014.

Comment: In a comment to the CY 2014 proposed PFS rule, one commenter argued that the crosswalked PE RVUs for these services should be maintained due to the negative impact of the PE methodology on certain specialties, especially clinical psychologists. This commenter also suggested that the reductions in PE RVUs that would result from implementing the AMA RUC recommended direct PE inputs for CY 2014 would fully offset any increases in work RVUs for these services.

Response: We do not agree that the reductions in PE RVUs that result from the AMA RUC-recommended inputs fully offset the increases in overall payment for these services that results from CMS' adoption of the AMA RUC-recommended work RVUs for most of the codes in this family. However, we will consider the commenter's concerns regarding the effect of the PE methodology for specialties like clinical psychologists for future rulemaking.

(29) Transitional Care Management Services (CPT Codes 99495, 99496)

In establishing interim final direct PE inputs for CY 2013, we refined the AMA RUC recommendation by incorporating the clinical labor inputs for dedicated non-face-to-face care management tasks as facility inputs in addition to increasing clinical labor minutes for 99496.

Comment: The AMA RUC disagreed with CMS's refinement to include clinical labor minutes in the facility setting based on the assertion that the non-face-to-face care management tasks are critical to the codes and cannot be separated from the care coordination delivered by the clinical staff in the non-facility setting. The AMA RUC also suggested that several medical specialty societies also disagreed with the refinement to include clinical labor minutes in the facility setting, while one specialty society agreed with our refinement.

Response: After considering the rationale of the AMA RUC, we agree that only non-facility direct PE inputs should be included for these services. Therefore, we are finalizing the CY 2013 interim final direct PE inputs for 99495 and 99496 as established with the additional refinement of removing the facility direct PE inputs.

c. Finalizing CY 2013 Interim and Proposed Malpractice Crosswalks for CY 2014

In accordance with our malpractice methodology, we adjusted the malpractice RVUs for the CY 2013 new/revised codes for the difference in work RVUs (or, if greater, the clinical labor portion of the PE RVUs) between the source codes and the new/revised codes to reflect the specific risk-of-service for the new/revised codes. The interim final malpractice crosswalks were listed in Table 75 of the CY 2013 PFS final rule with comment period.

We received no comments on the CY 2013 interim final malpractice crosswalks and are finalizing them without modification for CY 2014. The malpractices RVUs for these services are reflected in Addendum B of this CY 2014 PFS final rule with comment period.

Consistent with past practice when the MEI has been rebased or revised we proposed to make adjustments to ensure that estimates of the aggregate CY 2014 PFS payments for work, PE and malpractice are in proportion to the weights for these categories in the revised MEI. As discussed in the II.A., the MEI is being revised for CY 2014, the PE and malpractice RVUs, and the CF are being adjusted accordingly. For more information on this, see section II.B. We received no comments specifically on the adjustment to malpractice RVUs.

d. Other New, Revised or Potentially Misvalued Codes With CY 2013 Interim Final RVUs Not Specifically Discussed in the CY 2014 Final Rule With Comment Period

For all other new, revised, or potentially misvalued codes with CY 2013 interim final RVUs that are not specifically discussed in this CY 2014 PFS final rule with comment period, we are finalizing for CY 2014, without modification, the CY 2013 interim final or CY 2014 proposed work RVUs, malpractice crosswalks, and direct PE inputs. Unless otherwise indicated, we agreed with the time values recommended by the AMA RUC or HCPAC for all codes addressed in this section. The time values for all codes are listed in a file called "CY 2014 PFS Physician Time," available on the CMS Web site under downloads for the CY 2014 PFS final rule with comment period at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html.*

3. Establishing CY 2014 Interim Final RVUs

a. Establishing CY 2014 Interim Final Work RVUs

Table 27 contains the CY 2014 interim final work RVUs for all codes for which we received AMA RUC recommendations for CY 2014 and new G-codes created for CY 2014. These values are subject to public comment in this final rule with comment period. Codes for which work RVUs are not applicable have the appropriate PFS procedure status indicator in the relevant column. A description of all PFS procedure status indicators can be found in Addendum A. The column labeled "CMS Time Refinement" indicates for each code whether we refined the time values recommended by the AMA RUC or HCPAC.

The RVUs and other payment information for all CY 2014 payable codes are available in Addendum B. The RVUs and other payment information regarding all codes subject to public comment in this final rule with comment period are available in Addendum C. All addenda are available on the CMS Web site under downloads for the CY 2014 PFS final rule with comment period at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html.* The time values for all CY 2014 codes are listed in a file called "CY 2014 PFS Physician Time," available on the CMS Web site under downloads for the CY 2014 PFS final rule with comment period at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html.*

TABLE 27—INTERIM FINAL WORK RVUS FOR NEW/REVISED/POTENTIALLY MISVALUED CODES

HCPCS code	Long descriptor	CY 2013 work RVU	AMA RUC/ HCPAC recommended work RVU	CY 2014 work RVU	CMS time refinement
10030	Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst), soft tissue (eg, extremity, abdominal wall, neck), percutaneous.	New	3.00	3.00	No.
17000	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion.	0.65	0.61	0.61	No.
17003	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); second through 14 lesions, each (list separately in addition to code for first lesion).	0.07	0.04	0.04	No.
17004	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses), 15 or more lesions.	1.85	1.37	1.37	No.
17311	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; first stage, up to 5 tissue blocks.	6.20	6.20	6.20	No.

TABLE 27—INTERIM FINAL WORK RVUS FOR NEW/REVISED/POTENTIALLY MISVALUED CODES—Continued

HCPCS code	Long descriptor	CY 2013 work RVU	AMA RUC/ HCPAC recommended work RVU	CY 2014 work RVU	CMS time refinement
17312	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; each additional stage after the first stage, up to 5 tissue blocks (list separately in addition to code for primary procedure).	3.30	3.30	3.30	No.
17313	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; first stage, up to 5 tissue blocks.	5.56	5.56	5.56	No.
17314	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; each additional stage after the first stage, up to 5 tissue blocks (list separately in addition to code for primary procedure).	3.06	3.06	3.06	No.
17315	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), each additional block after the first 5 tissue blocks, any stage (list separately in addition to code for primary procedure).	0.87	0.87	0.87	No.
19081	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including stereotactic guidance.	New	3.29	3.29	No.
19082	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including stereotactic guidance (list separately in addition to code for primary procedure).	New	1.65	1.65	No.
19083	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including ultrasound guidance.	New	3.10	3.10	No.
19084	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including ultrasound guidance (list separately in addition to code for primary procedure).	New	1.55	1.55	No.
19085	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including magnetic resonance guidance.	New	3.64	3.64	No.
19086	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including magnetic resonance guidance (list separately in addition to code for primary procedure).	New	1.82	1.82	No.
19281	Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including mammographic guidance.	New	2.00	2.00	No.
19282	Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including mammographic guidance (list separately in addition to code for primary procedure).	New	1.00	1.00	No.
19283	Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including stereotactic guidance.	New	2.00	2.00	No.

TABLE 27—INTERIM FINAL WORK RVUS FOR NEW/REVISED/POTENTIALLY MISVALUED CODES—Continued

HCPCS code	Long descriptor	CY 2013 work RVU	AMA RUC/ HCPAC recommended work RVU	CY 2014 work RVU	CMS time refinement
19284	Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including stereotactic guidance (list separately in addition to code for primary procedure).	New	1.00	1.00	No.
19285	Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including ultrasound guidance.	New	1.70	1.70	No.
19286	Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including ultrasound guidance (list separately in addition to code for primary procedure).	New	0.85	0.85	Yes.
19287	Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including magnetic resonance guidance.	New	3.02	2.55	No.
19288	Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including magnetic resonance guidance (list separately in addition to code for primary procedure).	New	1.51	1.28	No.
23333	Removal of foreign body, shoulder; deep (subfascial or intramuscular).	New	6.00	6.00	No.
23334	Removal of prosthesis, includes debridement and synovectomy when performed; humeral or glenoid component.	New	18.89	15.50	No.
23335	Removal of prosthesis, includes debridement and synovectomy when performed; humeral and glenoid components (eg, total shoulder).	New	22.13	19.00	No.
24164	Removal of prosthesis, includes debridement and synovectomy when performed; radial head.	6.43	10.00	10.00	No.
27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft.	21.79	19.60	20.72	Yes.
27236	Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement.	17.61	17.61	17.61	Yes.
27446	Arthroplasty, knee, condyle and plateau; medial or lateral compartment.	16.38	17.48	17.48	No.
27447	Arthroplasty, knee, condyle and plateau; medial and lateral compartments with or without patella resurfacing (total knee arthroplasty).	23.25	19.60	20.72	Yes.
31237	Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure).	2.98	2.60	2.60	No.
31238	Nasal/sinus endoscopy, surgical; with control of nasal hemorrhage.	3.26	2.74	2.74	No.
31239	Nasal/sinus endoscopy, surgical; with dacryocystorhinostomy	9.33	9.04	9.04	No.
31240	Nasal/sinus endoscopy, surgical; with concha bullosa resection	2.61	2.61	2.61	No.
33282	Implantation of patient-activated cardiac event recorder	4.80	3.50	3.50	No.
33284	Removal of an implantable, patient-activated cardiac event recorder.	3.14	3.00	3.00	No.
33366	Transcatheter aortic valve replacement (tavr/tavi) with prosthetic valve; transapical exposure (eg, left thoracotomy).	New	40.00	35.88	No.
34841	Endovascular repair of visceral aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) by deployment of a fenestrated visceral aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including one visceral artery endoprosthesis (superior mesenteric, celiac or renal artery).	New	C	C	N/A.
34842	Endovascular repair of visceral aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) by deployment of a fenestrated visceral aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including two visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[s]).	New	C	C	N/A.

TABLE 27—INTERIM FINAL WORK RVUS FOR NEW/REVISED/POTENTIALLY MISVALUED CODES—Continued

HCPCS code	Long descriptor	CY 2013 work RVU	AMA RUC/ HCPAC recommended work RVU	CY 2014 work RVU	CMS time refinement
34843	Endovascular repair of visceral aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) by deployment of a fenestrated visceral aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including three visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[s]).	New	C	C	N/A.
34844	Endovascular repair of visceral aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) by deployment of a fenestrated visceral aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including four or more visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[s]).	New	C	C	N/A.
34845	Endovascular repair of visceral aorta and infrarenal abdominal aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) with a fenestrated visceral aortic endograft and concomitant unibody or modular infrarenal aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including one visceral artery endoprosthesis (superior mesenteric, celiac or renal artery).	New	C	C	N/A.
34846	Endovascular repair of visceral aorta and infrarenal abdominal aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) with a fenestrated visceral aortic endograft and concomitant unibody or modular infrarenal aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including two visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[s]).	New	C	C	N/A.
34847	Endovascular repair of visceral aorta and infrarenal abdominal aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) with a fenestrated visceral aortic endograft and concomitant unibody or modular infrarenal aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; Including three visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[s]).	New	C	C	N/A.
34848	Endovascular repair of visceral aorta and infrarenal abdominal aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) with a fenestrated visceral aortic endograft and concomitant unibody or modular infrarenal aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including four or more visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[s]).	New	C	C	N/A.
35301	Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision.	19.61	21.16	21.16	No.
36245	Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family.	4.67	4.90	4.90	No.
37217	Transcatheter placement of an intravascular stent(s), intrathoracic common carotid artery or innominate artery by retrograde treatment, via open ipsilateral cervical carotid artery exposure, including angioplasty, when performed, and radiological supervision and interpretation.	New	22.00	20.38	No.
37236	Transcatheter placement of an intravascular stent(s) (except lower extremity, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; initial artery.	New	9.00	9.00	No.

TABLE 27—INTERIM FINAL WORK RVUS FOR NEW/REVISED/POTENTIALLY MISVALUED CODES—Continued

HCPCS code	Long descriptor	CY 2013 work RVU	AMA RUC/ HCPAC recommended work RVU	CY 2014 work RVU	CMS time refinement
37237	Transcatheter placement of an intravascular stent(s) (except lower extremity, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; each additional artery (list separately in addition to code for primary procedure).	New	4.25	4.25	No.
37238	Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; initial vein.	New	6.29	6.29	No.
37239	Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; each additional vein (list separately in addition to code for primary procedure).	New	3.34	2.97	No.
37241	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; venous, other than hemorrhage (eg, congenital or acquired venous malformations, venous and capillary hemangiomas, varices, varicoceles).	New	9.00	9.00	No.
37242	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; arterial, other than hemorrhage or tumor (eg, congenital or acquired arterial malformations, arteriovenous malformations, arteriovenous fistulas, aneurysms, pseudoaneurysms).	New	11.98	10.05	No.
37243	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction.	New	14.00	11.99	No.
37244	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation.	New	14.00	14.00	No.
43191	Esophagoscopy, rigid, transoral; diagnostic, including collection of specimen(s) by brushing or washing when performed (separate procedure).	New	2.78	2.00	No.
43192	Esophagoscopy, rigid, transoral; with directed submucosal injection(s), any substance.	New	3.21	2.45	No.
43193	Esophagoscopy, rigid, transoral; with biopsy, single or multiple	New	3.36	3.00	No.
43194	Esophagoscopy, rigid, transoral; with removal of foreign body	New	3.99	3.00	No.
43195	Esophagoscopy, rigid, transoral; with balloon dilation (less than 30 mm diameter).	New	3.21	3.00	No.
43196	Esophagoscopy, rigid, transoral; with insertion of guide wire followed by dilation over guide wire.	New	3.36	3.30	No.
43197	Esophagoscopy, flexible, transnasal; diagnostic, includes collection of specimen(s) by brushing or washing when performed (separate procedure).	New	1.59	1.48	Yes.
43198	Esophagoscopy, flexible, transnasal; with biopsy, single or multiple.	New	1.89	1.78	Yes.
43200	Esophagoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure).	1.59	1.59	1.50	No.
43201	Esophagoscopy, flexible, transoral; with directed submucosal injection(s), any substance.	2.09	1.90	1.80	No.
43202	Esophagoscopy, flexible, transoral; with biopsy, single or multiple.	1.89	1.89	1.80	No.
43204	Esophagoscopy, flexible, transoral; with injection sclerosis of esophageal varices.	3.76	2.89	2.40	No.
43205	Esophagoscopy, flexible, transoral; with band ligation of esophageal varices.	3.78	3.00	2.51	No.
43211	Esophagoscopy, flexible, transoral; with endoscopic mucosal resection.	New	4.58	4.21	No.
43212	Esophagoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed).	New	3.73	3.38	No.

TABLE 27—INTERIM FINAL WORK RVUS FOR NEW/REVISED/POTENTIALLY MISVALUED CODES—Continued

HCPCS code	Long descriptor	CY 2013 work RVU	AMA RUC/ HCPAC recommended work RVU	CY 2014 work RVU	CMS time refinement
43213	Esophagoscopy, flexible, transoral; with dilation of esophagus, by balloon or dilator, retrograde (includes fluoroscopic guidance, when performed).	New	5.00	4.73	No.
43214	Esophagoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed).	New	3.78	3.38	No.
43215	Esophagoscopy, flexible, transoral; with removal of foreign body.	2.60	2.60	2.51	No.
43216	Esophagoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery.	2.40	2.40	2.40	No.
43217	Esophagoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique.	2.90	2.90	2.90	No.
43220	Esophagoscopy, flexible, transoral; with transendoscopic balloon dilation (less than 30 mm diameter).	2.10	2.10	2.10	No.
43226	Esophagoscopy, flexible, transoral; with insertion of guide wire followed by passage of dilator(s) over guide wire.	2.34	2.34	2.34	No.
43227	Esophagoscopy, flexible, transoral; with control of bleeding, any method.	3.59	3.26	2.99	No.
43229	Esophagoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed).	New	3.72	3.54	No.
43231	Esophagoscopy, flexible, transoral; with endoscopic ultrasound examination.	3.19	3.19	2.90	No.
43232	Esophagoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s).	4.47	3.83	3.54	No.
43233	Esophagogastroduodenoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed).	New	4.45	4.05	No.
43235	Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure).	2.39	2.26	2.17	No.
43236	Esophagogastroduodenoscopy, flexible, transoral; with directed submucosal injection(s), any substance.	2.92	2.57	2.47	No.
43237	Esophagogastroduodenoscopy, flexible, transoral; with endoscopic ultrasound examination limited to the esophagus, stomach or duodenum, and adjacent structures.	3.98	3.85	3.57	No.
43238	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), esophagus (includes endoscopic ultrasound examination limited to the esophagus, stomach or duodenum, and adjacent structures).	5.02	4.50	4.11	No.
43239	Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple.	2.87	2.56	2.47	No.
43240	Esophagogastroduodenoscopy, flexible, transoral; with transmural drainage of pseudocyst (includes placement of transmural drainage catheter[s]/stent[s], when performed, and endoscopic ultrasound, when performed).	6.85	7.25	7.25	No.
43241	Esophagogastroduodenoscopy, flexible, transoral; with insertion of intraluminal tube or catheter.	2.59	2.59	2.59	No.
43242	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis).	7.30	5.39	4.68	No.
43243	Esophagogastroduodenoscopy, flexible, transoral; with injection sclerosis of esophageal/gastric varices.	4.56	4.37	4.37	No.
43244	Esophagogastroduodenoscopy, flexible, transoral; with band ligation of esophageal/gastric varices.	5.04	4.50	4.50	No.
43245	Esophagogastroduodenoscopy, flexible, transoral; with dilation of gastric/duodenal stricture(s) (eg, balloon, bougie).	3.18	3.18	3.18	No.
43246	Esophagogastroduodenoscopy, flexible, transoral; with directed placement of percutaneous gastrostomy tube.	4.32	4.32	3.66	No.
43247	Esophagogastroduodenoscopy, flexible, transoral; with removal of foreign body.	3.38	3.27	3.18	No.

TABLE 27—INTERIM FINAL WORK RVUS FOR NEW/REVISED/POTENTIALLY MISVALUED CODES—Continued

HCPCS code	Long descriptor	CY 2013 work RVU	AMA RUC/ HCPAC recommended work RVU	CY 2014 work RVU	CMS time refinement
43248	Esophagogastroduodenoscopy, flexible, transoral; with insertion of guide wire followed by passage of dilator(s) through esophagus over guide wire.	3.15	3.01	3.01	No.
43249	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic balloon dilation of esophagus (less than 30 mm diameter).	2.90	2.77	2.77	No.
43250	Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery.	3.20	3.07	3.07	No.
43251	Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique.	3.69	3.57	3.57	No.
43253	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided transmural injection of diagnostic or therapeutic substance(s) (eg, anesthetic, neurolytic agent) or fiducial marker(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis).	New	5.39	4.68	No.
43254	Esophagogastroduodenoscopy, flexible, transoral; with endoscopic mucosal resection.	New	5.25	4.88	No.
43255	Esophagogastroduodenoscopy, flexible, transoral; with control of bleeding, any method.	4.81	4.20	3.66	No.
43257	Esophagogastroduodenoscopy, flexible, transoral; with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal reflux disease.	5.50	4.25	4.11	No.
43259	Esophagogastroduodenoscopy, flexible, transoral; with endoscopic ultrasound examination, including the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis.	5.19	4.74	4.14	No.
43260	Endoscopic retrograde cholangiopancreatography (ercp); diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure).	5.95	5.95	5.95	No.
43261	Endoscopic retrograde cholangiopancreatography (ercp); with biopsy, single or multiple.	6.26	6.25	6.25	No.
43262	Endoscopic retrograde cholangiopancreatography (ercp); with sphincterotomy/papillotomy.	7.38	6.60	6.60	No.
43263	Endoscopic retrograde cholangiopancreatography (ercp); with pressure measurement of sphincter of oddi.	7.28	7.28	6.60	No.
43264	Endoscopic retrograde cholangiopancreatography (ercp); with removal of calculi/debris from biliary/pancreatic duct(s).	8.89	6.73	6.73	No.
43265	Endoscopic retrograde cholangiopancreatography (ercp); with destruction of calculi, any method (eg, mechanical, electrohydraulic, lithotripsy).	10.00	8.03	8.03	No.
43266	Esophagogastroduodenoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed).	New	4.40	4.05	No.
43270	Esophagogastroduodenoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed).	New	4.39	4.21	No.
43273	Endoscopic cannulation of papilla with direct visualization of pancreatic/common bile duct(s) (list separately in addition to code(s) for primary procedure).	2.24	2.24	2.24	No.
43274	Endoscopic retrograde cholangiopancreatography (ercp); with placement of endoscopic stent into biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent.	New	8.74	8.48	No.
43275	Endoscopic retrograde cholangiopancreatography (ercp); with removal of foreign body(s) or stent(s) from biliary/pancreatic duct(s).	New	6.96	6.96	No.
43276	Endoscopic retrograde cholangiopancreatography (ercp); with removal and exchange of stent(s), biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent exchanged.	New	9.10	8.84	No.

TABLE 27—INTERIM FINAL WORK RVUS FOR NEW/REVISED/POTENTIALLY MISVALUED CODES—Continued

HCPCS code	Long descriptor	CY 2013 work RVU	AMA RUC/ HCPAC recommended work RVU	CY 2014 work RVU	CMS time refinement
43277	Endoscopic retrograde cholangiopancreatography (ercp); with trans-endoscopic balloon dilation of biliary/pancreatic duct(s) or of ampulla (sphincteroplasty), including sphincterotomy, when performed, each duct.	New	7.11	7.00	No.
43278	Endoscopic retrograde cholangiopancreatography (ercp); with ablation of tumor(s), polyp(s), or other lesion(s), including pre- and post-dilation and guide wire passage, when performed.	New	8.08	7.99	No.
43450	Dilation of esophagus, by unguided sound or bougie, single or multiple passes.	1.38	1.38	1.38	No.
43453	Dilation of esophagus, over guide wire	1.51	1.51	1.51	No.
49405	Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); visceral (eg, kidney, liver, spleen, lung/mediastinum), percutaneous.	New	4.25	4.25	No.
49406	Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); peritoneal or retroperitoneal, percutaneous.	New	4.25	4.25	No.
49407	Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); peritoneal or retroperitoneal, transvaginal or transrectal.	New	4.50	4.50	No.
50360	Renal allotransplantation, implantation of graft; without recipient nephrectomy.	40.90	40.90	39.88	No.
52332	Cystourethroscopy, with insertion of indwelling ureteral stent (eg, gibbons or double-j type).	2.82	2.82	2.82	No.
52356	Cystourethroscopy, with ureteroscopy and/cr pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent (eg, gibbons or double-j type).	New	8.00	8.00	No.
62310	Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic.	1.91	1.68	1.18	No.
62311	Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal).	1.54	1.54	1.17	No.
62318	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic.	2.04	2.04	1.54	No.
62319	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal).	1.87	1.87	1.50	No.
63047	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar.	15.37	15.37	15.37	No.
63048	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (list separately in addition to code for primary procedure).	3.47	3.47	3.47	No.
64616	Chemodenervation of muscle(s); neck muscle(s), excluding muscles of the larynx, unilateral (eg, for cervical dystonia, spasmodic torticollis).	New	1.79	1.53	No.
64617	Chemodenervation of muscle(s); larynx, unilateral, percutaneous (eg, for spasmodic dysphonia), includes guidance by needle electromyography, when performed.	New	2.06	1.90	No.
64642	Chemodenervation of one extremity; 1–4 muscle(s)	New	1.65	1.65	No.

TABLE 27—INTERIM FINAL WORK RVUS FOR NEW/REVISED/POTENTIALLY MISVALUED CODES—Continued

HCPCS code	Long descriptor	CY 2013 work RVU	AMA RUC/ HCPAC recommended work RVU	CY 2014 work RVU	CMS time refinement
64643	Chemodenervation of one extremity; each additional extremity, 1–4 muscle(s) (list separately in addition to code for primary procedure).	New	1.32	1.22	No.
64644	Chemodenervation of one extremity; 5 or more muscle(s)	New	1.82	1.82	No.
64645	Chemodenervation of one extremity; each additional extremity, 5 or more muscle(s) (list separately in addition to code for primary procedure).	New	1.52	1.39	No.
64646	Chemodenervation of trunk muscle(s); 1–5 muscle(s)	New	1.80	1.80	No.
64647	Chemodenervation of trunk muscle(s); 6 or more muscle(s)	New	2.11	2.11	No.
66183	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach.	New	13.20	13.20	No.
67914	Repair of ectropion; suture	3.75	3.75	3.75	No.
67915	Repair of ectropion; thermocauterization	3.26	2.03	2.03	No.
67916	Repair of ectropion; excision tarsal wedge	5.48	5.48	5.48	No.
67917	Repair of ectropion; extensive (eg, tarsal strip operations)	6.19	5.93	5.93	No.
67921	Repair of entropion; suture	3.47	3.47	3.47	No.
67922	Repair of entropion; thermocauterization	3.14	2.03	2.03	No.
67923	Repair of entropion; excision tarsal wedge	6.05	5.48	5.48	No.
67924	Repair of entropion; extensive (eg, tarsal strip or capsulopalpebral fascia repairs operation).	5.93	5.93	5.93	No.
69210	Removal impacted cerumen requiring instrumentation, unilateral.	0.61	0.58	0.61	No.
70450	Computed tomography, head or brain; without contrast material.	0.85	0.85	0.85	No.
70460	Computed tomography, head or brain; with contrast material(s)	1.13	1.13	1.13	No.
70551	Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material.	1.48	1.48	1.48	No.
70552	Magnetic resonance (eg, proton) imaging, brain (including brain stem); with contrast material(s).	1.78	1.78	1.78	No.
70553	Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences.	2.36	2.36	2.29	No.
72141	Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material.	1.60	1.48	1.48	No.
72142	Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; with contrast material(s).	1.92	1.78	1.78	No.
72146	Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; without contrast material.	1.60	1.48	1.48	No.
72147	Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; with contrast material(s).	1.92	1.78	1.78	No.
72148	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material.	1.48	1.48	1.48	No.
72149	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; with contrast material(s).	1.78	1.78	1.78	No.
72156	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; cervical.	2.57	2.29	2.29	No.
72157	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; thoracic.	2.57	2.29	2.29	No.
72158	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar.	2.36	2.29	2.29	No.
77280	Therapeutic radiology simulation-aided field setting; simple	0.70	0.70	0.70	No.
77285	Therapeutic radiology simulation-aided field setting; intermediate.	1.05	1.05	1.05	No.
77290	Therapeutic radiology simulation-aided field setting; complex	1.56	1.56	1.56	No.
77293	Respiratory motion management simulation (list separately in addition to code for primary procedure).	New	2.00	2.00	No.
77295	3-dimensional radiotherapy plan, including dose-volume histograms.	4.56	4.29	4.29	No.
81161	Dmd (dystrophin) (eg, duchenne/becker muscular dystrophy) deletion analysis, and duplication analysis, if performed.	New	1.85	X	N/A
88112	Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal.	1.18	0.56	0.56	No.

TABLE 27—INTERIM FINAL WORK RVUS FOR NEW/REVISED/POTENTIALLY MISVALUED CODES—Continued

HCPCS code	Long descriptor	CY 2013 work RVU	AMA RUC/ HCPAC recommended work RVU	CY 2014 work RVU	CMS time refinement
88342	Immunohistochemistry or immunocytochemistry, each separately identifiable antibody per block, cytologic preparation, or hematologic smear; first separately identifiable antibody per slide.	0.85	0.60	I	N/A
88343	Immunohistochemistry or immunocytochemistry, each separately identifiable antibody per block, cytologic preparation, or hematologic smear; each additional separately identifiable antibody per slide (list separately in addition to code for primary procedure).	New	0.24	I	N/A
92521	Evaluation of speech fluency (eg, stuttering, cluttering)	New	1.75	1.75	No.
92522	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria).	New	1.50	1.50	No.
92523	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive and expressive language).	New	3.36	3.00	No.
92524	Behavioral and qualitative analysis of voice and resonance	New	1.75	1.50	No.
93000	Electrocardiogram, routine ecg with at least 12 leads; with interpretation and report.	0.17	0.17	0.17	No.
93010	Electrocardiogram, routine ecg with at least 12 leads; interpretation and report only.	0.17	0.17	0.17	No.
93582	Percutaneous transcatheter closure of patent ductus arteriosus	New	14.00	12.56	No.
93583	Percutaneous transcatheter septal reduction therapy (eg, alcohol septal ablation) including temporary pacemaker insertion when performed.	New	14.00	14.00	No.
93880	Duplex scan of extracranial arteries; complete bilateral study	0.60	0.80	0.60	No.
93882	Duplex scan of extracranial arteries; unilateral or limited study	0.40	0.50	0.40	No.
95816	Electroencephalogram (eeg); including recording awake and drowsy.	1.08	1.08	1.08	No.
95819	Electroencephalogram (eeg); including recording awake and asleep.	1.08	1.08	1.08	No.
95822	Electroencephalogram (eeg); recording in coma or sleep only	1.08	1.08	1.08	No.
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour.	0.21	0.21	0.21	No.
96366	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (list separately in addition to code for primary procedure).	0.18	0.18	0.18	No.
96367	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion of a new drug/substance, up to 1 hour (list separately in addition to code for primary procedure).	0.19	0.19	0.19	No.
96368	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); concurrent infusion (list separately in addition to code for primary procedure).	0.17	0.17	0.17	No.
96413	Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug.	0.28	0.28	0.28	No.
96415	Chemotherapy administration, intravenous infusion technique; each additional hour (list separately in addition to code for primary procedure).	0.19	0.19	0.19	No.
96417	Chemotherapy administration, intravenous infusion technique; each additional sequential infusion (different substance/drug), up to 1 hour (list separately in addition to code for primary procedure).	0.21	0.21	0.21	No.
97610	Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day.	New	C	C	N/A
98940	Chiropractic manipulative treatment (cmt); spinal, 1–2 regions	0.45	0.46	0.46	No.
98941	Chiropractic manipulative treatment (cmt); spinal, 3–4 regions	0.65	0.71	0.71	No.
98942	Chiropractic manipulative treatment (cmt); spinal, 5 regions	0.87	0.96	0.96	No.
99446	Interprofessional telephone/internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5–10 minutes of medical consultative discussion and review.	New	0.35	B	No.
99447	Interprofessional telephone/internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 11–20 minutes of medical consultative discussion and review.	New	0.70	B	No.

TABLE 27—INTERIM FINAL WORK RVUS FOR NEW/REVISED/POTENTIALLY MISVALUED CODES—Continued

HCPCS code	Long descriptor	CY 2013 work RVU	AMA RUC/ HCPAC recommended work RVU	CY 2014 work RVU	CMS time refinement
99448	Interprofessional telephone/internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 21–30 minutes of medical consultative discussion and review.	New	1.05	B	No.
99449	Interprofessional telephone/internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 31 minutes or more of medical consultative discussion and review.	New	1.40	B	No.
99481	Total body systemic hypothermia in a critically ill neonate per day (list separately in addition to code for primary procedure).	New	C	C	N/A
99482	Selective head hypothermia in a critically ill neonate per day (list separately in addition to code for primary procedure).	New	C	C	N/A
G0461	Immunohistochemistry or immunocytochemistry, per specimen; first separately identifiable antibody.	New	N/A	0.60	No.
G0462	Immunohistochemistry or immunocytochemistry, per specimen; each additional separately identifiable antibody (List separately in addition to code for primary procedure).	New	N/A	0.24	No.

As previously discussed in section III.E.2 of this final rule with comment period, each year, the AMA RUC and HCPAC, along with other public commenters, provide us with recommendations regarding physician work values for new, revised, and potentially misvalued CPT codes. This section discusses codes for which the interim final work RVU or time values assigned for CY 2014 vary from those recommended by the AMA RUC. It also discusses work RVU and time values for new and revised HCPCS G-codes.

i. Code Specific Issues

(1) Breast Biopsy (CPT Codes 19081, 19082, 19083, 19084, 19085, 19086, 19281, 19282, 19283, 19284, 19285, 19286, 19287, and 19288)

The AMA RUC identified several breast intervention codes as potentially misvalued using the codes reported together 75 percent or more screen as potentially misvalued. For CY 2014, the CPT Editorial Panel created 14 new codes, CPT codes 19081 through 19288, to describe breast biopsy and placement of breast localization devices.

We are establishing the AMA RUC-recommended values as CY 2014 interim final values for all of the breast biopsy codes with the exception of CPT code 19287 and its add-on CPT code, 19288. We believe that the work RVU recommended by the AMA RUC for CPT code 19287 would create a rank order anomaly with other codes in the family. To avoid this anomaly, we are assigning a CY 2014 interim final work RVU of 2.55, which is between the 25th percentile and the median work RVU in the survey. In determining how to value this service, we examined the work RVU relationship among the breast biopsy codes as established by the AMA RUC and believed those to be correct. We used those relationships to establish the value for CPT code 19287. We believe that using this work value creates the appropriate relativity with other codes in the family.

To value CPT code 19288, we followed the same procedure used by the AMA RUC in making its recommendation for the add-on codes, which was to value add-on services at 50 percent of the applicable base code value, resulting in a work RVU of 1.28 for CPT code 19288.

We received public input suggesting that when one of these procedures is performed without mammography guidance, mammography is commonly performed afterwards to confirm appropriate placement. We seek public input as to whether or not post-procedure mammography is commonly furnished with breast biopsy and marker placement, and if so, whether the services should be bundled together.

Finally, we note that the physician intraservice time for CPT code 19286, which is an add-on code, is 19 minutes, which is higher than the 15 minutes of intraservice time for its base code, CPT code 19285. Therefore we are reducing the intraservice time for CPT code 19286 to the survey 25th percentile value of 14 minutes.

(2) Shoulder Prosthesis Removal (CPT Codes 23333, 23334, and 23335)

Three new codes, CPT codes 23333, 23334 and 23335, were created to replace CPT codes 23331 (removal of foreign body, shoulder; deep (eg, Neer hemiarthroplasty removal)) and 23332 (removal of foreign body, shoulder; complicated (eg, total shoulder)).

We are establishing a CY 2014 interim final work RVU of 6.00 for CPT code 23333, as recommended by the AMA RUC.

The AMA RUC recommended a work RVU of 18.89 for CPT code 23334 based on a crosswalk to the work value of CPT code 27269 (Open treatment of femoral fracture, proximal end, head, includes internal fixation, when performed). The code currently reported for this service, CPT code 23331, has a work RVU of 7.63. Recognizing that more physician time is involved with CPT code 23334 than CPT code 23331 and that the technique for removal of prosthesis may have changed since its last valuation, we still do not believe that the work has more than doubled for this service. Therefore, instead of assigning a work RVU of 18.89, we are assigning CPT 23334 a CY 2014 interim final work RVU of 15.50, based upon the 25th percentile of the survey. We believe this more appropriately reflects the work required to furnish this service.

Similarly, we believe that the 25th percentile of the survey also provides the appropriate work RVU for CPT code 23335. The AMA RUC recommended a work RVU of 22.13 based on a crosswalk to the CY 2013 interim final value of

CPT code 23472 (Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))). CPT code 23332 is currently billed for the work of new CPT code 23335 and has a work RVU of 12.37. Although the physician time for CPT code 23335 has increased from that of the predecessor code, CPT code 22332, and the technique for removal of prosthesis may have changed, we do not believe that the work has almost doubled for this service. Therefore, we are assigning a work RVU of 19.00 based upon the 25th percentile work RVU in the survey. We believe this appropriately reflects the work required to perform this service.

(3) Hip and Knee Replacement (CPT Codes 27130, 27236, 27446 and 27447)

CPT codes CY 27130, 27446 and 27447 were identified as potentially misvalued codes under the CMS high expenditure procedural code screen in the CY 2012 final rule with comment period. The AMA RUC reviewed the family of codes for hip and knee replacement (CPT codes 27130, 27236, 27446 and 27447) and provided us with recommendations for work RVUs and physician time for these services for CY 2014. We are establishing the AMA RUC-recommended values of 17.61 and 17.48 a CY 2014 interim final work RVUs for CPT codes 27236 and 27446, respectively.

For CPT codes 27130 and 27447, we are establishing work RVUs that vary from those recommended by the AMA RUC. In addition to the recommendation we received from the AMA RUC, we received alternative recommendations and input regarding appropriate values for codes within this family from the relevant specialty societies. These societies raised several objections to the AMA RUC's recommended values, including the inconsistent data sources used for determining the time for this recommendation relative to its last recommendation in 2005, concerns regarding the thoroughness of the AMA RUC's review of the services, and questions regarding the appropriate number of visits estimated to be furnished within the global period for the codes.

We have examined the information presented by the specialty societies and the AMA RUC regarding these services and we share concerns raised by stakeholders regarding the appropriate valuation of these services, especially related to using the most accurate data source available for determining the intraservice time involved in furnishing PFS services. Specifically, there appears to be significant variation between the time values estimated through a survey versus those collected through specialty databases. However, we also note that the AMA RUC, in making its recommendation, acknowledged that there has been a change in the source for time estimates since these services were previously valued.

We note that one source of disagreement regarding the appropriate valuation of these services result from differing views as to the postoperative visits that typically occur in the global period for both of these procedures. The AMA RUC recommended including three inpatient postoperative visits (2 CPT code 99231 and one CPT code 99232), one discharge day management visit (99238), and three outpatient postoperative office visits (1 CPT code 99212 and 2 CPT code 99213) in the global periods for both CPT codes 27130 and 27447. The specialty societies agreed with the number of visits included in the AMA RUC recommendation, but contended that the visits were not assigned to the appropriate level. Specifically, the specialty societies believe that the three inpatient postoperative visits should be 1 CPT code 99231 and 2 CPT code 99232. Similarly, the specialty societies indicated that the three outpatient postoperative visits should all be CPT code 99213. The visits recommended by the specialty societies would result in greater resources in the global period and thus higher work values.

The divergent recommendations from the specialty societies and the AMA RUC regarding the accuracy of the estimates of time for these services, including both the source of time estimates for the procedure itself as well as the inpatient and outpatient visits included in the global periods for these codes, lead us to take a cautious approach in valuing these services.

We agree with the AMA RUC's recommendation to value CPT codes 27130 and 27447 equally so we are establishing the same CY 2014 interim final work RVUs for these two procedures. However, based upon the information that we have at this time, we believe it is also appropriate to modify the AMA RUC-recommended RVU to reflect the visits in the global period as recommended by the specialty societies. This change results in a 1.12 work RVU increase for the visits in the global period. We added the additional work to the AMA RUC-recommended work RVU of 19.60 for CPT codes 27130 and 27447, resulting in an interim final work RVU of 20.72 for both services.

To finalize values for these services for CY 2015, we seek public comment regarding not only the appropriate work RVUs for these services, but also the most appropriate reconciliation for the conflicting information regarding time values for these services as presented to us by the physician community. We are also interested in public comment on the use of specialty databases as compared to surveys for determining time values. We are especially interested in potential sources of objective data regarding procedure times and levels of visits furnished during the global periods for the services described by these codes.

(4) Transcatheter Aortic Valve Replacement (TAVR) (CPT Code 33366)

For the CY 2013 final rule with comment period, we reviewed and valued several codes within the transcatheter aortic valve replacement (TAVR) family including CPT Codes 33361 (transcatheter aortic valve replacement (tavr/tavi) with prosthetic valve; percutaneous femoral artery approach), 33362 (transcatheter aortic valve replacement (tavr/tavi) with prosthetic valve; open femoral artery approach), 33363 (transcatheter aortic valve replacement (tavr/tavi) with prosthetic valve; open axillary artery approach), 33364 (transcatheter aortic valve replacement (tavr/tavi) with prosthetic valve; open iliac artery approach) and 33365 (transcatheter aortic valve replacement (tavr/tavi) with prosthetic valve; transaortic approach (eg, median sternotomy, mediastinotomy)). For these codes, we finalized the CY 2013 interim final values for CY 2014 (see section II.E.2.a.ii.) For CY 2014, CPT created a new code in the TAVR family, CPT code 33366, (Trcath replace aortic value).

The AMA RUC has recommended the median survey value RVU of 40.00 for CPT Code 33366. After review, we believe that a work RVU of 35.88, which is between the survey's 25th percentile of 30.00 and the median of 40.00, accurately reflects the work associated with this service. The median intraservice time from the survey for CPT code 33365 is 180 minutes and for CPT code 33366 is 195. Using a ratio between the times for these procedures we determined the current work RVU of 33.12 for CPT code 33365 results in the work RVU of 35.88 for CPT code 33366. We believe that an RVU of 35.88 more appropriately reflects the work required to perform CPT code 33366 and maintains appropriate relativity among these five codes. We are establishing a CY 2014 interim final work RVU of 35.88 for CPT code 33366.

(5) Retrograde Treatment Open Carotid Stent (CPT Code 37217)

The CPT Editorial Panel created CPT Code 37217, effective January 1, 2014. The AMA RUC recommended a work RVU of 22.00, the median from the survey, and an intraservice time of 120 minutes.

The AMA RUC identified CPT Code 37215 (Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection), which has an RVU of 19.68, as the key reference code for CPT code 37217. For its recommendations, the AMA RUC also compared CPT code 37217 to CPT Code 35301 (thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision), which has a work RVU of 19.61, and CPT code 35606 (Bypass graft, with other than vein; carotid-subclavian), which has a work RVU of 22.46.

In our review, we used the same comparison codes for CPT code 37217 as the AMA RUC used in valuing CPT code 37217. To assess the work RVUs for CPT code 37217 relative to CPT code 35606, we compared the AMA RUC-recommended work RVUs after removing the inpatient and outpatient visits in each code's 90-day global period, resulting in work RVUs of 15.39 and 15.85, respectively. Although these RVUs are similar, the intraservice times are not. CPT code 35606 has an intraservice time of 145 minutes compared with 120 minutes for CPT code 37217. To address the variation in intraservice times, we calculated a work RVU for CPT code 37217 that results in its work RVU having the same relationship to its time as does CPT code 35606. This results in a work RVU of 13.12 for the intraservice time. Adding back the RVUs for the visits results in a total work RVU of 19.73. This value, along with the RVUs of the other comparison codes used by the AMA RUC (CPT codes 37215 and 35301), supports our decision to establish a CY 2014 interim final work RVU of 20.38, the 25th percentile of the survey. We believe that this work RVU of 20.38 more accurately reflects the work involved and maintains relatively among the other codes involving similar work.

(6) Transcatheter Placement Intravascular Stent (CPT Code 37236, 37237, 37238, and 37239)

For CY 2014, the CPT Editorial Panel deleted four intravascular stent placement codes and created four new bundled codes, CPT codes 37236, 37237, 37238, and 37239.

We agreed with the AMA RUC recommendations for all of the codes in the family except CPT code 37239. The AMA RUC recommended a work RVU of 3.34 for CPT code 37239, which they crosswalked to the work value of 35686 (Creation of distal arteriovenous fistula during lower extremity bypass surgery (non-hemodialysis) (List separately in addition to code for primary procedure)). CPT code 37239 is the add-on code to 37238 for placement of an intravascular stent in each additional vein. The AMA RUC valued placement of a stent in the initial artery (CPT code 37236) at 9.0 work RVUs and its corresponding add-on code (37237) for placement of a stent in an additional artery at 4.25 work RVUs. After review, we believe that the ratio of the work of placement of the initial stent and additional stents would be the same regardless of whether the stent is placed in an artery or a vein, and that the appropriate ratio is found in the AMA RUC-recommended work RVUs of CPT codes 37236 and 37237. To determine the work RVU for CPT code 37239, we applied that ratio to the AMA RUC-recommended work RVU of 6.29 for CPT code 37238. Therefore, we are assigning an interim final work RVU of 2.97 to CPT code 37239 for CY 2014.

(7) Embolization and Occlusion Procedures (CPT Codes 37241, 37242, 37243, and 37244)

For CY 2014, the CPT Editorial Panel deleted CPT code 37204 (transcatheter occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non-head or neck)) and created four new bundled codes to describe embolization and occlusion procedures, CPT codes 37241, 37242, 37423, and 37244.

We agreed with the AMA RUC recommendations for CPT codes 37241 and 37244. However, we disagree with the AMA RUC-recommended work RVU of 11.98 for CPT code 37242. The AMA RUC recommended a direct crosswalk to CPT code 34833 (Open iliac artery exposure with creation of conduit for delivery of aortic or iliac endovascular prosthesis, by abdominal or retroperitoneal incision, unilateral) because of the similarity in intraservice time. The service described by CPT code 37242 was previously reported using CPT codes 37204 (Transcatheter occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non-head or neck, 75894 (Transcatheter therapy, embolization, any method, radiological supervision and interpretation), and 75898 (Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion, other than for thrombolysis). The intraservice time for CPT code 37204 is 240 minutes and the work RVU is 18.11. The AMA RUC-recommended intraservice time for CPT code 37242 is 100 minutes. We believe that the AMA RUC-recommended work RVU does not adequately consider the substantial decrease in intraservice time for CPT code 37242 as compared to CPT code 37204. Therefore, we believe that the survey's 25th percentile work RVU of 10.05 is consistent with the decreases in intraservice time and more appropriately reflects the work of this procedure.

We also disagree with the AMA RUC-recommended work RVU of 14.00 for CPT code 37243, which the AMA RUC crosswalked from CPT code 37244, which has a work RVU of 14.00. The AMA RUC stated that work RVU of CPT codes 37243 and 37244 should be the same despite a 30-minute intraservice time difference between the codes because the work of CPT code 37244 (recommended intraservice time of 90 minutes) was more intense than CPT code 37243 (recommended intraservice time of 120 minutes). This service was previously reported using CPT codes 37204, 75894 and 75898; or 37210 (Uterine fibroid embolization (UFE, embolization of the uterine arteries to treat uterine fibroids, leiomyoma), percutaneous approach inclusive of vascular access, vessel selection, embolization, and all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the procedure). The current intraservice time for CPT code 37204 is 240 minutes and the work RVU is 18.11. The current intraservice time for CPT code 37210 is 90 minutes and the work RVU is 10.60. The AMA RUC-recommended intraservice time for 37243 is 120 minutes. We do not believe that the AMA RUC-recommended work RVU adequately considers the substantial decrease in intraservice time for CPT code 37243 as compared to CPT code 37204. We also note that the AMA recognized that CPT code 37243 is less intense than CPT code 37244. Therefore, we believe that the survey's 25th percentile work RVU of 11.99 more appropriately reflects the work required to perform this service.

(8a) Gastrointestinal (GI) Endoscopy (CPT Codes 43191–43453)

In CY 2011, numerous esophagoscopy codes were identified as potentially misvalued because they were on the CMS multi-specialty points of comparison list. For CY 2014, the CPT Editorial Panel revised the code sets for these services. The AMA RUC submitted recommendations for 65 codes that describe esophagoscopy, esophagogastroduodenoscopy (EGD), and endoscopic retrograde cholangiopancreatography (ERCP) of the esophagus, stomach, duodenum, and pancreas/gall bladder.

In valuing this revised set of codes, we note that the AMA RUC recommendations included information demonstrating significant overall reduction in time resources associated with furnishing these services. In the absence of information supporting an increase in intensity, we would expect that the work RVUs would decrease if there are reductions in time. However, the AMA RUC-recommended work RVUs do not reflect overall reductions in work RVUs proportionate to the reductions in time. Therefore, we questioned the recommended work RVUs unless the recommendations included information indicating that the intensity of the work had increased.

We note that in assigning values that maintain the appropriate relativity throughout the PFS, it is extremely important to review a family of services together and we aim to address recommendations regarding potentially misvalued codes in the first possible rulemaking cycle. Therefore, we are establishing interim final values for these codes for CY 2014 although we do not have the AMA RUC recommendations for the remaining lower GI tract codes. We expect to receive these recommendations in time to include them in the CY 2015 final rule with comment period. At that time, we may revise the interim final values established in this final rule with comment period to address any family relativity issues that may arise once we have more complete information for the entire family.

The AMA RUC used a number of methodologies in valuing these codes. These include accepting survey medians or 25th percentiles, crosswalking to other codes, and calculating work RVUs using the building block methodology. These are reviewed in section II.E.1. above. The AMA RUC also made extensive use of a methodology that uses the incremental difference in codes to determine values for many of these services. This methodology, which we call the incremental difference methodology, uses a base code or other comparable code and considers what the difference should be between that code and another code by comparing the differentials to those for other similar codes. Many of the procedures described within the esophagoscopy subfamily have identical counterparts in the esophagogastroduodenoscopy (EGD) subfamily. For instance, the base esophagoscopy CPT code 43200 is described as "Esophagoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing when performed." The base EGD CPT code 43235 is described as "Esophagogastroduodenoscopy, flexible, transoral; diagnostic, with collection of specimen(s) by brushing or washing, when performed." In valuing other codes within both subfamilies, the AMA RUC frequently used the difference between these two base codes as an increment for measuring the difference in work involved in doing a similar procedure utilizing esophagoscopy versus utilizing EGD. For example, the EGD CPT code 43239 includes a biopsy in addition to the base diagnostic EGD CPT code 43235. The AMA RUC valued this by adding the incremental difference in the base esophagoscopy code over the base EGD CPT code to the value it recommended for the esophagoscopy biopsy, CPT code 43202. With some variations, the AMA RUC extensively used this incremental difference methodology in valuing subfamilies of codes. We have made use of similar methodologies, in addition to the methodologies listed above, in establishing work RVUs for codes in this family. We have also made use of an additional methodology not typically utilized by the AMA RUC. As noted above in this section, we believe that the significant decreases in intraservice and total times for these services should result in corresponding changes to the work RVUs for the services. In keeping with this principle, we chose, in some cases, to decrement the work RVUs for particular codes in direct proportion to the decrement in time. For example, for a CPT code with a current work RVU of 4.00 and an intraservice time of 20 minutes that decreases to 15 minutes following the survey, we might have reconciled the 25 percent reduction in overall time by reducing the work RVU to 3.00, a reduction of 25 percent.

(8b) Esophagoscopy

The rigid and flexible esophagoscopy services are currently combined into one code, but under the new coding structure the services are separated into rigid transoral, flexible transnasal and flexible transoral procedure CPT codes.

(8c) Rigid Transoral Esophagoscopy

To determine the interim final values for the rigid transoral esophagoscopy codes, CPT codes 43191, 43192, 43193, 43194, 43195, and 43196, we considered the AMA RUC-recommended intraservice times and found that the surveys showed that half of the rigid transoral esophagoscopy codes had 30 minutes of intraservice time and a work RVU survey low of 3.00, a ratio of 1 RVU per 10 minutes (1 work RVU/10 minutes). This ratio was further supported by the relationship between the CY 2013 work value of 1.59 RVUs for CPT code 43200 (Esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)) and its intraservice time of 15 minutes. Based upon the 1 work RVU/10 minutes ratio, we are establishing CY 2014 interim final work RVU of 2.00 for CPT code 43191, 3.00 for CPT code 43193, 3.00 for CPT code 43194, 3.00 for CPT code 43195, and 3.30 for CPT code 43196.

For CPT code 43192, the 1 work RVU/10 minute ratio resulted in a value that was less than the survey low, and thus did not appear to work appropriately for this procedure. Therefore, we are establishing a CY 2014 interim final work RVU for CPT code 43192 of 2.45 based upon the survey low.

(8d) Flexible Transnasal Esophagoscopy

In recommending work RVUs for the two CPT codes 43197 and 43198, which describe flexible transnasal services, the AMA RUC recommended the same work RVUs as it recommended for the corresponding flexible transoral CPT codes (43200 and 43202). We believe these recommendations overstate the work involved in the transnasal codes since, unlike the transoral codes, they are not typically furnished with moderate sedation. Therefore, to value CPT code 43197 and 43198, we removed 2 minutes of the pre-scrub, dress and wait preservice time from the calculation of the work RVUs that we are establishing for CY 2014 for CPT codes 43200 and 43202. We are establishing CY 2014 interim final values of 1.48 for CPT code 43197 and 1.78 for CPT code 43198.

(8e) Flexible Transoral Esophagoscopy

We established values for CPT codes 43216 through 43226 based on the AMA RUC recommendations.

We used CPT code 43200 as the base code for evaluating all the flexible esophagoscopy services. The CY 2013

code descriptor for 43200 includes both flexible and rigid esophagoscopy, while for CY 2014, the descriptor has been revised to include only flexible esophagoscopy. Despite this change in the code descriptor for CY 2014, the AMA RUC-recommended maintaining a work RVU of 1.59 for this code. However, we believe that the rigid esophagoscopy, described by the new CPT code 43191, is a more difficult procedure and by removing the rigid service from CPT code 43200 the intensity of services described by the revised CPT code 43200 are lower than the intensity of services described by the existing code. To establish an appropriate interim final value for the new code, we followed the 1 work RVU per 10 minutes of intraservice time methodology described above resulting in an interim final work RVU of 1.50 for the service. This interim final work RVU valuation is further supported by the AMA RUC's recommendation that would decrease total time from 55 minutes to 52 minutes.

We believe that the work value difference between CPT code 43200 and 43202 as recommended by the AMA RUC is correct. Therefore, we added the difference in the AMA RUC recommended values for CPT codes 43200 and 43202, 0.30 RVUs, to CPT code 43200, resulting in a work RVU of 1.80 for CPT codes 43201. We note that the resulting difference between 43200 and 43201 of 0.30 RVUs is also similar to the 0.31 difference between the values the AMA RUC recommended for these two codes.

We also believe that the work involved in CPT code 43201 is similar to the work involved in CPT code 43202. Accordingly we are establishing a CY 2014 interim final work RVU of 1.80.

For CPT code 43204, the AMA RUC recommended a work RVU of 2.89. We believe that this code is similar to CPT code 43201 in that both codes involve injections in the esophagus. However, CPT code 43204 has 20 minutes of intraservice time compared to 15 minutes for CPT code 43201. Applying this increase in intraservice time to the work RVU that we are establishing for CPT code 43201 results in a work RVU of 2.40 for this code. The AMA RUC recommended a work RVU of 3.00 for CPT code 43205, an increment of 0.11 RVUs over its recommended value for CPT code 43204. Both of these codes involve treatment of esophageal varices. We agree with that increment and are adding that to our CY 2014 interim final work RVU for CPT code 43204 of 2.40 to arrive at a CY 2014 interim final work RVU of 2.51 for CPT code 43205.

In establishing interim final work RVUs for CPT code 43211, we followed the methodology used by the AMA RUC to develop its recommendation. The AMA RUC decreased the work RVU of the corresponding esophagogastroduodenoscopy (EGD for mucosal resection), CPT code 43254, by the difference between the base esophagoscopy code 43200 and the base EGD code 43235, which is 0.67 RVU. Reducing our CY 2014 interim final work RVU of 4.88 for CPT code 43254 by this difference results in a CY 2014 interim final work RVU of 4.21 for CPT code 43211.

Since CPT code 43212 has almost identical times and intensities as CPT code 43214, we crosswalked the work RVU from our CY 2014 interim final work RVU of 3.38.

In valuing CPT code 43213, we believe it is comparable to CPT code 43200, but has intraservice time of 45 minutes, while CPT code 43200 has only 20 minutes. We are establishing a CY 2014 interim final work RVU of 4.73, which is based upon the difference in intraservice time between the two codes.

CPT code 43214 is esophageal dilatation using fluoroscopic guidance. We believe that the service described by CPT code 43214 is similar in intensity and intraservice time to CPT code 31622 (Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)), another endoscopic code using fluoroscopic guidance. However, CPT code 43214 includes an endoscopic dilation in addition to the fluoroscopic guided endoscopy. Therefore, we added the incremental increase between the work RVU of the esophagoscopy base code for dilation without fluoroscopic guidance, CPT code 43220, and the base code to the work RVU for CPT code 31622 and are establishing a CY 2014 interim final work RVU of 3.38 for CPT code 43214.

We believe that the time and work for CPT 43215 are identical to those for CPT code 43205. Therefore, we crosswalked the work RVU for CPT code 43215 to CPT code 43205, and are establishing a CY 2014 interim final work RVU of 2.51.

For current CPT code 43227, the survey reflected a decrease in intraservice time from the current, 36 minutes to 30 minutes. The AMA RUC recommended a small decrease in RVUs, but not one that was proportionate to the difference in intraservice time. Therefore, we decreased the current work RVU proportionate to the decrease in intraservice time, resulting in a CY 2014 interim final work RVU of 2.99.

CPT code 43231 is a basic esophagoscopy procedure done with endoscopic ultrasound. We disagree with the AMA RUC recommendation to maintain the current work RVU of 3.19, despite a decrease in intraservice time. Instead, we used the work RVU of another endoscopic code using endoscopic ultrasound to value the incremental difference in work between this service and the esophagoscopy base code. CPT code 31620 (Endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s) (List separately in addition to code for primary procedure[s])) is an add-on code for EBUS to other bronchoscopy codes, with a current work RVU of 1.40. We added this EBUS work RUV to the work RVU of base esophagoscopy code 43200 and are establishing a CY 2014 interim final work RVU of 2.90.

For CPT code 43232, we believe that the work value difference between CPT code 43231 and 43232 as recommended by the AMA RUC is correct. We added that difference of 0.64 work RVUs to our CY 2014 interim final work RVU for CPT code 43231 to arrive at our CY 2014 interim final work RVU of 3.54 for CPT code 43232.

CPT code 43229 has similar times and intensity to CPT code 43232 and therefore, we directly crosswalked the work value of CPT code 43229 to CPT code 43232, resulting in a CY 2014 interim final work RVU of 3.54.

(8f) Esophagogastroduodenoscopy (EGD)

Various EGD codes were identified as potentially misvalued through the multi-specialty point of comparison, high expenditures, and fastest growing screens. The AMA RUC recommended values for all EGD codes. We agreed with the AMA RUC recommended values and are establishing CY 2014 interim final work RVUs for CPT codes 43240, 43241, 43243, 43244, 43245, 43248, 43249, 43250, and 43251 based on its recommendations.

In reviewing the base EGD code, CPT code 43235, we determined that we agreed with the AMA RUC's recommended work RVU difference between this EGD base code and the esophagoscopy base code, CPT 43200. We applied this difference to our CY 2014 interim final work RVU of 1.50 for CPT code 43200 and are establishing a CY 2014 interim final RVU of 2.17 for CPT code 43235.

CPT code 43233 is an identical procedure to CPT code 43214 except that it uses EGD rather than esophagoscopy. We added the

additional work RVU of furnishing an EGD as compared to an esophagoscopy to our CY 2014 interim final work RVU of 3.38 for CPT code 43214, resulting in a CY 2014 interim final work RVU of 4.05 for CPT 43233.

CPT code 43236 is the EGD equivalent of the esophagoscopy CPT code 43201. In valuing CPT code 43236, the AMA RUC used the incremental difference methodology using CPT codes 43200 and 43201 and added that difference to its recommended work value for CPT code 43235 to arrive at its recommended RVU of 2.57 for CPT code 43236. We used the same methodology but instead of using the AMA RUC recommended work RVU for CPT code 43235, we used our CY 2014 interim final value of 2.17 for CPT code 43235. We are establishing a CY 2014 interim final work RVU of 2.47 for CPT code 43236.

CPT code 43237 is the EGD equivalent to the esophagoscopy CPT code 43231. We do not believe that the AMA RUC-recommended work RVU adequately accounts for the 20 percent decrease from current time to the AMA RUC-recommended intraservice time. Therefore, we applied an incremental difference methodology as discussed above for CPT code 43233. We used the comparable esophagoscopy code 43231 and added its CY 2014 interim final work RVUs to the incremental value of a base EGD over the base esophagoscopy, resulting in a CY 2014 interim final work RVU of 3.57 for CPT code 43237.

CPT code 43238 is the EGD equivalent to the esophagoscopy CPT code 43232. We valued this code similarly to CPT code 43237 using the incremental difference approach. We do not believe that the AMA RUC recommended RVU adequately accounts for the 36 percent decrease in intraservice time. We used the CY 2014 interim final work RVU for the comparable esophagoscopy CPT code 43232 and added that to that the incremental work RVU of an EGD over esophagoscopy, resulting in a CY 2014 interim final work RVU of 4.11 for CPT code 43238.

CPT code 43239 is the EGD equivalent to the esophagoscopy CPT code 43202 and we used the incremental difference methodology described above. We do not believe that the AMA RUC recommended RVU adequately accounts for the 56 percent decrease in intraservice time. We used the CY 2014 interim final work RVU for the comparable esophagoscopy code 43202 and added that to the incremental work RVU value of an EGD over esophagoscopy, resulting in a work RVU of 2.47, which we are establishing as the CY 2014 interim final work RVU for CPT code 43239.

CPT code 43242 is an equivalent service to CPT code 43238 except that CPT code 43242 includes diagnostic services in a surgically altered GI tract. The AMA RUC recommendation used a methodology that took the increment between CPT code 43238 and CPT code 43237, which is an ultrasound examination of a gastrointestinal (GI) tract that has not been surgically altered. The AMA RUC then applied that difference in its recommended work RVUs for these two codes to CPT code 43259, which is an ultrasound of a GI tract that has been surgically altered. We agree with that methodology but instead applied our CY 2014 interim final work RVUs for those codes. Accordingly, we are establishing a CY 2014 interim final RVU of 4.68 for CPT code 43242.

In valuing CPT code 43246, we note that the work and time are very similar to CPT code 43255. Therefore, we directly crosswalked the service to the CY 2014 interim final work RVU of CPT code 43255 and are establishing a CY 2014 interim final value of 3.66.

CPT code 43247 is the EGD equivalent to the esophagoscopy CPT code 43215. In valuing this code, the AMA RUC applied the increment between CPT code 43200 and 43215 to the EGD base CPT code 43235 to arrive at its recommended RVU of 3.27. We agree with this methodology but applied the values we have established for these codes, resulting in a work RVU of 3.18 for CPT code 43247.

In valuing CPT code 43253, the AMA RUC applied the same methodology as it used in valuing CPT code 43242, resulting in a recommended RVU of 5.39. We agree with that methodology, but instead of using the AMA RUC-recommended values, we are using our CY 2014 interim final work RVUs. We are establishing a CY 2014 interim final work RVU of 4.68 for CPT code 43253.

CPT code 43254 is the EGD equivalent to the esophagoscopy CPT code 43211. The AMA RUC-recommended a work RVU of the survey's 25th percentile of 5.25. We believe that this overstates the work involved in this code and that the incremental methodology used by the AMA RUC for many of these codes is more appropriate. Thus, we applied the incremental difference methodology between the base EGD and esophagoscopy codes to the equivalent esophagoscopy CPT code 43211 and are establishing a CY 2014 interim final RVU of 4.88.

CPT code 43255 is the EGD equivalent to the esophagoscopy CPT code 43227. We do not believe that the AMA RUC-recommended 13 percent work RVU decrease adequately accounts for the 44 percent decrease in intraservice time. Therefore, we applied the incremental difference methodology, using our CY 2014 interim final values and the comparable esophagoscopy code, CPT code 43227. We are establishing a CY 2014 interim final work RVU of 3.66 for CPT code 43255.

CPT code 43257 is a CY 2013 code for which the AMA RUC recommended the survey's 25th percentile. We note that the service has an identical intraservice time and similar intensity to CPT code 43238. Thus, we directly crosswalked the work RVU from CPT code 43238 to CPT code 43257. We are establishing a CY 2014 interim final work RVU of 4.11 for CPT code 43257, which is consistent with the 25 percent reduction from current intraservice time.

In valuing CPT code 43259, the AMA RUC recommended the survey's 25th percentile RVU of 4.74. We disagree with that value and note that the intraservice time has decreased 35 percent and the total time has decreased 20 percent. Applying the intraservice time decrease to the CY 2013 work RVU would result in an RVU of 3.38. We believe that value does not maintain the appropriate rank order with the other EGD codes. Adjusting the current RVU to account for the reduction in total time results in a work RVU of 4.14. We believe that this work RVU more accurately values the work involved in this service. Thus, we are establishing a CY 2014 interim final RVU of 4.14 for this code.

CPT code 43266 is the EGD equivalent to the esophagoscopy CPT code 43212. In valuing CPT code 43266, the AMA RUC recommended the survey's 25th percentile RVU of 4.40, higher than the current value of 4.34 even though the intraservice time decreased from 45 minutes to 40 minutes. We disagree with this recommended work RVU. Therefore, we used the incremental difference methodology and added the difference in work RVUs between the base esophagoscopy code and the base EGD code to the equivalent esophagoscopy CPT code 43212 for an RVU of 4.05. Thus, we are establishing a CY 2014 interim final work RVU of 4.05 for CPT code 43266.

CPT code 43270 is the EGD equivalent to the esophagoscopy CPT code 43229. The AMA RUC recommended the survey's 25th percentile work RVU of 4.39. We disagree with this value and believe that utilizing the incremental difference methodology more accurately determines the appropriate work for this service. For CPT code 43270, we added the difference in work RVUs between the base EGD code over the base

esophagoscopy code to our CY 2014 interim final work RVU for CPT 43229, resulting in a work RVU of 4.21. Thus, we are establishing a CY 2014 interim final value of 4.21 for CPT code 43270.

(8g) Endoscopic Retrograde Cholangiopancreatography

In CY 2011, several endoscopic retrograde cholangiopancreatography (ERCP) codes were identified by CMS through the multi-specialty points of comparison screen. The AMA RUC provided recommendations for seven current codes and five new codes. CPT codes 43260–43265 and 43273–43278 were reviewed. We agreed with the AMA RUC-recommended values for CPT codes 43260, 43261, 43262, 43264, 43265, 43273, 43275, and 43277 as shown on Table 27.

The AMA RUC recommended that the work RVU for CPT code 43263 be maintained at its current RVU of 7.28 in spite of a 25 percent decrease to its recommended intraservice time for this code. This code has identical times to CPT code 43262 for which the AMA RUC recommended a decrease in the work RVU from its current value of 7.38 to 6.60, consistent with the decrease in time. We believe that this reduction more accurately reflects the work involved in this code, so we crosswalked the work RVU for CPT code 43263 to CPT code 43262. We are establishing a CY 2014 interim final work RVU of 6.60 for CPT code 43263.

CPT code 43274 is a new code involving stent placement and sphincterotomy. The AMA RUC valued this code by adding the increment of a sphincterotomy and stent placement to the work RVU of the base ERCP, CPT code 43260, resulting in an AMA RUC-recommended work RVU of 8.74. We agree with this methodology, except we have used our CY 2014 interim final work RVUs. We are establishing an interim final RVU of 8.48 for CPT code 43274.

CPT code 43276 is a new code without previous physician times to compare that involves the removal and replacement of a stent. The AMA RUC developed its recommendation using the incremental difference methodology. It determined the incremental work RVU associated with removing a foreign body by comparing CPT code 43215 to the base esophagoscopy code, CPT code 43200. It also determined the incremental value of placing a stent with esophagoscopy, CPT code 43212, over the base esophagoscopy, CPT code 43200. By adding these two increments to the work RVU of the ERCP base code, CPT code 43260, the AMA recommended a work RVU for CPT code 43276 of 9.10. The median survey value was 9.88 and the survey's 25th percentile was 6.95. The combination of 60 minutes of intraservice time with an RVU of 9.10 is not comparable with other ERCP codes. For CPT code 43274, for example, the AMA RUC recommended 68 minutes intraservice time and a work RVU of 8.74. We accepted the AMA RUC recommendations for CPT code 43265 of 78 minutes intraservice time and a work RVU of 8.03. Both CPT codes 43262 and 43263 have intraservice times of 60 minutes and a CY 2014 interim final work RVU of 6.60. Based on these comparisons, we believe that the AMA RUC recommendation for this code of 9.10 is inconsistent with the RVUs assigned to codes that describe similar services with similar intraservice times. Therefore, we are using the incremental difference methodology to arrive at the appropriate work RVU. CPT code 43275 describes the removal of a stent using ERCP. We used CPT code 43275 with a CY 2014 interim final work RVU of 6.96 and added the incremental difference of placing a stent utilizing esophagoscopy, CPT code 43212, over the base esophagoscopy code CPT code 43200. We believe that this valuation approach results in values that are more consistent with other codes in this family than the AMA RUC recommendation. We are establishing a CY 2014 interim final RVU of 8.84 for CPT code 43276.

CPT code 43277 is a new code for CY 2014, which describes ERCP with dilation and if furnished, sphincterotomy. The AMA RUC recommended a work RVU of 7.11 RVU. The AMA RUC determined this value using an incremental approach. Specifically, the work RVU for dilation was calculated as the difference between the esophagoscopy dilation code (CPT code 43220) and the esophagoscopy base code, CPT code 43200, and the sphincterotomy work RVU was calculated as the difference between the base ERCP code, CPT 43260, and the ERCP sphincterotomy code, CPT code 43262. By adding these two values to the work RVU of CPT code 43260, the AMA RUC calculated its recommended work RVU of 7.11. The survey's 25th percentile is 7.00.

Currently, ERCP sphincterotomy is billed using a single code, CPT code 43262, and duct dilation using ERCP is currently billed using CPT code 43271. Adding together the current work RVUs for these two codes results in a RVU of 8.81. The total combined intraservice time for these two codes is 90 minutes. Since the new CPT code 43277 has an intraservice time of only 70 minutes, we applied the percentage decrease in time to the current combined work RVU for CPT 43262 and 43271 of 8.81, resulting in a work RVU of 6.85. Although this value reflects a proportional reduction in intraservice time between the current codes and the time presumed for the AMA RUC recommendation, we believe that a work RVU of 6.85 does not adequately reflect the intensity of this service and are therefore establishing an interim final RVU for CPT code of 43277 of 7.00, which is the survey's 25th percentile.

CPT code 43278 is a new code involving lesion ablation. The AMA RUC valued this code by adding the incremental work RVU difference between the base esophagoscopy code and the esophagoscopy ablation code, CPT code 43229, to the base ERCP code, resulting in a RVU of 8.08. We agree with this methodology. However, using our CY 2014 interim final values we are establishing a CY 2014 interim final work RVU of 7.99.

(8h) Dilation of Esophagus

We agree with the AMA RUC recommended values for the dilation of the esophagus, CPT codes 43450 and 43453, as shown on Table 27.

(9) Transplantation of Kidney (CPT Code 50360)

We received an AMA RUC work RVU recommendation of 40.90 for CPT code 50360 which included an increase in the service's intraservice time, from 183 minutes to 210 minutes. We also note that there is a significant decrease in the number of AMA RUC-recommended visits in the global period for this procedure.

In CY 2006, the work RVU for CPT 50360 was 31.48. In CY 2007 and CY 2010, the work RVUs for all services with global periods, including CPT code 50360, were increased to take into account increases in the work RVUs for E/M services. These changes resulted in the current work RVU for CPT code 50360 of 40.90. We note that this increase was based on an assumption of 32 visits in the global period. Based upon information that we now have, it appears that an assumption of 10 visits may have been more appropriate. If we had used an assumption of 10 visits when adding E/M services in 2007 and 2010, the current work RVU would be 34.68.

In determining a CY 2014 interim final work RVU, we began with the 34.68 work RVU value. The AMA RUC recommended a 14.75 percent increase in intraservice time, from 183 min to 210 min. Applying this ratio to the refined base work RVU of 34.68 results

in a new base work RVU of 39.80. Adding the changes in work RVU resulting from the changes in the preservice and postservice times recommended by the AMA RUC results in an interim final work RVU of 39.88 for CPT code 50360.

(10) Spinal Injections (CPT Codes 62310, 62311, 62318, and 62319)

For CY 2014, we received AMA RUC recommendations for CPT codes 62310, 62311, 62318, and 62319. Although the AMA RUC recommendations show a significant reduction in intraservice and total times for the family, the recommended work RVUs do not reflect a similar decrease.

For CPT code 62310, we disagree with the work RVU of 1.68 recommended by the AMA RUC because the reduction from the current work is not comparable to the 63 percent reduction in time being recommended by the AMA RUC. We, however, agree that the methodology used by the AMA RUC to develop a recommendation was appropriate. Using this methodology, we calculated the difference in the AMA RUC recommendations for CPT 62310 and 62318 and subtracted this from our CY 2014 interim work RVU for CPT 62318, which results in a work RVU of 1.18, which we are establishing as the CY 2014 interim final work RVU for CPT code 62310.

The AMA RUC recommended maintaining the current work RVU for CPT code 62311 of 1.54 even though its recommended intraservice time decreased 50 percent. We disagreed with this approach.To determine the CY 2014 interim final work RVU we subtracted the difference between the AMA RUC-recommended work RVUs of 62311 and 62319 from our CY 2014 interim final work RVU for CPT code 62319. We believe that the resultant work RVU of 1.17 is a better approximation of the work involved in CPT code 62311.

CPT code 62318 currently has an intraservice time of 20 minutes and a work RVU of 2.04. The intraservice time reduced by 25 percent but the AMA RUC recommended no change in the work RVU. The low value of the survey is 1.54, which is consistent with the reduction in intraservice time. Therefore, we are establishing an interim final RVU for CPT code 62318 of 1.54.

The AMA RUC recommended a 50 percent decrease in intraservice time for CPT 62319 but no change in the work RVU. Similar to the CPT code 62318, we believe the low value of 1.50 more accurately represents the work involved in the code and the significant reduction in intraservice time.

(11) Laminectomy (CPT Codes 63047 and 63048)

We identified CPT code 63047 through the high expenditure procedure code screen. For CY 2014, we received AMA RUC recommendations on CPT codes 63047 and 63048.

In reviewing the AMA RUC recommendations for these codes, we determined that to appropriately value these codes, we need to consider the other two codes in this family: CPT codes 63045 (Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; cervical) and 63046 (Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; thoracic). Since the AMA RUC did not submit recommendations for these codes, we are valuing CPT codes 63047 and 63048 on an interim final basis for CY 2014 at work RVUs of 15.37 and 3.47, respectively, based upon the AMA RUC recommendations. We note that expect to review these values in concert with the AMA RUC recommendations for CPT codes 63045 and 63046.

(12) Chemodenervation of Neck Muscles (CPT Codes 64616 and 64617)

For CY 2014, we received AMA RUC recommendations for two new chemodenervation codes, CPT codes 64616 and 64617, which replace CPT code 64613 (chemodenervation of muscle(s); neck muscle(s) (eg, for spasmodic torticollis, spasmodic dysphonia)). We disagree with the AMA RUC-recommended work RVUs of 1.79 for CPT code 64616 and 2.06 for CPT code 64617. We do not think that these recommended values account for the absence of the outpatient visit that was included in the predecessor code, CPT 64613. To adjust for this, we subtracted the 0.48 work RVUs associated with the outpatient visit from the 2.01 work RVU of the predecessor code, CPT code 64613; resulting in a work RVU of 1.53, which we are assigning as an interim final value for CPT 64616.

CPT code 64617 is chemodenervation of the larynx and includes EMG guidance when furnished. The EMG guidance CPT code 95874 (Needle electromyography for guidance in conjunction with chemodenervation (List separately in addition to code for primary procedure)) has a work RVU of 0.37. To calculate the work RVU for CPT 64617 we added the work RVU for CPT 95874, EMG guidance, to the 1.53 work RVU for CPT 64616, which results in a work RVU of 1.90.

Therefore, on an interim final basis for CY 2014, we are assigning a work RVU of 1.53 to CPT code 64616 and 1.90 to CPT code 64617.

(13) Chemodenervation of Extremity or Trunk Muscles (CPT Codes 64642, 64643, 64644, 64645, and 64647)

For CY 2014, the CPT Editorial Panel created six new codes to more precisely describe chemodenervation of extremity and trunk muscles. We assigned CY 2014 interim final work RVUs for four of these CPT codes (64642, 64644, 64646 and 64647), based upon the AMA RUC recommendations.

CPT Codes 64643 and 64645 are add-on codes to CPT codes 64642 and 64644, respectively. We disagree with the AMA RUC-recommended work RVUs of 1.32 for CPT code 64643 and 1.52 for CPT code 64645. We agree with the AMA RUC that the intraservice times for each base code and its add-on code should be the same. However, the AMA RUC-recommendations for the add-on codes contain 19 minutes less time than the base codes because of decreased preservice and post-times in the add-on codes. Therefore, we are adjusting the add-on codes by subtracting the RVUs equal to 19 minutes of preservice and postservice from the AMA RUC recommended work RVU for each base code to account for the decrease in time for performing the add-on service. Using the methodology outlined above, we are assigning a CY 2014 interim final work RVU for CPT code 64643 of 1.22 and a work RVU for CPT code 64645 of 1.39.

We are basing the global period for these codes on their predecessor code, CPT code 64614 (chemodenervation of muscle(s); extremity and/or trunk muscle(s) (eg, for dystonia, cerebral palsy, multiple sclerosis)), which is being deleted for CY 2014. Therefore, we are assigning these codes a 010-day global period.

(14) Cerumen Removal (CPT Code 69210)

This code was reviewed as a potentially misvalued code pursuant to the CMS high expenditure screen. The CPT Editorial Panel changed the code descriptor for removal of impacted cerumen from "1 or both ears" to "unilateral," effective January 1, 2014. The AMA RUC recommended a work RVU for this code of 0.58. In its recommendation to the AMA RUC, the specialty society stated that there was

no information to determine how often the service was performed unilaterally but asserted, and the AMA RUC agreed, that the service was performed bilaterally 10 percent of the time. In determining its recommendation, the AMA RUC applied work neutrality to the current work RVU of 0.61 to arrive at the recommended work RVU of 0.58 based upon the assertion that the code that was previously only reported once if furnished bilaterally, would now be reported for two units, due the descriptor change.

We disagree with the assumption by the AMA RUC that the procedure will be furnished in both ears only 10 percent of the time as the physiologic processes that create cerumen impaction likely would affect both ears. Given this, we will continue to allow only one unit of CPT 69210 to be billed when furnished bilaterally. We do not believe the AMA RUC's recommended value reflects this and therefore, we will maintain the CY 2013 work value of 0.61 for CPT code 69210 when the service is furnished.

(15) MRI Brain (CPT Code 70551, 70552, 70553, 72141, 72142, 72146, 72147, 72148, 72149, 72156, 72157, and 72158)

For CY 2014, the AMA RUC reviewed the family of magnetic resonance imaging (MRI) for the brain (CPT codes 70551, 70552, and 70553) and the family for MRI for the spine (CPT codes 72141, 72142, 72146, 72147, 72148, 72149, 72156, 72157, and 72158). We are assigning the AMA RUC-recommended work RVUs as CY 2014 interim final values for all of these codes except for CPT code 70553.

The AMA RUC found that the codes in these two families required a similar amount of work and valued the codes with similar work identically, except for CPT code 70553, which is the MRI code for brain imaging. CPT code 70553 is brain imaging without contrast followed by brain imaging with contrast. The AMA RUC recommended that the work RVU for this code remain at its current value of 2.36, while recommending that the work RVUs of CPT codes 72156, 72157 and 72158 be decreased to 2.29. These three codes are similar to CPT code 70553 in that they identify MRI services without contrast followed by contrast for the three sections of the spine—cervical, thoracic and lumbar. We agree with the AMA RUC that the work is similar for the two families of codes and that the codes should be valued accordingly. The AMA RUC-recommended value for CPT code 70553 is not consistent with the determination that these codes require a similar amount of work. Therefore, we are assigning a CY 2014 interim final work RVU of 2.29 to CPT code 70553.

(16) Molecular Pathology (CPT Code 81161)

The AMA RUC submitted a recommended value for CPT code 81161, a newly created molecular pathology code, for CY 2014. Consistent with our policy established in the CY 2013 final rule with comment period that molecular pathology codes are paid under the CLFS as lab tests, rather than under the PFS as physician services, we are assigning CPT code 81161, a PFS procedure status indicator of X (Statutory exclusion (not within definition of 'physician service' for physician fee schedule payment purposes. Physician Fee Schedule does not allow payment, but perhaps another Medicare Fee Schedule does)). (77 FR 68994–69002). As explained in the CY 2013 final rule with comment period, HCPCS code G0452 can be used under the PFS by a physician to bill for medically necessary interpretation and written report of a molecular pathology test, above and beyond the report of laboratory results.

(17) Immunohistochemistry (CPT Codes 88342 and 88343)

The CPT Editorial Panel revised the existing immunohistochemistry code, CPT code 88342 and created a new add-on code 88343 for CY 2014. Current coding requirements only allow CPT code 88342 to be billed once per specimen for each antibody, but the revised CPT codes and descriptors would allow the reporting of multiple units for each slide and each block per antibody (88342 for the first antibody and 88343 for subsequent antibodies). We believe that this coding would encourage overutilization by allowing multiple blocks and slides to be billed.

To avoid this incentive, we are creating G0461 (Immunohistochemistry or immunocytochemistry, per specimen; first single or multiplex antibody stain) and G0462 (Immunohistochemistry or immunocytochemistry, per specimen; each additional single or multiplex antibody stain (List separately in addition to code for primary procedure)) to ensure that the services are only reported once for each antibody per specimen. We believe this will result in appropriate values for these services without creating incentives for overutilization.

We examined the AMA RUC recommendations for work RVUs CPT codes 88342 and 88343 in order to determine whether it would be appropriate to use these recommendations as the basis for establishing work RVUs for the new G-codes. To determine whether the AMA RUC-recommended work RVUs were appropriate for use in valuing the new G-codes, we examined whether the change in descriptors between the CPT and G-codes would change the underlying assumptions regarding the physician work and resource costs of the typical services described by the codes. We note that the existing CPT code 88342 is to be reported per specimen, per antibody. To crosswalk the utilization for the service described by the current CPT code 88342 to the new CPT coding structure, the AMA RUC recommended that 90 percent of the utilization previously reported with CPT code 88342 would continue to be reported with as a single unit of 88342 and that 10 percent of the utilization previously reported with CPT code 88342 would be reported with the new add-on code, CPT code 88343. It seems clear, then, that in recommending values for the new services, the AMA RUC did not anticipate that any additional services would be reported despite the new descriptors that would allow for units to be reported for each block and each slide for each antibody. Therefore, we assume that the AMA RUC's recommended work RVUs and direct PE inputs for the new CPT codes were also developed with the assumption that the typical case would continue to be one unit reported per specimen, per antibody. Since the descriptors for the G-codes we are adopting in lieu of the new and revised CPT codes make explicit what appears to be the premise underlying the AMA RUC-recommended values for these services, we believe it is appropriate to use the AMA RUC recommendations for CPT codes 88342 and 88343 as the basis for establishing interim final work RVUs and direct PE inputs for the new G-codes for CY 2014.

Therefore, we are assigning an interim final work RVU of 0.60 for code G0461, which is the AMA RUC recommendation for CPT code 88342; and we are assigning an interim final work RVU of 0.24 for code G0462, which is the AMA RUC recommendation for CPT code 88343.

(18) Psychiatry (CPT Code 90863)

For CY 2013, the CPT Editorial Panel restructured the psychiatry/psychotherapy CPT codes allowing for separate reporting of E/M codes, eliminating the site-of-service differential, creation of CPT codes for crisis, and a series of add-on CPT codes to psychotherapy to describe interactive complexity and medication management. In CY 2013, the AMA RUC

provided us with recommendations for the majority, but not all, of the updated psychiatry/psychotherapy CPT codes. Due to the absence of AMA RUC recommendations for the entire family, we established interim final values for the codes based on a general approach of maintaining the previous values for the services, or as close to the previous values as possible, pending our receipt of recommended values for all codes in the new structure in CY 2014. See section II.E.2.a.ii.(25) of this final rule with comment period for a discussion of the finalization of the CY 2013 interim final RVUs.

For CY 2014, we received the outstanding AMA RUC recommendations for the psychiatry/psychotherapy CPT code family. We are establishing interim final work RVUs for CPT codes 90785, 90839, and 90840 based upon the AMA RUC's recommended work RVUs.

We are assigning CPT code 90863 a PFS procedure status indicator of I (Not valid for Medicare purposes. Medicare uses another code for the reporting of and the payment for these services.). The CPT Editorial Panel created CPT add-on code 90863 to describe medication management by a nonphysician when furnished with psychotherapy. As detailed in the CY 2013 final rule with comment period, clinical psychologists are precluded from billing Medicare for pharmacologic management services under CPT code 90863 because pharmacologic management services require some knowledge and ability to perform evaluation and management services, as some stakeholders acknowledged.

(19) Speech Evaluation (CPT Codes 92521, 92522, 92523, and 92524)

For CY 2014, the CPT Editorial Panel replaced CPT code 92506 (evaluation of speech, language, voice, communication, and/or auditory processing) with four new speech evaluation codes, CPT codes 92521, 92522, 92523, and 92524, to more accurately describe speech-language pathology evaluation services.

We are assigning CY 2014 interim final work RVUs of 1.75 and 1.50 for CPT codes 92521 and 92522, respectively, as the HCPAC recommended.

For CPT code 92523, we disagree with the HCPAC-recommended work RVU of 3.36. In arguing that this service should have a higher work RVU than the survey median of 1.86, the affected specialty society stated that its survey results were faulty for this CPT code because surveyees did not consider all the work necessary to perform the service. We believe that the appropriate value for 60 minutes of work for the speech evaluation codes is reflected in CPT code 92522, for which the HCPAC recommended 1.50 RVUs. Because the intraservice time for CPT code 92523 is twice that for CPT code 92522, we are assigning a work RVU of 3.0 to CPT code 92523.

Similarly, since CPT codes 92524 and 92522 have identical intraservice time recommendations and similar descriptions of work we believe that the work RVU for CPT code 92524 should be the same as the work RVU for CPT code 95922. Therefore, we are assigning a work RVU of 1.50 to CPT code 92524.

Additionally, it is important to note that these codes are defined as "always therapy" services, regardless of the type of practitioner who performs them. As a result, CPT codes 92521, 92522, 92523 and 92524 always require a therapy modifier (GP, GO, or GN). Also, as noted in Addendum H, these codes will be subject to the therapy MPPR.

In accordance with longstanding Medicare policy, we also note that in general, we would expect that only one evaluation code would be billed for a therapy episode of care.

(20) Cardiovascular: Cardiac Catheterization (93582)

For CY 2014, we reviewed new CPT code 93582. Although the AMA RUC compared this code to CPT code 92941 (percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary), which has a work RVU of 12.56 and 70 minutes of intraservice time, it recommended a work RVU of 14.00, the survey's 25th percentile. We agree with the AMA RUC that CPT code 92941 is an appropriate comparison code and believe that due to the similarity in intensity and time that the codes should be valued with the same work RVU. Therefore, we are assigning an interim final work RVU of 12.56 to CPT code 93582 for CY 2014.

(21) Duplex Scans (CPT Codes 93880, 93882, 93925, 93926, 93930, 93931, 93970, 93971, 93975, 93976, 93978 and 93979)

CPT Code 93880 was identified as a high expenditure procedure code and referred to the AMA RUC for review. As part of its recommendations, the AMA RUC included recommendations for CPT code 93882. The AMA RUC recommended an increase in the work RVUs for 92880 and 92882 from 0.60 and 0.40 to 0.80 and 0.50, respectively.

In the 2013 PFS final rule with comment period, we reviewed 93925 (Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study) and 93926 (Duplex scan of lower extremity arteries or arterial bypass grafts; unilateral or limited study), which were identified by the AMA RUC as potentially misvalued because the time and PE inputs for these services were Harvard valued and these services have utilization of 500,000 service per year. We disagreed with the respective AMA RUC-recommended work RVUs of 0.90 and 0.70 and established interim final values of 0.80 and 0.50 instead.

We believe the AMA RUC-recommended values for these two sets of codes do not maintain the appropriate relative values within the family of duplex scans. In addition to these four codes, there are several other duplex scan codes that may fit within this family, including CPT codes: 93880 (Duplex scan of extracranial arteries; complete bilateral study), 93882 (Duplex scan of extracranial arteries; unilateral or limited study), 93925 (Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study), 93926 (Duplex scan of lower extremity arteries or arterial bypass grafts; unilateral or limited study), 93930 (Duplex scan of upper extremity arteries or arterial bypass grafts; complete bilateral study), 93931 (Duplex scan of upper extremity arteries or arterial bypass grafts; unilateral or limited study), 93970 (Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study), 93971 (Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study), 93975 (Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study), 93976 (Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; limited study), 93978 (Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; complete study) and 93979 (Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; unilateral or limited study).

We are concerned that the AMA RUC-recommended values for 93880 and 93882, as well as our interim final values for 93925 and 93926, do not maintain the appropriate relativity within this family and we are referring the entire family to the AMA RUC to assess relativity among the codes and then recommend appropriate work RVUs. We also request that the AMA RUC consider CPT codes 93886

(Transcranial Doppler study of the intracranial arteries; complete study) and 93888 (Transcranial Doppler study of the intracranial arteries; limited study) in conjunction with the duplex scan codes in order to assess the relativity between and among these codes.

Therefore, we will maintain the CY 2013 RVUs for CPT codes 93880 and 93882 on an interim final basis until we receive further recommendations from the AMA RUC

(22) Ultrasonic Wound Assessment (CPT Code 97610)

For CY 2014, the AMA RUC reviewed new CPT code 97610. We are contractor pricing this code for CY 2014 as recommended by the AMA RUC. Although the code will be contractor priced, we are designating this service as a "sometimes therapy" service. Like other "sometimes therapy" codes, when a therapist furnishes this service all outpatient therapy policies apply.

(23) Interprofessional Telephone Consultative Services (CPT Code 99446, 99447, 99448, and 99449)

For CY 2014, the CPT Editorial Panel created CPT codes 99446–99449 to describe telephone/internet consultative services. The AMA RUC-recommended work RVUs for these codes. Medicare pays for telephone consultations about a beneficiary services as a part of other services furnished to the beneficiary. Therefore, for CY 2014 we are assigning CPT codes 99446, 99447, 99448, and 99449 a PFS procedure status indicator of B (Bundled code. Payments for covered services are always bundled into payment for other services, which are not specified. If RVUs are shown, they are not used for Medicare payment. If these services are covered, payment for them is subsumed by the payment for the services to which they are bundled (for example, a telephone call from a hospital nurse regarding care of a patient).)

b. Establishing Interim Final Direct PE RVUs for CY 2014

i. Background and Methodology

The AMA RUC provides CMS with recommendations regarding direct PE inputs, including clinical labor, supplies, and equipment, for new, revised, and potentially misvalued codes. We review the AMA RUC-recommended direct PE inputs on a code-by-code basis, including the recommended facility PE inputs and/or nonfacility PE inputs. This review is informed by both our clinical assessment of the typical resource requirements for furnishing the service and our intention to maintain the principles of accuracy and relativity in the database. We determine whether we agree with the AMA RUC's recommended direct PE inputs for a service or, if we disagree, we refine the PE inputs to represent inputs that better reflect our estimate of the PE resources required to furnish the service in the facility and/or nonfacility settings. We also confirm that CPT codes should have facility and/or nonfacility direct PE inputs and make changes based on our clinical judgment and any PFS payment policies that would apply to the code.

We have accepted for CY 2014, as interim final and without refinement, the direct PE inputs based on the recommendations submitted by the AMA RUC for the codes listed in Table 28. For the remainder of the AMA RUC's direct PE recommendations, we have accepted the PE recommendations submitted by the AMA RUC as interim final, but with refinements. These codes and the refinements to their direct PE inputs are listed in Table 29.

We note that the final CY 2014 PFS direct PE input database reflects the refined direct PE inputs that we are adopting on an interim final basis for CY 2014. That database is available under downloads for the CY 2014 PFS final rule with comment period on the CMS Web site at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html*. We also note that the PE RVUs displayed in Addenda B and C reflect the interim final values and policies described in this section. All PE RVUs adopted on an interim final basis for CY 2014 are included in Addendum C and are open for comment in this final rule with comment period.

ii. Common Refinements

Table 29 details our refinements of the AMA RUC's direct PE recommendations at the code-specific level. In this section, we discuss the general nature of some common refinements and the reasons for particular refinements.

(a) Changes in Physician Time

Some direct PE inputs are directly affected by revisions in physician time described in section II.E.3.a. of this final rule with comment period. We note that for many codes, changes in the intraservice portions of the physician time and changes in the number or level of postoperative visits included in the global periods result in corresponding changes to direct PE inputs. We also note that, for a significant number of services, especially diagnostic tests, the procedure time assumptions used in determining direct PE inputs are distinct from, and therefore not dependent on, physician intraservice time assumptions. For these services, we do not make refinements to the direct PE inputs based on changes to estimated physician intraservice times.

Changes in Intraservice Physician Time in the Nonfacility Setting. For most codes valued in the nonfacility setting, a portion of the clinical labor time allocated to the intraservice period reflects minutes assigned for assisting the physician with the procedure. To the extent that we are refining the times associated with the intraservice portion of such procedures, we have adjusted the corresponding intraservice clinical labor minutes in the nonfacility setting.

For equipment associated with the intraservice period in the nonfacility setting, we generally allocate time based on the typical number of minutes a piece of equipment is being used, and therefore, not available for use with another patient during that period. In general, we allocate these minutes based on the description of typical clinical labor activities. To the extent that we are making changes in the clinical labor times associated with the intraservice portion of procedures, we have adjusted the corresponding equipment minutes associated with the codes.

Changes in the Number or Level of Postoperative Office Visits in the Global Period. For codes valued with postservice physician office visits during a global period, most of the clinical labor time allocated to the postservice period reflects a standard number of minutes allocated for each of those visits. To the extent that we are refining the number or level of postoperative visits, we have modified the clinical staff time in the postservice period to reflect the change. For codes valued with postservice physician office visits during a global period, we allocate standard equipment for each of those visits. To the extent that we are making a change in the number or level of postoperative visits associated with a code, we have adjusted the corresponding equipment minutes. For codes valued with postservice physician office visits during a global period, a certain number of supply items are allocated for each of those office visits. To the extent that we are making a change in the number of postoperative visits, we have adjusted the corresponding supply item quantities associated with the codes. We note that many supply items associated with postservice physician office visits are allocated for each office visit (for

example, a minimum multi-specialty visit pack (SA048) in the CY 2014 direct PE input database). For these supply items, the quantities in the direct PE input database should reflect the number of office visits associated with the code's global period. However, some supply items are associated with postservice physician office visits but are only allocated once during the global period because they are typically used during only one of the postservice office visits (for example, pack, post-op incision care (suture) (SA054) in the direct PE input database). For these supply items, the quantities in the direct PE input database reflect that single quantity.

These refinements are reflected in the final CY 2014 PFS direct PE input database and detailed in Table 29.

(b) Equipment Minutes

In general, the equipment time inputs reflect the sum of the times within the intraservice period when a clinician is using the piece of equipment, plus any additional time the piece of equipment is not available for use for another patient due to its use during the designated procedure. While some services include equipment that is typically unavailable during the entire clinical labor service period, certain highly technical pieces of equipment and equipment rooms are less likely to be used by a clinician for all tasks associated with a service, and therefore, are typically available for other patients during the preservice and postservice components of the service period. We adjust those equipment times accordingly. We refer interested stakeholders to our extensive discussion of these policies in the CY 2012 PFS final rule with comment period (76 FR 73182–73183) and in section II.E.2.b. of this final rule with comment period. We are refining the CY 2014 AMA RUC direct PE recommendations to conform to these equipment time policies. These refinements are reflected in the final CY 2013 PFS direct PE input database and detailed in Table 29.

(c) Moderate Sedation Inputs

In the CY 2012 PFS final rule (76 FR 73043–73049), we finalized a standard package of direct PE inputs for services where moderate sedation is considered inherent in the procedure. We are refining the CY 2014 AMA RUC direct PE recommendations to conform to these policies. These refinements are reflected in the final CY 2013 PFS direct PE input database and detailed in Table 29.

(d) Standard Minutes for Clinical Labor Tasks

In general, the preservice, service period, and postservice clinical labor minutes associated with clinical labor inputs in the direct PE input database reflect the sum of particular tasks described in the information that accompanies the recommended direct PE inputs on "PE worksheets." For most of these described tasks, there are a standardized number of minutes, depending on the type of procedure, its typical setting, its global period, and the other procedures with which it is typically reported. At times, the AMA RUC recommends a number of minutes either greater than or less than the time typically allotted for certain tasks. In those cases, CMS clinical staff reviews the deviations from the standards to assess whether they are clinically appropriate. Where the AMA RUC-recommended exceptions are not accepted, we refine the interim final direct PE inputs to match the standard times for those tasks. In addition, in cases when a service is typically billed with an E/M, we remove the preservice clinical labor tasks so that the inputs are not duplicative and reflect the resource costs of furnishing the typical service.

In some cases the AMA RUC recommendations include additional minutes described by a category called "other clinical activity," or through the addition of clinical labor tasks that are different from those previously included as standard. In these instances, CMS clinical staff reviews the tasks as described in the recommendation to determine whether they are already incorporated into the total number of minutes based on the standard tasks. Additionally, CMS reviews these tasks in the context of the kinds of tasks delineated for other services under the PFS. For those tasks that are duplicative or not separately incorporated for other services, we do not accept those additional clinical labor tasks as direct inputs. These refinements are reflected in the final CY 2013 PFS direct PE input database and detailed in Table 29.

(e) New Supply and Equipment Items

The AMA RUC generally recommends the use of supply and equipment items that already exist in the direct PE input database for new, revised, and potentially misvalued codes. Some recommendations include supply or equipment items that are not currently in the direct PE input database. In these cases, the AMA RUC has historically recommended a new item be created and has facilitated CMS's pricing of that item by working with the specialty societies to provide sales invoices to us.

We received invoices for several new supply and equipment items for CY 2014. We have accepted the majority of these items and added them to the direct PE input database. However, in many cases we cannot adequately price a newly recommended item due to inadequate information. In some cases, no supporting information regarding the price of the item has been included in the recommendation to create a new item. In other cases, the supporting information does not demonstrate that the item has been purchased at the listed price (for example, price quotes instead of paid invoices). In cases where the information provided allowed us to identify clinically appropriate proxy items, we have used currently existing items as proxies for the newly recommended items. In other cases, we have included the item in the direct PE input database without an associated price. While including the item without an associated price means that the item does not contribute to the calculation of the PE RVU for particular services, it facilitates our ability to incorporate a price once we are able to do so.

(f) Recommended Items That Are Not Direct PE Inputs

In some cases, the recommended direct PE inputs included items that are not clinical labor, disposable supplies, or medical equipment resources. We have addressed these kinds of recommendations in previous rulemaking and in sections II.E.2.b. and II.B.4.a. of this final rule with comment period. Refinements to adjust for these recommended inputs are reflected in the final CY 2013 PFS direct PE input database and detailed in Table 29.

iii. Code-Specific Refinements

(a) Breast Biopsy (CPT Codes 19085, 19086, 19287, and 19288)

The AMA RUC submitted recommended direct PE inputs for CPT codes 19085, 19086, 19287, 19288, including suggestions to create new PE inputs for items called "20MM handpiece—MR," "vacuum line assembly," "introducer localization set (trocar)," and "tissue filter." CMS clinical staff reviewed these recommended items and concluded that each of these items serve redundant clinical purposes with other biopsy supplies already included as direct PE inputs for the codes. Similarly, CMS clinical staff reviewed three newly recommended equipment items described as "breast biopsy software," "breast biopsy device (coil)," and

"lateral grid," and determined that these items serve clinical functions to similar items already included in MR room equipment package (EL008). Therefore, we did not create new direct PE inputs for these seven items. These refinements, as well as other applicable standard and common refinements for these codes, are reflected in the final CY 2014 PFS direct PE input database and detailed in Table 29.

(b) Esophagoscopy, Esophagogastroduodenoscopy and Endoscopic Retrograde Cholangiopancreatography (CPT Codes 43270, 43229, and 43198)

For CY 2014, the CPT Editorial Panel revised the set of codes that describe esophagoscopy, esophagogastroduodenoscopy (EGD) and endoscopic retrograde cholangiopancreatography (ERCP). These revisions included the addition and deletion of several codes and the development of new guidelines and coding instructions. The AMA RUC provided CMS with recommended direct PE inputs for these services.

For two codes within this family, CPT codes 43270 and 43229, the AMA RUC recommended including the supply item called "kit, probe, radiofrequency, XIi-enhanced RF probe" (SA100) as a proxy for an RF ablation catheter, as well as a new recommended equipment item called "radiofrequency generator (Angiodynamics)." The AMA RUC did not provide additional information regarding what portion of the RF ablation catheter might be reusable. Additionally, the recommendation did not provide information regarding why the supply item SA100 that is priced at $2,695 would be an appropriate proxy for the RF ablation catheter. The CY 2013 codes that would be used to report these services do not include these or similar items, so we believe that it would not be appropriate to assume such a significant increase in resource costs without more detail regarding the item for which the recommended input would serve as a proxy. We note that in previous rulemaking (77 FR 69031) we have addressed recommendations for other codes that also suggested using this expensive disposable supply as a proxy input. For these other services, we created a proxy equipment item instead of a proxy supply item, pending the submission of additional information regarding the newly recommended item.

We also note that the AMA RUC recommendation did not include adequate information that would allow us to price the newly recommended item called "'radiofrequency generator (Angiodynamics)." To incorporate the best estimate of resource costs for these items for these new codes for CY 2014, we followed the precedents set in previous rulemaking and created a new equipment item to serve as a proxy for the "RF ablation catheter," and used a currently existing radiofrequency generator equipment item (EQ214) as a proxy item pending the submission of additional information regarding these items.

For another new code in the family, CPT code 43198, the AMA RUC recommended including a disposable supply item called "endoscopic biopsy forceps" (SD066). However, additional information included with the recommendation suggested that a reusable biopsy forceps is typically used in furnishing the service. Therefore, we did not incorporate the disposable forceps in the direct PE input database.

These refinements, as well as other applicable standard and common refinements for these codes, are reflected in the final CY 2014 PFS direct PE input database and detailed in Table 29.

(c) Dilation of Esophagus (CPT Codes 43450 and 43453)

The AMA RUC recommended direct PE input updates for CTP codes 43450 and 43453. The recommendation included a new item listed as a supply called "esophageal bougies." We note that we did not receive an invoice or additional description of this item and, based on CMS clinical staff clinical review, we believe the functionality of this kind of item can be accomplished through the use of a reusable piece of equipment. Therefore, we created a new equipment item called "esophageal bougies, set, reusable." Once we receive appropriate pricing information regarding the new item, we will update the price in the direct PE input database. This refinement and other applicable standard and common refinements for these codes are reflected in the final CY 2014 PFS direct PE input database and detailed in Table 29.

(d) MRI of Brain (CPT Codes 70551, 70552, and 70553)

The AMA RUC recommended updated direct PE inputs for a series of codes that describe magnetic resonance imaging (MRI) of the brain. We note the AMA RUC recommended that the typical length of time it takes for the MRI technician to acquire images is equal to the time it took in 2002, when the PE inputs for the codes were last evaluated.

When reviewing the direct PE inputs for this code, CMS clinical staff concluded that there should be no significant difference between the assumed time to acquire images for MRI of the brain and MRI of the spine; therefore, we have adjusted the direct PE inputs accordingly. This refinement and other applicable standard and common refinements for these codes are reflected in the final CY 2014 PFS direct PE input database and detailed in Table 29.

(e) Selective Catheter Placement (CPT Codes 36245 and 75726)

The AMA RUC submitted new direct PE inputs for CPT code 36245 (Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family). We have reviewed the recommended direct PE inputs for this service and made the applicable standard and common refinements which are reflected in the final CY 2014 PFS direct PE input database and detailed in Table 29. However, we note that the review of CPT code 36245 was initiated based on the identification of the code through two misvalued code screens. One of these was the screen that identifies codes reported together at least 75 percent of the time. As the RUC noted in its recommendation, CPT 36245 may be reported with a number of different radiologic supervision and interpretation codes including 75726 (Angiography, visceral, selective or supraselective (with or without flush aortogram), radiological supervision and interpretation). The AMA RUC recommendation stated that, because these code combinations were valued as individual component codes, no potential for duplication of physician work exists. The recommended direct PE inputs for CPT 36245 did not address whether or not the direct PE inputs for CPT code 75726 should be updated given that it is typically reported with CPT code 36245.

The current direct PE inputs for 75726 include 73 clinical labor minutes for "assist physician in performing procedure." This time matches the precise number of minutes assumed for the same task for CPT code 36245 in the existing direct PE inputs. The AMA RUC has recommended changing the amount of time considered typical for that task from 73 minutes to 45 minutes and we are accepting that change, without refinement, on an interim final basis for CY 2014. Given that these codes are typically reported together and the underlying procedure time assumption used in valuing 75726 is dependent on the assumed times for 36245, we believe it is appropriate to make a corresponding change to 75726

on an interim final basis to reflect the best estimate of resources for these services which are frequently furnished together. This change is reflected in the final CY 2014 PFS direct PE input database and detailed in Table 29.

(g) Respiratory Motion Management Simulation (CPT Code 77293)

The AMA RUC submitted direct PE inputs recommendations for CPT code 77293 (Respiratory motion management simulation). Among these was the recommendation to create a new equipment item called "virtual simulation package." However, the information that accompanied the recommendation included a price quote for the new item instead of a copy of paid invoice. We believe that the currently existing item "radiation virtual simulation system" (ER057) will serve as an appropriate proxy for the new item pending our receipt of additional information regarding the newly recommended item. This refinement and other applicable standard and common refinements for these codes are reflected in the final CY 2014 PFS direct PE input database and detailed in Table 29.

(h) Stereotactic Body Radiation Therapy (CPT Code 77373)

The AMA RUC recommended updated direct PE inputs for CPT code 77373 (Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions). We note that we previously established final direct PE inputs for this code in the CY 2013 PFS final rule with comment period (77 FR 68922) in response to direct PE inputs we proposed in the CY 2013 PFS proposed rule (77 FR 44743). In finalizing the direct PE inputs for this code, we explained that we were including the equipment item called "radiation treatment vault" (ER056) based on public comment, and noting that we had questions regarding whether the item is appropriately categorized as equipment within the established PE methodology. The AMA RUC recommendations did not include the "radiation treatment vault" (ER056) for CPT 77373. Because we intend to address that issue in future rulemaking, we believe that we should continue to include the item as a direct PE input for CY 2014. This refinement and other applicable standard and common refinements for these codes are reflected in the final CY 2014 PFS direct PE input database and detailed in Table 29.

(i) Immunohistochemistry (CPT Codes 88342 and 88343 and HCPCS Codes G0461 and G0462

The AMA RUC recommended direct PE inputs for revised CPT code 88342 and new CPT code 88343. We direct the reader to section II.E.3 of this final rule with comment period. There, we discuss our decision for CY 2014 to use HCPCS codes G0461 and G0462 for Medicare services instead of reporting the CPT codes describing immunohistochemistry services and to use the AMA RUC recommended values for the CPT codes in establishing interim final values for the HCPCS codes. We based the interim final direct PE inputs for G0461 and G0462 on the recommended inputs for CPT codes 88342 and 88343, therefore the standard and common refinements to the recommended direct PE inputs for these CPT codes are detailed in Table 29 as the inputs for G0461 and G0462. Likewise, the interim final direct PE inputs for G0461 and G0462 appear in the final CY 2014 PFS direct PE input database.

(j) Anogenital Examination With Colposcopic Magnification in Childhood for Suspected Trauma (CPT Code 99170)

The AMA RUC recommended updated direct PE inputs for CPT code 99170. As part of that recommendation, the AMA RUC recommended that we create a new clinical labor type called "Child Life Specialist" to be included in the direct PE input database for this particular service. The recommendation also contained additional information that might facilitate the development of an appropriate cost/minute for this new clinical labor type. After reviewing that information, we conclude that the resource costs for the new clinical labor type are very similar to the costs associated with the existing nurse blend clinical labor type (L037D). Therefore, we have created a new clinical labor category called "Child Life Specialist" (L037E) with a rate per minute crosswalked from the existing labor type L037D.

We also note that the direct PE input recommendation for this code did not conform to the usual format. The PE worksheet included minutes for the new clinical labor type but instead of assigning minutes to specified clinical labor tasks, the worksheet referenced a narrative description of the tasks for the clinical labor type in the preservice, intra-, and postservice periods. This format did not limit our clinical staff from reviewing the recommendation, but it does not allow us to display refinements for particular tasks in Table 29. Instead, the refinements to the recommended aggregate number of minutes for each time component appear in the table along with other applicable standard and common refinements to the recommended direct PE inputs.

TABLE 28—CY 2014 INTERIM FINAL CODES WITH DIRECT PE INPUT RECOMMENDATIONS ACCEPTED WITHOUT REFINEMENT

CPT code	CPT code description
17003 ..	Destruct premalg les 2–14.
17311 ..	Mohs 1 stage h/n/hf/g.
17312 ..	Mohs addl stage.
17313 ..	Mohs 1 stage t/a/l.
17314 ..	Mohs addl stage t/a/l.
17315 ..	Mohs surg addl block.
19081 ..	Bx breast 1st lesion strtctc.
19082 ..	Bx breast add lesion strtctc.
19083 ..	Bx breast 1st lesion us imag.
19084 ..	Bx breast add lesion us imag.
19283 ..	Perq dev breast 1st strtctc.
19284 ..	Perq dev breast add strtctc.
19285 ..	Perq dev breast 1st us imag.
23333 ..	Remove shoulder fb deep.
23334 ..	Shoulder prosthesis removal.
23335 ..	Shoulder prosthesis removal.
24160 ..	Remove elbow joint implant.
24164 ..	Remove radius head implant.
27130 ..	Total hip arthroplasty.
27236 ..	Treat thigh fracture.
27446 ..	Revision of knee joint.
27447 ..	Total knee arthroplasty.
27466 ..	Lengthening of thigh bone.
31239 ..	Nasal/sinus endoscopy surg.
31240 ..	Nasal/sinus endoscopy surg.
33282 ..	Implant pat-active ht record.
33284 ..	Remove pat-active ht record.
35301 ..	Rechanneling of artery.
37217 ..	Stent placemt retro carotid.
37239 ..	Open/perq place stent ea add.
43191 ..	Esophagoscopy rigid trnso dx.
43192 ..	Esophagoscp rig trnso inject.
43193 ..	Esophagoscp rig trnso biopsy.
43194 ..	Esophagoscp rig trnso rem fb.
43195 ..	Esophagoscopy rigid balloon.
43196 ..	Esophagoscp guide wire dilat.
43204 ..	Esoph scope w/sclerosis inj.
43205 ..	Esophagus endoscopy/ligation.
43211 ..	Esophagoscop mucosal resect.
43212 ..	Esophagoscop stent placement.
43214 ..	Esophagosc dilate balloon 30.
43233 ..	Egd balloon dil esoph30 mm/>.
43237 ..	Endoscopic us exam esoph.
43238 ..	Egd us fine needle bx/aspir.
43240 ..	Egd w/transmural drain cyst.
43241 ..	Egd tube/cath insertion.
43242 ..	Egd us fine needle bx/aspir.
43243 ..	Egd injection varices.
43244 ..	Egd varices ligation.
43246 ..	Egd place gastrostomy tube.
43251 ..	Egd remove lesion snare.
43253 ..	Egd us transmural injxn/mark.
43254 ..	Egd endo mucosal resection.
43257 ..	Egd w/thrml txmnt gerd.
43259 ..	Egd us exam duodenum/jejunum.
43260 ..	Ercp w/specimen collection.
43261 ..	Endo cholangiopancreatograph.
43262 ..	Endo cholangiopancreatograph.

TABLE 28—CY 2014 INTERIM FINAL CODES WITH DIRECT PE INPUT RECOMMENDATIONS ACCEPTED WITHOUT REFINEMENT—Continued

CPT code	CPT code description
43263 ..	Ercp sphincter pressure meas.
43264 ..	Ercp remove duct calculi.
43265 ..	Ercp lithotripsy calculi.
43266 ..	Egd endoscopic stent place.
43273 ..	Endoscopic pancreatoscopy.
43274 ..	Ercp duct stent placement.
43275 ..	Ercp remove forgn body duct.
43276 ..	Ercp stent exchange w/dilate.
43277 ..	Ercp ea duct/ampulla dilate.
43278 ..	Ercp lesion ablate w/dilate.
50360 ..	Transplantation of kidney.
52356 ..	Cysto/uretero w/lithotripsy.
62310 ..	Inject spine cerv/thoracic.
62311 ..	Inject spine lumbar/sacral.
62318 ..	Inject spine w/cath crv/thrc.
62319 ..	Inject spine w/cath lmb/scrl.
63047 ..	Remove spine lamina 1 lmbr.
63048 ..	Remove spinal lamina add-on.
64643 ..	Chemodenerv 1 extrem 1–4 ea.
64645 ..	Chemodenerv 1 extrem 5/> ea.

TABLE 28—CY 2014 INTERIM FINAL CODES WITH DIRECT PE INPUT RECOMMENDATIONS ACCEPTED WITHOUT REFINEMENT—Continued

CPT code	CPT code description
66183 ..	Insert ant drainage device.
69210 ..	Remove impacted ear wax uni.
77001 ..	Fluoroguide for vein device.
77002 ..	Needle localization by xray.
77003 ..	Fluoroguide for spine inject.
77280 ..	Set radiation therapy field.
77285 ..	Set radiation therapy field.
77290 ..	Set radiation therapy field.
77295 ..	3-d radiotherapy plan.
77301 ..	Radiotherapy dose plan imrt.
77336 ..	Radiation physics consult.
77338 ..	Design mlc device for imrt.
77372 ..	Srs linear based.
88112 ..	Cytopath cell enhance tech.
90839 ..	Psytx crisis initial 60 min.
90840 ..	Psytx crisis ea addl 30 min.
90875 ..	Psychophysiological therapy.
91065 ..	Breath hydrogen/methane test.
92521 ..	Evaluation of speech fluency.
92522 ..	Evaluate speech production.

TABLE 28—CY 2014 INTERIM FINAL CODES WITH DIRECT PE INPUT RECOMMENDATIONS ACCEPTED WITHOUT REFINEMENT—Continued

CPT code	CPT code description
92523 ..	Speech sound lang comprehen.
92524 ..	Behavral qualit analys voice.
93000 ..	Electrocardiogram complete.
93005 ..	Electrocardiogram tracing.
93010 ..	Electrocardiogram report.
95928 ..	C motor evoked uppr limbs.
95929 ..	C motor evoked lwr limbs.
96365 ..	Ther/proph/diag iv inf init.
96366 ..	Ther/proph/diag iv inf addon.
96367 ..	Tx/proph/dg addl seq iv inf.
96368 ..	Ther/diag concurrent inf.
96413 ..	Chemo iv infusion 1 hr.
96415 ..	Chemo iv infusion addl hr.
96417 ..	Chemo iv infus each addl seq.
98940 ..	Chiropract manj 1–2 regions.
98941 ..	Chiropract manj 3–4 regions.
98942 ..	Chiropractic manj 5 regions.
98943 ..	Chiropract manj xtrspinl 1/>.

TABLE 29—CY 2014 INTERIM FINAL CODES WITH DIRECT PE INPUT RECOMMENDATIONS ACCEPTED WITH REFINEMENTS

HCPCS code	HCPCS code description	Input code	Input code description	Non-fac/fac	Labor activity (if applicable)	RUC recommendation or current value (min or qty)	CMS Refinement (min or qty)	Comment
10030	Guide cathet fluid drainage.	EF018	stretcher	NF	.....	120	0	Non-standard input for Moderate Sedation.
		EF027	table, instrument, mobile.	NF	.....	159	152	Standard input for Moderate Sedation.
		EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp).	NF	.....	159	152	Standard input for Moderate Sedation.
		EQ032	IV infusion pump	NF	.....	159	152	Standard input for Moderate Sedation.
		L037D	RN/LPN/MTA	NF	Circulating throughout procedure (25%).	8	7	Conforms to proportionate allocation of intraservice time among clinical labor types.
17000	Destruct premalg lesion.	ED004	camera, digital (6 mexapixel).	NF	.....	22	13	Refined equipment time to conform to changes in clinical labor time.
		EF031	table, power	NF	.....	46	40	Refined equipment time to conform to changes in clinical labor time.
		EQ093	cryosurgery equipment (for liquid nitrogen).	NF	.....	22	13	Refined equipment time to conform to changes in clinical labor time.
		EQ168	light, exam	NF	.....	46	40	Refined equipment time to conform to changes in clinical labor time.
		SA048	pack, minimum multispecialty visit.	NF	.....	1	2	CMS clinical review.
		SA048	pack, minimum multispecialty visit.	F	.....	0	1	CMS clinical review.
17004	Destroy premal lesions 15/>.	ED004	camera, digital (6 mexapixel).	NF	.....	41	30	Refined equipment time to conform to changes in clinical labor time.
		EQ093	cryosurgery equipment (for liquid nitrogen).	NF	.....	41	30	Refined equipment time to conform to changes in clinical labor time.
		SA048	pack, minimum multispecialty visit.	NF	.....	1	2	CMS clinical review.

TABLE 29—CY 2014 INTERIM FINAL CODES WITH DIRECT PE INPUT RECOMMENDATIONS ACCEPTED WITH REFINEMENTS—Continued

HCPCS code	HCPCS code description	Input code	Input code description	Non-fac/ fac	Labor activity (if applicable)	RUC recommendation or current value (min or qty)	CMS Refinement (min or qty)	Comment
		SA048	pack, minimum multi-specialty visit.	F		0	1	CMS clinical review.
19085	Bx breast 1st lesion mr imag.	S	20MM handpiece—MR	NF		1	0	CMS clinical review; functionality of items redundant with other direct PE inputs.
		S	vacuum line assembly	NF		1	0	CMS clinical review; functionality of items redundant with other direct PE inputs.
		S	introducer localization set (trocar).	NF		1	0	CMS clinical review; functionality of items redundant with other direct PE inputs.
		S	tissue filter	NF		1	0	CMS clinical review; functionality of items redundant with other direct PE inputs.
		E	breast biopsy software	NF		54	0	CMS clinical review; functionality of items redundant with other direct PE inputs.
		E	breast biopsy device (coil).	NF		54	0	CMS clinical review; functionality of items redundant with other direct PE inputs.
		E	lateral grid	NF		54	0	CMS clinical review; functionality of items redundant with other direct PE inputs.
19086	Bx breast add lesion mr imag.	S	20MM handpiece—MR	NF		1	0	CMS clinical review; functionality of items redundant with other direct PE inputs.
		S	vacuum line assembly	NF		1	0	CMS clinical review; functionality of items redundant with other direct PE inputs.
		S	introducer localization set (trocar).	NF		1	0	CMS clinical review; functionality of items redundant with other direct PE inputs.
		S	tissue filter	NF		1	0	CMS clinical review; functionality of items redundant with other direct PE inputs.
		E	breast biopsy software	NF		43	0	CMS clinical review; functionality of items redundant with other direct PE inputs.
		E	breast biopsy device (coil).	NF		43	0	CMS clinical review; functionality of items redundant with other direct PE inputs.
		E	lateral grid	NF		43	0	CMS clinical review; functionality of items redundant with other direct PE inputs.
19281	Perq device breast 1st imag.	ED025	film processor, wet	NF		9	5	Refined equipment time to conform to changes in clinical labor time.
		ER029	film alternator (motorized film viewbox).	NF		9	5	CMS clinical review.
		L043A	Mammography Technologist.	NF	Process images, complete data sheet, present images and data to the interpreting physician.	9	5	CMS clinical review.
19282	Perq device breast ea imag.	ED025	film processor, wet	NF		9	5	Refined equipment time to conform to changes in clinical labor time.

TABLE 29—CY 2014 INTERIM FINAL CODES WITH DIRECT PE INPUT RECOMMENDATIONS ACCEPTED WITH REFINEMENTS—Continued

HCPCS code	HCPCS code description	Input code	Input code description	Non-fac/ fac	Labor activity (if applicable)	RUC recommendation or current value (min or qty)	CMS Refinement (min or qty)	Comment
		ER029	film alternator (motorized film viewbox).	NF		9	5	Refined equipment time to conform to changes in clinical labor time.
		L043A	Mammography Technologist.	NF	Other Clinical Activity (Service).	9	5	CMS clinical review.
19286	Perq dev breast add us imag.	L043A	Mammography Technologist.	NF	Assist physician in performing procedure.	19	14	Conforming to physician time.
19287	Perq dev breast 1st mr guide.	S	20MM handpiece—MR	NF		1	0	CMS clinical review; functionality of items redundant with other direct PE inputs.
		S	vacuum line assembly	NF		1	0	CMS clinical review; functionality of items redundant with other direct PE inputs.
		S	introducer localization set (trocar).	NF		1	0	CMS clinical review; functionality of items redundant with other direct PE inputs.
		S	tissue filter	NF		1	0	CMS clinical review; functionality of items redundant with other direct PE inputs.
		E	breast biopsy software	NF		46	0	CMS clinical review; functionality of items redundant with other direct PE inputs.
		E	breast biopsy device (coil).	NF		46	0	CMS clinical review; functionality of items redundant with other direct PE inputs.
		E	lateral grid	NF		46	0	CMS clinical review; functionality of items redundant with other direct PE inputs.
19288	Perq dev breast add mr guide.	S	20MM handpiece—MR	NF		1	0	CMS clinical review; functionality of items redundant with other direct PE inputs.
		S	vacuum line assembly	NF		1	0	CMS clinical review; functionality of items redundant with other direct PE inputs.
		S	introducer localization set (trocar).	NF		1	0	CMS clinical review; functionality of items redundant with other direct PE inputs.
		S	tissue filter	NF		1	0	CMS clinical review; functionality of items redundant with other direct PE inputs.
		E	breast biopsy software	NF		35	0	CMS clinical review; functionality of items redundant with other direct PE inputs.
		E	breast biopsy device (coil).	NF		35	0	CMS clinical review; functionality of items redundant with other direct PE inputs.
		E	lateral grid	NF		35	0	CMS clinical review; functionality of items redundant with other direct PE inputs.
23333	Remove shoulder fb deep.	EF031	table, power	F		90	63	Refined equipment time to conform to changes in clinical labor time.
		EQ168	light, exam	F		90	63	Refined equipment time to conform to changes in clinical labor time.
		L037D	RN/LPN/MTA	F	Total Office Visit Time	90	63	Conforming to physician time.
		SA048	pack, minimum multispecialty visit.	F		3	2	Conforming to physician time.

TABLE 29—CY 2014 INTERIM FINAL CODES WITH DIRECT PE INPUT RECOMMENDATIONS ACCEPTED WITH REFINEMENTS—Continued

HCPCS code	HCPCS code description	Input code	Input code description	Non-fac/ fac	Labor activity (if applicable)	RUC recommendation or current value (min or qty)	CMS Refinement (min or qty)	Comment
27130	Total hip arthroplasty	L037D	RN/LPN/MTA	F	Post Service Period	99	108	Conforming to physician time.
		EF031	table, power	F		99	108	Refined equipment time to conform to changes in clinical labor time.
27447	Total knee arthroplasty	L037D	RN/LPN/MTA	F	Post Service Period	99	108	Conforming to physician time.
		EF031	table, power	F		99	108	Refined equipment time to conform to changes in clinical labor time.
31237	Nasal/sinus endoscopy surg.	L037D	RN/LPN/MTA	NF	Monitor pt. following service/check tubes, monitors, drains.	15	5	CMS clinical review.
31238	Nasal/sinus endoscopy surg.	L037D	RN/LPN/MTA	NF	Monitor pt. following service/check tubes, monitors, drains.	15	5	CMS clinical review.
33366	Trcath replace aortic valve.	L037D	RN/LPN/MTA	F	Coordinate pre-surgery services.	40	20	CMS clinical review; refinement reflects standard preservice times.
36245	Ins cath abd/l-ext art 1st.	EF018	stretcher	NF		240	0	Non-standard input for Moderate Sedation.
37236	Open/perq place stent 1st.	EF018	stretcher	NF		240	0	Non-standard input for Moderate Sedation.
		EF027	table, instrument, mobile.	NF		347	332	Standard input for Moderate Sedation.
		EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp).	NF		347	332	Standard input for Moderate Sedation.
		EQ032	IV infusion pump	NF		347	332	Standard input for Moderate Sedation.
		S	Balloon expandable	NF		1	0	CMS clinical review; input already exists.
		SD152	catheter, balloon, PTA	NF		0	1	CMS clinical review; input already exists.
37237	Open/perq place stent ea add.	S	Balloon expandable	NF		1	0	CMS clinical review; input already exists.
		SD152	catheter, balloon, PTA	NF		0	1	CMS clinical review; input already exists.
37238	Open/perq place stent same.	EF018	stretcher	NF		180	0	Non-standard input for Moderate Sedation.
		EF027	table, instrument, mobile.	NF		257	302	Standard input for Moderate Sedation.
		EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp).	NF		257	302	Standard input for Moderate Sedation.
		EQ032	IV infusion pump	NF		257	302	Standard input for Moderate Sedation.
37241	Vasc embolize/occlude venous.	EF018	stretcher	NF		180	0	Non-standard input for Moderate Sedation.
		EF027	table, instrument, mobile.	NF		287	272	Standard input for Moderate Sedation.
		EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp).	NF		287	272	Standard input for Moderate Sedation.
		EQ032	IV infusion pump	NF		287	272	Standard input for Moderate Sedation.
		L037D	RN/LPN/MTA	NF	Circulating throughout procedure (25%).	23	22	Conforms to proportionate allocation of intraservice time among clinical labor types.
37242	Vasc embolize/occlude artery.	EF018	stretcher	NF		240	0	Non-standard input for Moderate Sedation.
		EF027	table, instrument, mobile.	NF		357	342	Standard input for Moderate Sedation.
		EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp).	NF		357	342	Standard input for Moderate Sedation.
		EQ032	IV infusion pump	NF		357	342	Standard input for Moderate Sedation.
37243	Vasc embolize/occlude organ.	EF018	stretcher	NF		240	0	Non-standard input for Moderate Sedation.

TABLE 29—CY 2014 INTERIM FINAL CODES WITH DIRECT PE INPUT RECOMMENDATIONS ACCEPTED WITH REFINEMENTS—Continued

HCPCS code	HCPCS code description	Input code	Input code description	Non-fac/ fac	Labor activity (if applicable)	RUC recommendation or current value (min or qty)	CMS Refinement (min or qty)	Comment
		EF027	table, instrument, mobile.	NF		377	362	Standard input for Moderate Sedation.
		EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp).	NF		377	362	Standard input for Moderate Sedation.
		EQ032	IV infusion pump	NF		377	362	Standard input for Moderate Sedation.
37244	Vasc embolize/occlude bleed.	EF018	stretcher	NF		240	0	Non-standard input for Moderate Sedation.
		EF027	table, instrument, mobile.	NF		347	332	Standard input for Moderate Sedation.
		EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp).	NF		347	332	Standard input for Moderate Sedation.
		EQ032	IV infusion pump	NF		347	332	Standard input for Moderate Sedation.
		L037D	RN/LPN/MTA	NF	Circulating throughout procedure (25%).	23	22	Conforms to proportionate allocation of intraservice time among clinical labor types.
43197	Esophagoscopy flex dx brush.	ED036	video printer, color (Sony medical grade).	NF		15	39	Refined equipment time to conform to established policies for technical equipment.
		EF008	chair with headrest, exam, reclining.	NF		15	39	Refined equipment time to conform to established policies for technical equipment.
		EF015	mayo stand	NF		15	39	Refined equipment time to conform to established policies for technical equipment.
		EQ170	light, fiberoptic headlight w-source.	NF		15	39	Refined equipment time to conform to established policies for technical equipment.
		EQ234	suction and pressure cabinet, ENT (SMR).	NF		15	39	Refined equipment time to conform to established policies for technical equipment.
		ER095	transnasal esophagoscope 80K series.	NF		15	66	Refined equipment time to conform to established policies for technical equipment.
		ES026	video add-on camera system w-monitor (endoscopy).	NF		15	39	Refined equipment time to conform to established policies for technical equipment.
		ES031	video system, endoscopy (processor, digital capture, monitor, printer, cart).	NF		15	39	Refined equipment time to conform to established policies for technical equipment.
		L026A	Medical/Technical Assistant.	NF	Clean Surgical Instrument Package.	10	0	Standardized time input; surgical instrument package not included.
43198	Esophagosc flex trnsn biopsy.	ED036	video printer, color (Sony medical grade).	NF		20	46	Refined equipment time to conform to established policies for technical equipment.
		EF008	chair with headrest, exam, reclining.	NF		20	46	Refined equipment time to conform to established policies for technical equipment.

TABLE 29—CY 2014 INTERIM FINAL CODES WITH DIRECT PE INPUT RECOMMENDATIONS ACCEPTED WITH REFINEMENTS—Continued

HCPCS code	HCPCS code description	Input code	Input code description	Non-fac/ fac	Labor activity (if applicable)	RUC recommendation or current value (min or qty)	CMS Refinement (min or qty)	Comment
		EF015	mayo stand	NF		20	46	Refined equipment time to conform to established policies for technical equipment.
		EQ170	light, fiberoptic headlight w-source.	NF		20	46	Refined equipment time to conform to established policies for technical equipment.
		EQ234	suction and pressure cabinet, ENT (SMR).	NF		20	46	Refined equipment time to conform to established policies for technical equipment.
		ER095	transnasal esophagoscope 80K series.	NF		20	73	Refined equipment time to conform to established policies for technical equipment.
		ES026	video add-on camera system w-monitor (endoscopy).	NF		20	46	Refined equipment time to conform to established policies for technical equipment.
		ES031	video system, endoscopy (processor, digital capture, monitor, printer, cart).	NF		20	46	Refined equipment time to conform to established policies for technical equipment.
		L026A	Medical/Technical Assistant.	NF	Clean Surgical Instrument Package.	10	0	Standardized time input.
		SD066	endoscopic biopsy forceps.	NF		1	0	CMS clinical review.
43200	Esophagoscopy flexible brush.	EF018	stretcher	NF		73	0	Non-standard input for Moderate Sedation.
		EF027	table, instrument, mobile.	NF		29	77	Standard input for Moderate Sedation.
		EF031	table, power	NF		29	43	Refined equipment time to conform to established policies for technical equipment.
		EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp).	NF		52	77	Standard input for Moderate Sedation.
		EQ032	IV infusion pump	NF		52	77	Standard input for Moderate Sedation.
		EQ235	suction machine (Gomco).	NF		29	43	Refined equipment time to conform to established policies for technical equipment.
		ES031	video system, endoscopy (processor, digital capture, monitor, printer, cart).	NF		29	43	Refined equipment time to conform to established policies for technical equipment.
		ES034	videoscope, gastroscopy.	NF		59	70	Refined equipment time to conform to established policies for technical equipment.
		SD009	canister, suction	NF		2	1	CMS clinical review.
43201	Esoph scope w/submucous inj.	EF018	stretcher	NF		76	0	Non-standard input for Moderate Sedation.
		EF027	table, instrument, mobile.	NF		32	80	Standard input for Moderate Sedation.
		EF031	table, power	NF		32	46	Refined equipment time to conform to changes in clinical labor time.
		EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp).	NF		55	80	Standard input for Moderate Sedation.

TABLE 29—CY 2014 INTERIM FINAL CODES WITH DIRECT PE INPUT RECOMMENDATIONS ACCEPTED WITH REFINEMENTS—Continued

HCPCS code	HCPCS code description	Input code	Input code description	Non-fac/ fac	Labor activity (if applicable)	RUC recommendation or current value (min or qty)	CMS Refinement (min or qty)	Comment
		EQ032	IV infusion pump	NF		55	80	Standard input for Moderate Sedation.
		EQ235	suction machine (Gomco).	NF		32	46	Refined equipment time to conform to changes in clinical labor time.
		ES031	video system, endoscopy (processor, digital capture, monitor, printer, cart).	NF		32	46	Refined equipment time to conform to changes in clinical labor time.
		ES034	videoscope, gastroscopy.	NF		62	73	Refined equipment time to conform to changes in clinical labor time.
		L037D	RN/LPN/MTA	NF	Assist physician in performing procedure.	18	15	Conforming to physician time.
		L051A	RN	NF	Monitor patient during Moderate Sedation.	18	15	Conforming to physician time.
		SC079	needle, micropigmentation (tattoo).	NF		1	0	CMS clinical review.
		SD009	canister, suction	NF		2	1	CMS clinical review.
		SL035	cup, biopsy-specimen non-sterile 4 oz.	NF		1	0	CMS clinical review.
43202	Esophagoscopy flex biopsy.	EF018	stretcher	NF		78	0	Non-standard input for Moderate Sedation.
		EF027	table, instrument, mobile.	NF		34	82	Standard input for Moderate Sedation.
		EF031	table, power	NF		34	48	Refined equipment time to conform to changes in clinical labor time.
		EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp).	NF		57	82	Standard input for Moderate Sedation.
		EQ032	IV infusion pump	NF		57	82	Standard input for Moderate Sedation.
		EQ235	suction machine (Gomco).	NF		34	48	Refined equipment time to conform to changes in clinical labor time.
		ES031	video system, endoscopy (processor, digital capture, monitor, printer, cart).	NF		34	48	Refined equipment time to conform to changes in clinical labor time.
		ES034	videoscope, gastroscopy.	NF		64	75	Refined equipment time to conform to changes in clinical labor time.
		L037D	RN/LPN/MTA	NF	Assist physician in performing procedure.	20	15	Conforming to physician time.
		L051A	RN	NF	Monitor patient during Moderate Sedation.	20	15	Conforming to physician time.
		SD009	canister, suction	NF		2	1	CMS clinical review.
43206	Esoph optical endomicroscopy.	EF018	stretcher	NF		91	0	Non-standard input for Moderate Sedation.
		EF027	table, instrument, mobile.	NF		47	92	Standard input for Moderate Sedation.
		EF031	table, power	NF		47	61	Refined equipment time to conform to established policies for technical equipment.
		EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp).	NF		70	92	Standard input for Moderate Sedation.
		EQ032	IV infusion pump	NF		70	92	Standard input for Moderate Sedation.
		EQ235	suction machine (Gomco).	NF		47	61	Refined equipment time to conform to established policies for technical equipment.

TABLE 29—CY 2014 INTERIM FINAL CODES WITH DIRECT PE INPUT RECOMMENDATIONS ACCEPTED WITH REFINEMENTS—Continued

HCPCS code	HCPCS code description	Input code	Input code description	Non-fac/ fac	Labor activity (if applicable)	RUC recommendation or current value (min or qty)	CMS Refinement (min or qty)	Comment
		EQ355	optical endcmicroscope processor unit system.	NF		77	61	Refined equipment time to conform to established policies for technical equipment.
		ES031	video system, endoscopy (processor, digital capture, monitor, printer, cart).	NF		47	61	Refined equipment time to conform to established policies for technical equipment.
		ES034	videoscope, gastroscopy.	NF		77	88	Refined equipment time to conform to established policies for technical equipment.
		SD009	canister, suction	NF		2	1	CMS clinical review.
43213	Esophagoscopy retro balloon.	EF018	stretcher	NF		103	0	Non-standard input for Moderate Sedation.
		EF027	table, instrument, mobile.	NF		59	107	Standard input for Moderate Sedation.
		EF031	table, power	NF		59	73	Refined equipment time to conform to established policies for technical equipment.
		EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp).	NF		82	107	Standard input for Moderate Sedation.
		EQ032	IV infusion pump	NF		82	107	Standard input for Moderate Sedation.
		EQ235	suction machine (Gomco).	NF		59	73	Refined equipment time to conform to established policies for technical equipment.
		ES031	video system, endoscopy (processor, digital capture, monitor, printer, cart).	NF		59	73	Refined equipment time to conform to established policies for technical equipment.
		ES034	videoscope, gastroscopy.	NF		89	100	Refined equipment time to conform to established policies for technical equipment.
43215	Esophagoscopy flex remove fb.	EF018	stretcher	NF		78	0	Non-standard input for Moderate Sedation.
		EF027	table, instrument, mobile.	NF		34	82	Standard input for Moderate Sedation.
		EF031	table, power	NF		34	48	Refined equipment time to conform to established policies for technical equipment.
		EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp).	NF		57	82	Standard input for Moderate Sedation.
		EQ032	IV infusion pump	NF		57	82	Standard input for Moderate Sedation.
		EQ235	suction machine (Gomco).	NF		34	48	Refined equipment time to conform to established policies for technical equipment.
		ES031	video system, endoscopy (processor, digital capture, monitor, printer, cart).	NF		34	48	Refined equipment time to conform to established policies for technical equipment.

TABLE 29—CY 2014 INTERIM FINAL CODES WITH DIRECT PE INPUT RECOMMENDATIONS ACCEPTED WITH REFINEMENTS—Continued

HCPCS code	HCPCS code description	Input code	Input code description	Non-fac/ fac	Labor activity (if applicable)	RUC recommendation or current value (min or qty)	CMS Refinement (min or qty)	Comment
		ES034	videoscope, gastroscopy.	NF		64	75	Refined equipment time to conform to established policies for technical equipment.
		SD009	canister, suction	NF		2	1	CMS clinical review.
43216	Esophagoscopy lesion removal.	EF018	stretcher	NF		80	0	Non-standard Input for Moderate Sedation.
		EF027	table, instrument, mobile.	NF		36	84	Standard input for Moderate Sedation.
		EF031	table, power	NF		36	50	Refined equipment time to conform to established policies for technical equipment.
		EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp).	NF		59	84	Standard input for Moderate Sedation.
		EQ032	IV infusion pump	NF		59	84	Standard input for Moderate Sedation.
		EQ113	electrosurgical generator, gastrocautery.	NF		36	50	Refined equipment time to conform to established policies for technical equipment.
		EQ235	suction machine (Gomco).	NF		36	50	Refined equipment time to conform to established policies for technical equipment.
		ES031	video system, endoscopy (processor, digital capture, monitor, printer, cart).	NF		36	50	Refined equipment time to conform to established policies for technical equipment.
		ES034	videoscope, gastroscopy.	NF		66	77	Refined equipment time to conform to established policies for technical equipment.
		SD009	canister, suction	NF		2	1	CMS clinical review.
43217	Esophagoscopy snare les remv.	EF018	stretcher	NF		88	0	Non-standard input for Moderate Sedation.
		EF027	table, instrument, mobile.	NF		44	92	Standard input for Moderate Sedation.
		EF031	table, power	NF		44	58	Refined equipment time to conform to established policies for technical equipment.
		EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp).	NF		67	92	Standard input for Moderate Sedation.
		EQ032	IV infusion pump	NF		67	92	Standard input for Moderate Sedation.
		EQ113	electrosurgical generator, gastrocautery.	NF		44	58	Refined equipment time to conform to established policies for technical equipment.
		EQ235	suction machine (Gomco).	NF		44	58	Refined equipment time to conform to established policies for technical equipment.
		ES031	video system, endoscopy (processor, digital capture, monitor, printer, cart).	NF		44	58	Refined equipment time to conform to established policies for technical equipment.
		ES034	videoscope, gastroscopy.	NF		74	85	Refined equipment time to conform to established policies for technical equipment.
		SD009	canister, suction	NF		2	1	CMS clinical review.

TABLE 29—CY 2014 INTERIM FINAL CODES WITH DIRECT PE INPUT RECOMMENDATIONS ACCEPTED WITH REFINEMENTS—Continued

HCPCS code	HCPCS code description	Input code	Input code description	Non-fac/ fac	Labor activity (if applicable)	RUC recommendation or current value (min or qty)	CMS Refinement (min or qty)	Comment
43220	Esophagoscopy balloon <30mm.	EF018	stretcher	NF		78	0	Non-standard input for Moderate Sedation.
		EF027	table, instrument, mobile.	NF		34	82	Standard input for Moderate Sedation.
		EF031	table, power	NF		34	48	Refined equipment time to conform to established policies for technical equipment.
		EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp).	NF		57	82	Standard input for Moderate Sedation.
		EQ032	IV infusion pump	NF		57	82	Standard input for Moderate Sedation.
		EQ235	suction machine (Gomco).	NF		34	48	Refined equipment time to conform to established policies for technical equipment.
		ES031	video system, endoscopy (processor, digital capture, monitor, printer, cart).	NF		34	48	Refined equipment time to conform to established policies for technical equipment.
		ES034	videoscope, gastroscopy.	NF		64	75	Refined equipment time to conform to established policies for technical equipment.
		SD009	canister, suction	NF		2	1	CMS clinical review.
		SD019	catheter, balloon, ureteral-GI (strictures).	NF		SD205	SD019	Supply proxy change due to CMS clinical review.
		SD090	guidewire, STIFF	NF		1	0	CMS clinical review.
		SL035	cup, biopsy-specimen non-sterile 4 oz.	NF		1	0	CMS clinical review.
43226	Esoph endoscopy dilation.	EF018	stretcher	NF		83	0	Non-standard input for Moderate Sedation.
		EF027	table, instrument, mobile.	NF		39	87	Standard input for Moderate Sedation.
		EF031	table, power	NF		39	53	Refined equipment time to conform to established policies for technical equipment.
		EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp).	NF		62	87	Standard input for Moderate Sedation.
		EQ032	IV infusion pump	NF		62	87	Standard input for Moderate Sedation.
		EQ235	suction machine (Gomco).	NF		39	53	Refined equipment time to conform to established policies for technical equipment.
		ES031	video system, endoscopy (processor, digital capture, monitor, printer, cart).	NF		39	53	Refined equipment time to conform to established policies for technical equipment.
		ES034	videoscope, gastroscopy.	NF		69	80	Refined equipment time to conform to established policies for technical equipment.
		L037D	RN/LPN/MTA	NF	Clean Surgical Instrument Package.	0	10	Standardized time input.
		SD009	canister, suction	NF		2	1	CMS clinical review.
		SL035	cup, biopsy-specimen non-sterile 4 oz.	NF		1	0	CMS clinical review.
43227	Esophagoscopy control bleed.	EF018	stretcher	NF		88	0	Non-standard input for Moderate Sedation.
		EF027	table, instrument, mobile.	NF		44	92	Standard input for Moderate Sedation.

TABLE 29—CY 2014 INTERIM FINAL CODES WITH DIRECT PE INPUT RECOMMENDATIONS ACCEPTED WITH REFINEMENTS—Continued

HCPCS code	HCPCS code description	Input code	Input code description	Non-fac/ fac	Labor activity (if applicable)	RUC recommendation or current value (min or qty)	CMS Refinement (min or qty)	Comment
		EF031	table, power	NF		44	58	Refined equipment time to conform to established policies for technical equipment.
		EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp).	NF		67	92	Standard input for Moderate Sedation.
		EQ032	IV infusion pump	NF		67	92	Standard input for Moderate Sedation.
		EQ113	electrosurgical generator, gastrocautery.	NF		44	58	Refined equipment time to conform to established policies for technical equipment.
		EQ235	suction machine (Gomco).	NF		44	58	Refined equipment time to conform to established policies for technical equipment.
		ES031	video system, endoscopy (processor, digital capture, monitor, printer, cart).	NF		44	58	Refined equipment time to conform to established policies for technical equipment.
			videoscope, gastroscopy.	NF		74	85	Refined equipment time to conform to established policies for technical equipment.
		SD009	canister, suction	NF		2	1	CMS clinical review.
43229	Esophagoscopy lesion ablate.	EF018	stretcher	NF		103	0	Non-standard input for Moderate Sedation.
		EF027	table, instrument, mobile.	NF		59	107	Standard input for Moderate Sedation.
		EF031	table, power	NF		59	73	Refined equipment time to conform to established policies for technical equipment.
		EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp).	NF		82	107	Standard input for Moderate Sedation.
		EQ032	IV infusion pump	NF		82	107	Standard input for Moderate Sedation.
		EQ113	electrosurgical generator, gastrocautery.	NF		59	73	Refined equipment time to conform to established policies for technical equipment.
		EQ214	radiofrequency generator (NEURO).	NF		59	73	CMS clinical review; see discussion in section II.D.3.b. of this final rule.
		EQ235	suction machine (Gomco).	NF		59	73	Refined equipment time to conform to established policies for technical equipment.
		EQ356	kit, probe, radiofrequency, Xli-enhanced RF probe (proxy for catheter, RF ablation, endoscopic).	NF		0	73	CMS clinical review; see discussion in section II.D.3.b. of this final rule.
		ES031	video system, endoscopy (processor, digital capture, monitor, printer, cart).	NF		59	73	Refined equipment time to conform to established policies for technical equipment.
		ES034	videoscope, gastroscopy.	NF		89	100	Refined equipment time to conform to established policies for technical equipment.

TABLE 29—CY 2014 INTERIM FINAL CODES WITH DIRECT PE INPUT RECOMMENDATIONS ACCEPTED WITH REFINEMENTS—Continued

HCPCS code	HCPCS code description	Input code	Input code description	Non-fac/ fac	Labor activity (if applicable)	RUC recommendation or current value (min or qty)	CMS Refinement (min or qty)	Comment
		SA100	kit, probe, radio-frequency, Xli-enhanced RF probe.	NF		1	0	CMS clinical review.
43231	Esophagoscop ultrasound exam.	EF018	stretcher	NF		103	0	Non-standard input for Moderate Sedation.
		EF027	table, instrument, mobile.	NF		59	107	Standard input for Moderate Sedation.
		EF031	table, power	NF		59	73	Refined equipment time to conform to changes in clinical labor time.
		EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp).	NF		82	107	Standard input for Moderate Sedation.
		EQ032	IV infusion pump	NF		82	107	Standard input for Moderate Sedation.
		EQ235	suction machine (Gomco).	NF		59	73	Refined equipment time to conform to changes in clinical labor time.
		ER094	endoscopic ultrasound processor.	NF		59	73	Refined equipment time to conform to changes in clinical labor time.
		ES031	video system, endoscopy (processor, digital capture, monitor, printer, cart).	NF		59	73	Refined equipment time to conform to changes in clinical labor time.
		ES038	videoscope, endoscopic ultrasound.	NF		89	100	Refined equipment time to conform to changes in clinical labor time.
		L037D	RN/LPN/MTA	NF	Assist physician in performing procedure.	45	30	Conforming to physician time.
		L051A	RN	NF	Monitor patient during Moderate Sedation.	45	30	Conforming to physician time.
		SD009	canister, suction	NF		2	1	CMS clinical review.
		SL035	cup, biopsy-specimen non-sterile 4 oz.	NF		1	0	CMS clinical review.
43232	Esophagoscopy w/us needle bx.	EF018	stretcher	NF		118	0	Non-standard input for Moderate Sedation.
		EF027	table, instrument, mobile.	NF		74	122	Standard input for Moderate Sedation.
		EF031	table, power	NF		74	88	Refined equipment time to conform to changes in clinical labor time.
		EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp).	NF		97	122	Standard input for Moderate Sedation.
		EQ032	IV infusion pump	NF		97	122	Standard input for Moderate Sedation.
		EQ235	suction machine (Gomco).	NF		74	88	Refined equipment time to conform to changes in clinical labor time.
		ER094	endoscopic ultrasound processor.	NF		74	88	Refined equipment time to conform to changes in clinical labor time.
		ES031	video system, endoscopy (processor, digital capture, monitor, printer, cart).	NF		74	88	Refined equipment time to conform to changes in clinical labor time.
		ES038	videoscope, endoscopic ultrasound.	NF		104	115	Refined equipment time to conform to changes in clinical labor time.
		L037D	RN/LPN/MTA	NF	Assist physician in performing procedure.	60	45	Conforming to physician time.
		L051A	RN	NF	Monitor patient during Moderate Sedation.	60	45	Conforming to physician time.
		SD009	canister, suction	NF		2	1	CMS clinical review.
43235	Egd diagnostic brush wash.	EF018	stretcher	NF		73	0	Non-standard input for Moderate Sedation.

TABLE 29—CY 2014 INTERIM FINAL CODES WITH DIRECT PE INPUT RECOMMENDATIONS ACCEPTED WITH REFINEMENTS—Continued

HCPCS code	HCPCS code description	Input code	Input code description	Non-fac/ fac	Labor activity (if applicable)	RUC recommendation or current value (min or qty)	CMS Refinement (min or qty)	Comment
		EF027	table, instrument, mobile.	NF		29	77	Standard input for Moderate Sedation.
		EF031	table, power	NF		29	43	Refined equipment time to conform to established policies for technical equipment.
		EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp).	NF		52	77	Standard input for Moderate Sedation.
		EQ032	IV infusion pump	NF		52	77	Standard input for Moderate Sedation.
		EQ235	suction machine (Gomco).	NF		29	43	Refined equipment time to conform to established policies for technical equipment.
		ES031	video system, endoscopy (processor, digital capture, monitor, printer, cart).	NF		29	43	Refined equipment time to conform to established policies for technical equipment.
		ES034	videoscope, gastroscopy.	NF		59	70	Refined equipment time to conform to established policies for technical equipment.
		SD009	canister, suction	NF		2	1	CMS clinical review.
43236	Uppr gi scope w/ submuc inj.	EF018	stretcher	NF		78	0	Non-standard input for Moderate Sedation.
		EF027	table, instrument, mobile.	NF		34	82	Standard input for Moderate Sedation.
		EF031	table, power	NF		34	48	Refined equipment time to conform to established policies for technical equipment.
		EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp).	NF		57	82	Standard input for Moderate Sedation.
		EQ032	IV infusion pump	NF		57	82	Standard input for Moderate Sedation.
		EQ235	suction machine (Gomco).	NF		34	48	Refined equipment time to conform to established policies for technical equipment.
		ES031	video system, endoscopy (processor, digital capture, monitor, printer, cart).	NF		34	48	Refined equipment time to conform to established policies for technical equipment.
		ES034	videoscope, gastroscopy.	NF		64	75	Refined equipment time to conform to established policies for technical equipment.
		SD009	canister, suction	NF		2	1	CMS clinical review.
43239	Egd biopsy single/multiple.	EF018	stretcher	NF		73	0	Non-standard input for Moderate Sedation.
		EF027	table, instrument, mobile.	NF		29	77	Standard input for Moderate Sedation.
		EF031	table, power	NF		29	43	Refined equipment time to conform to established policies for technical equipment.
		EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp).	NF		52	77	Standard input for Moderate Sedation.
		EQ032	IV infusion pump	NF		52	77	Standard input for Moderate Sedation.

TABLE 29—CY 2014 INTERIM FINAL CODES WITH DIRECT PE INPUT RECOMMENDATIONS ACCEPTED WITH REFINEMENTS—Continued

HCPCS code	HCPCS code description	Input code	Input code description	Non-fac/ fac	Labor activity (if applicable)	RUC recommendation or current value (min or qty)	CMS Refinement (min or qty)	Comment
		EQ235	suction machine (Gomco).	NF		29	43	Refined equipment time to conform to established policies for technical equipment.
		ES031	video system, endoscopy (processor, digital capture, monitor, printer, cart).	NF		29	43	Refined equipment time to conform to established policies for technical equipment.
		ES034	videoscope, gastroscopy.	NF		59	70	Refined equipment time to conform to established policies for technical equipment.
		SD009	canister, suction	NF		2	1	CMS clinical review.
43245	Egd dilate stricture	EF018	stretcher	NF		81	0	Non-standard input for Moderate Sedation.
		EF027	table, instrument, mobile.	NF		37	85	Standard input for Moderate Sedation.
		EF031	table, power	NF		37	51	Refined equipment time to conform to established policies for technical equipment.
		EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp).	NF		60	85	Standard input for Moderate Sedation.
		EQ032	IV infusion pump	NF		60	85	Standard input for Moderate Sedation.
		EQ235	suction machine (Gomco).	NF		37	51	Refined equipment time to conform to established policies for technical equipment.
		ES031	video system, endoscopy (processor, digital capture, monitor, printer, cart).	NF		37	51	Refined equipment time to conform to established policies for technical equipment.
		ES034	videoscope, gastroscopy.	NF		67	78	Refined equipment time to conform to established policies for technical equipment.
		SD009	canister, suction	NF		2	1	CMS clinical review.
43247	Egd remove foreign body.	EF018	stretcher	NF		88	0	Non-standard input for Moderate Sedation.
		EF027	table, instrument, mobile.	NF		44	92	Standard input for Moderate Sedation.
		EF031	table, power	NF		44	58	Refined equipment time to conform to established policies for technical equipment.
		EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp).	NF		67	92	Standard input for Moderate Sedation.
		EQ032	IV infusion pump	NF		67	92	Standard input for Moderate Sedation.
		EQ235	suction machine (Gomco).	NF		44	58	Refined equipment time to conform to established policies for technical equipment.
		ES031	video system, endoscopy (processor, digital capture, monitor, printer, cart).	NF		44	58	Refined equipment time to conform to established policies for technical equipment.
		ES034	videoscope, gastroscopy.	NF		74	85	Refined equipment time to conform to established policies for technical equipment.
		SD009	canister, suction	NF		2	1	CMS clinical review.

TABLE 29—CY 2014 INTERIM FINAL CODES WITH DIRECT PE INPUT RECOMMENDATIONS ACCEPTED WITH REFINEMENTS—Continued

HCPCS code	HCPCS code description	Input code	Input code description	Non-fac/ fac	Labor activity (if applicable)	RUC recommendation or current value (min or qty)	CMS Refinement (min or qty)	Comment
43248	Egd guide wire insertion.	EF018	stretcher	NF	.....	78	0	Non-standard input for Moderate Sedation.
		EF027	table, instrument, mobile.	NF	.....	34	82	Standard input for Moderate Sedation.
		EF031	table, power	NF	.....	34	48	Refined equipment time to conform to established policies for technical equipment.
		EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp).	NF	.....	57	82	Standard input for Moderate Sedation.
		EQ032	IV infusion pump	NF	.....	57	82	Standard input for Moderate Sedation.
		EQ137	instrument pack, basic ($500–$1499).	NF	.....	64	55	Refined equipment time to conform to established policies for technical equipment.
		EQ235	suction machine (Gomco).	NF	.....	34	48	Refined equipment time to conform to established policies for technical equipment.
		ES031	video system, endoscopy (processor, digital capture, monitor, printer, cart).	NF	.....	34	48	Refined equipment time to conform to established policies for technical equipment.
		ES034	videoscope, gastroscopy.	NF	.....	64	75	Refined equipment time to conform to established policies for technical equipment.
		SD009	canister, suction	NF	.....	2	1	CMS clinical review.
43249	Esoph egd dilation <30 mm.	EF018	stretcher	NF	.....	78	0	Non-standard input for Moderate Sedation.
		EF027	table, instrument, mobile.	NF	.....	34	82	Standard input for Moderate Sedation.
		EF031	table, power	NF	.....	34	48	Refined equipment time to conform to established policies for technical equipment.
		EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp).	NF	.....	57	82	Standard input for Moderate Sedation.
		EQ032	IV infusion pump	NF	.....	57	82	Standard input for Moderate Sedation.
		EQ235	suction machine (Gomco).	NF	.....	34	48	Refined equipment time to conform to established policies for technical equipment.
		ES031	video system, endoscopy (processor, digital capture, monitor, printer, cart).	NF	.....	34	48	Refined equipment time to conform to established policies for technical equipment.
		ES034	videoscope, gastroscopy.	NF	.....	64	75	Refined equipment time to conform to established policies for technical equipment.
		SD009	canister, suction	NF	.....	2	1	CMS clinical review.
		SD090	guidewire, STIFF	NF	.....	1	0	CMS clinical review.
43250	Egd cautery tumor polyp.	EF018	stretcher	NF	.....	78	0	Non-standard input for Moderate Sedation.
		EF027	table, instrument, mobile.	NF	.....	34	82	Standard input for Moderate Sedation.
		EF031	table, power	NF	.....	34	48	Refined equipment time to conform to established policies for technical equipment.

TABLE 29—CY 2014 INTERIM FINAL CODES WITH DIRECT PE INPUT RECOMMENDATIONS ACCEPTED WITH REFINEMENTS—Continued

HCPCS code	HCPCS code description	Input code	Input code description	Non-fac/ fac	Labor activity (if applicable)	RUC recommendation or current value (min or qty)	CMS Refinement (min or qty)	Comment
		EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp).	NF		57	82	Standard input for Moderate Sedation.
		EQ032	IV infusion pump	NF		57	82	Standard input for Moderate Sedation.
		EQ113	electrosurgical generator, gastrocautery.	NF		34	48	Refined equipment time to conform to established policies for technical equipment.
		EQ235	suction machine (Gomco).	NF		34	48	Refined equipment time to conform to established policies for technical equipment.
		ES031	video system, endoscopy (processor, digital capture, monitor, printer, cart).	NF		34	48	Refined equipment time to conform to established policies for technical equipment.
		ES034	videoscope, gastroscopy.	NF		64	75	Refined equipment time to conform to established policies for technical equipment.
		SD009	canister, suction	NF		2	1	CMS clinical review.
43251	Egd remove lesion snare.	EF018	stretcher	NF		78	0	Non-standard input for Moderate Sedation.
		EF027	table, instrument, mobile.	NF		34	82	Standard input for Moderate Sedation.
		EF031	table, power	NF		34	48	Refined equipment time to conform to established policies for technical equipment.
		EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp).	NF		57	82	Standard input for Moderate Sedation.
		EQ032	IV infusion pump	NF		57	82	Standard input for Moderate Sedation.
		EQ113	electrosurgical generator, gastrocautery.	NF		34	48	Refined equipment time to conform to established policies for technical equipment.
		EQ235	suction machine (Gomco).	NF		34	48	Refined equipment time to conform to established policies for technical equipment.
		ES031	video system, endoscopy (processor, digital capture, monitor, printer, cart).	NF		34	48	Refined equipment time to conform to established policies for technical equipment.
		ES034	videoscope, gastroscopy.	NF		64	75	Refined equipment time to conform to established policies for technical equipment.
		SD009	canister, suction	NF		2	1	CMS clinical review.
43252	Egd optical endomicroscopy.	EF018	stretcher	NF		78	0	Non-standard input for Moderate Sedation.
		EF027	table, instrument, mobile.	NF		34	92	Standard input for Moderate Sedation.
		EF031	table, power	NF		34	61	Refined equipment time to conform to established policies for technical equipment.
		EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp).	NF		70	92	Standard input for Moderate Sedation.
		EQ032	IV infusion pump	NF		57	92	Standard input for Moderate Sedation.

TABLE 29—CY 2014 INTERIM FINAL CODES WITH DIRECT PE INPUT RECOMMENDATIONS ACCEPTED WITH REFINEMENTS—Continued

HCPCS code	HCPCS code description	Input code	Input code description	Non-fac/ fac	Labor activity (if applicable)	RUC recommendation or current value (min or qty)	CMS Refinement (min or qty)	Comment
		EQ235	suction machine (Gomco).	NF		34	61	Refined equipment time to conform to established policies for technical equipment.
		EQ355	optical endomicroscope processor unit system.	NF		77	61	Refined equipment time to conform to established policies for technical equipment.
		ES031	video system, endoscopy (processor, digital capture, monitor, printer, cart).	NF		34	61	Refined equipment time to conform to established policies for technical equipment.
		ES034	videoscope, gastroscopy.	NF		64	88	Refined equipment time to conform to established policies for technical equipment.
		SD009	canister, suction	NF		2	1	CMS clinical review.
43255	Egd control bleeding any.	EF018	stretcher	NF		88	0	Non-standard input for Moderate Sedation.
		EF027	table, instrument, mobile.	NF		44	92	Standard input for Moderate Sedation.
		EF031	table, power	NF		44	58	Refined equipment time to conform to established policies for technical equipment.
		EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp).	NF		67	92	Standard input for Moderate Sedation.
		EQ032	IV infusion pump	NF		67	92	Standard input for Moderate Sedation.
		EQ113	electrosurgical generator, gastrocautery.	NF		44	58	Refined equipment time to conform to established policies for technical equipment.
		EQ235	suction machine (Gomco).	NF		44	58	Refined equipment time to conform to established policies for technical equipment.
		ES031	video system, endoscopy (processor, digital capture, monitor, printer, cart).	NF		44	58	Refined equipment time to conform to established policies for technical equipment.
		ES034	videoscope, gastroscopy.	NF		74	85	Refined equipment time to conform to established policies for technical equipment.
		SD009	canister, suction	NF		2	1	CMS clinical review.
43270	Egd lesion ablation	EF018	stretcher	NF		103	0	Non-standard input for Moderate Sedation.
		EF027	table, instrument, mobile.	NF		82	107	Standard input for Moderate Sedation.
		EF031	table, power	NF		59	73	Refined equipment time to conform to established policies for technical equipment.
		EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp).	NF		82	107	Standard input for Moderate Sedation.
		EQ032	IV infusion pump	NF		82	107	Standard input for Moderate Sedation.
		EQ113	electrosurgical generator, gastrocautery.	NF		59	73	Refined equipment time to conform to established policies for technical equipment.

TABLE 29—CY 2014 INTERIM FINAL CODES WITH DIRECT PE INPUT RECOMMENDATIONS ACCEPTED WITH REFINEMENTS—Continued

HCPCS code	HCPCS code description	Input code	Input code description	Non-fac/ fac	Labor activity (if applicable)	RUC recommendation or current value (min or qty)	CMS Refinement (min or qty)	Comment
		EQ214	radiofrequency generator (NEURO).	NF		59	73	CMS clinical review; see discussion in section II.D.3.b. of this final rule.
		EQ235	suction machine (Gomco).	NF		59	73	Refined equipment time to conform to established policies for technical equipment.
		EQ356	kit, probe, radiofrequency, Xli-enhanced RF probe (proxy for catheter, RF ablation, endoscopic).	NF		0	73	CMS clinical review; see discussion in section II.D.3.b. of this final rule.
		ES031	video system, endoscopy (processor, digital capture, monitor, printer, cart).	NF		59	73	Refined equipment time to conform to established policies for technical equipment.
		ES034	videoscope, gastroscopy.	NF		89	100	Refined equipment time to conform to established policies for technical equipment.
		SA100	kit, probe, radiofrequency, Xli-enhanced RF probe.	NF		1	0	CMS clinical review.
		SD009	canister, suction	NF		2	1	CMS clinical review.
		SD090	guidewire, STIFF	NF		1	0	CMS clinical review.
43450	Dilate esophagus 1/ mult pass.	E	Mobile stand, Vital Signs Monitor.	NF		47	0	Non-standard input for Moderate Sedation.
		EF014	light, surgical	NF		24	36	Refined equipment time to conform to established policies for technical equipment.
		EF018	stretcher	NF		51	0	Non-standard input for Moderate Sedation.
		EF027	table, instrument, mobile.	NF		24	77	Standard input for Moderate Sedation.
		EF031	table, power	NF		24	36	Refined equipment time to conform to established policies for technical equipment.
		EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp).	NF		47	77	Standard input for Moderate Sedation.
		EQ032	IV infusion pump	NF		47	77	Standard input for Moderate Sedation.
		EQ235	suction machine (Gomco).	NF		24	36	Refined equipment time to conform to established policies for technical equipment.
		EQ357	esophageal bougies, set, reusable.	NF		0	36	CMS clinical review; see discussion in section II.D.3.b. of this final rule.
		ES005	endoscope disinfector, rigid or fiberoptic, w-cart.	NF		15	0	CMS clinical review.
43453	Dilate esophagus	E	Mobile stand, Vital Signs Monitor.	NF		57	0	CMS clinical review.
		EF014	light, surgical	NF		34	46	Refined equipment time to conform to changes in clinical labor time.
		EF018	stretcher	NF		61	0	Non-standard input for Moderate Sedation.
		EF027	table, instrument, mobile.	NF		34	87	Standard input for Moderate Sedation.

TABLE 29—CY 2014 INTERIM FINAL CODES WITH DIRECT PE INPUT RECOMMENDATIONS ACCEPTED WITH REFINEMENTS—Continued

HCPCS code	HCPCS code description	Input code	Input code description	Non-fac/ fac	Labor activity (if applicable)	RUC recommendation or current value (min or qty)	CMS Refinement (min or qty)	Comment
		EF031	table, power	NF		34	46	Refined equipment time to conform to changes in clinical labor time.
		EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp).	NF		57	87	Standard input for Moderate Sedation.
		EQ032	IV infusion pump	NF		57	87	Standard input for Moderate Sedation.
		EQ235	suction machine (Gomco).	NF		34	46	Refined equipment time to conform to changes in clinical labor time.
		ES005	endoscope disinfector, rigid or fiberoptic, w-cart.	NF		15	0	CMS clinical review; an endoscope is not included.
		L037D	RN/LPN/MTA	NF	Assist physician in performing procedure.	25	20	Conforming to physician time.
		L051A	RN	NF	Monitor patient during Moderate Sedation.	25	20	Conforming to physician time.
49405	Image cath fluid colxn visc.	EF018	stretcher	NF		120	0	Non-standard input for Moderate Sedation.
		EF027	table, instrument, mobile.	NF		169	162	Standard input for Moderate Sedation.
		EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp).	NF		169	162	Standard input for Moderate Sedation.
		EQ032	IV infusion pump	NF		169	162	Standard input for Moderate Sedation.
49406	Image cath fluid peri/ retro.	EF018	stretcher	NF		120	0	Non-standard input for Moderate Sedation.
		EF027	table, instrument, mobile.	NF		169	162	Standard input for Moderate Sedation.
		EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp).	NF		169	162	Standard input for Moderate Sedation.
		EQ032	IV infusion pump	NF		169	162	Standard input for Moderate Sedation.
49407	Image cath fluid trns/ vgnl.	EF018	stretcher	NF		120	0	Non-standard input for Moderate Sedation.
		EF027	table, instrument, mobile.	NF		174	167	Standard input for Moderate Sedation.
		EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp).	NF		174	167	Standard input for Moderate Sedation.
		EQ032	IV infusion pump	NF		174	167	Standard input for Moderate Sedation.
63650	Implant neuroelectrodes.	EF018	stretcher	NF		10	15	Refined equipment time to conform to established policies for technical equipment.
		EF024	table, fluoroscopy	NF		60	84	Refined equipment time to conform to established policies for technical equipment.
		EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp).	NF		60	84	Refined equipment time to conform to established policies for technical equipment.
		ER031	fluoroscopic system, mobile C-Arm.	NF		60	69	Refined equipment time to conform to established policies for technical equipment.
		L037D	RN/LPN/MTA	NF	Clean Surgical Instrument Package.	15	0	Standardized time input.
		SA043	pack, cleaning, surgical instruments.	NF		1	0	CMS clinical review.
64616	Chemodenerv musc neck dyston.	EF023	table, exam	NF		28	24	Refined equipment time to conform to changes in clinical labor time.

TABLE 29—CY 2014 INTERIM FINAL CODES WITH DIRECT PE INPUT RECOMMENDATIONS ACCEPTED WITH REFINEMENTS—Continued

HCPCS code	HCPCS code description	Input code	Input code description	Non-fac/ fac	Labor activity (if applicable)	RUC recommendation or current value (min or qty)	CMS Refinement (min or qty)	Comment
		L037D	RN/LPN/MTA	NF	Other Clinical Activity: Complete botox log.	3	0	CMS clinical review.
		L037D	RN/LPN/MTA	NF	Assist physician in performing procedure.	7	5	Conforming to physician time.
64617	Chemodener muscle larynx emg.	EF023	table, exam	NF		30	33	Refined equipment time to conform to changes in clinical labor time.
		EQ024	EMG–NCV–EP system, 8 channel.	NF		30	33	Refined equipment time to conform to changes in clinical labor time.
64642	Chemodenerv 1 extremity 1–4.	EF023	table, exam	NF		44	38	Refined equipment time to conform to changes in clinical labor time.
		L037D	RN/LPN/MTA	NF	Other Clinical Activity: Complete botox log.	3	0	CMS clinical review.
64644	Chemodenerv 1 extrem 5/> mus.	EF023	table, exam	NF		49	43	Refined equipment time to conform to established policies for technical equipment.
		L037D	RN/LPN/MTA	NF	Other Clinical Activity: Complete botox log.	3	0	CMS clinical review.
64646	Chemodenerv trunk musc 1–5.	EF023	table, exam	NF		44	38	Refined equipment time to conform to established policies for technical equipment.
		L037D	RN/LPN/MTA	NF	Other Clinical Activity: Complete botox log.	3	0	CMS clinical review.
64647	Chemodenerv trunk musc 6/>.	EF023	table, exam	NF		49	43	Refined equipment time to conform to established policies for technical equipment.
		L037D	RN/LPN/MTA	NF	Other Clinical Activity: Complete botox log.	3	0	CMS clinical review.
67914	Repair eyelid defect	EF015	mayo stand	NF		31	20	Refined equipment time to conform to established policies for technical equipment.
		EL006	lane, screening (oph)	NF		121	110	Refined equipment time to conform to established policies for technical equipment.
		EQ114	electrosurgical generator, up to 120 watts.	NF		31	20	Refined equipment time to conform to established policies for technical equipment.
		EQ138	instrument pack, medium ($1500 and up).	NF		43	20	Refined equipment time to conform to established policies for technical equipment.
		EQ176	loupes, standard, up to 3.5x.	NF		31	20	Refined equipment time to conform to established policies for technical equipment.
		L038A	COMT/COT/RN/CST	NF	Clean Surgical Instrument Package.	15	10	Standardized time input.
		SC027	needle, 18–19g, filter	NF		SB034	SC027	Supply/Equipment code correction.
		SC057	syringe 5–6ml	NF		SK057	SC057	Supply/Equipment code correction.
67915	Repair eyelid defect	EF015	mayo stand	NF		21	10	Refined equipment time to conform to established policies for technical equipment.

TABLE 29—CY 2014 INTERIM FINAL CODES WITH DIRECT PE INPUT RECOMMENDATIONS ACCEPTED WITH REFINEMENTS—Continued

HCPCS code	HCPCS code description	Input code	Input code description	Non-fac/ fac	Labor activity (if applicable)	RUC recommendation or current value (min or qty)	CMS Refinement (min or qty)	Comment
		EL006	lane, screening (oph) ..	NF	.....	71	64	Refined equipment time to conform to established policies for technical equipment.
		EQ114	electrosurgical generator, up to 120 watts.	NF	.....	21	10	Refined equipment time to conform to established policies for technical equipment.
		EQ176	loupes, standard, up to 3.5x.	NF	.....	21	10	Refined equipment time to conform to established policies for technical equipment.
		SB027	gown, staff, impervious	NF	.....	SB034	SB027	Supply/Equipment code correction.
		SC057	syringe 5–6ml	NF	.....	SK057	SC057	Supply/Equipment code correction.
67916	Repair eyelid defect	SB027	gown, staff, impervious	NF	.....	SB034	SB027	Supply/Equipment code correction.
		SC057	syringe 5–6ml	NF	.....	SK057	SC057	Supply/Equipment code correction.
67917	Repair eyelid defect	SB027	gown, staff, impervious	NF	.....	SB034	SB027	Supply/Equipment code correction.
		SC057	syringe 5–6ml	NF	.....	SK057	SC057	Supply/Equipment code correction.
67921	Repair eyelid defect	SB027	gown, staff, impervious	NF	.....	SB034	SB027	Supply/Equipment code correction.
		SC057	syringe 5–6ml	NF	.....	SK057	SC057	Supply/Equipment code correction.
67922	Repair eyelid defect	SB027	gown, staff, impervious	NF	.....	SB034	SB027	Supply/Equipment code correction.
		SC057	syringe 5–6ml	NF	.....	SK057	SC057	Supply/Equipment code correction.
67923	Repair eyelid defect	SB027	gown, staff, impervious	NF	.....	SB034	SB027	Supply/Equipment code correction.
		SC057	syringe 5–6ml	NF	.....	SK057	SC057	Supply/Equipment code correction.
67924	Repair eyelid defect	SB027	gown, staff, impervious	NF	.....	SB034	SB027	Supply/Equipment code correction.
		SC057	syringe 5–6ml	NF	.....	SK057	SC057	Supply/Equipment code correction.
70450	Ct head/brain w/o dye	ED024	film processor, dry, laser.	NF	.....	15	4	Refined equipment time to conform to established policies for technical equlpment.
		EL007	room, CT	NF	.....	26	17	Refined equipment time to conform to established policies for technical equipment.
		ER029	film alternator (motorized film viewbox).	NF	.....	15	4	Refined equipment time to conform to established policies for technical equipment.
70460	Ct head/brain w/dye	ED024	film processor, dry, laser.	NF	.....	15	4	Refined equipment time to conform to established policies for technical equipment.
		EL007	room, CT	NF	.....	34	24	Refined equipment time to conform to established policies for technical equipment.
		ER029	film alternator (motorized film viewbox).	NF	.....	15	4	Refined equipment time to conform to established policies for technical equipment.

TABLE 29—CY 2014 INTERIM FINAL CODES WITH DIRECT PE INPUT RECOMMENDATIONS ACCEPTED WITH REFINEMENTS—Continued

HCPCS code	HCPCS code description	Input code	Input code description	Non-fac/ fac	Labor activity (if applicable)	RUC recommendation or current value (min or qty)	CMS Refinement (min or qty)	Comment
70470	Ct head/brain w/o & w/ dye.	ED024	film processor, dry, laser.	NF		15	6	Refined equipment time to conform to established policies for technical equipment.
		EL007	room, CT	NF		42	30	Refined equipment time to conform to established policies for technical equipment.
		ER029	film alternator (motorized film viewbox).	NF		15	6	Refined equipment time to conform to established policies for technical equipment.
70551	Mri brain stem w/o dye	EL008	room, MRI	NF		33	31	Refined equipment time to conform to established policies for technical equipment.
		L047A	MRI Technologist	NF	Other Clinical Activity: Retrieve prior appropriate imaging exams and hang for MD review, verify orders, review the chart to incorporate relevant clinical information and confirm contrast protocol with interpreting MD.	8	3	CMS clinical review.
		L047A	MRI Technologist	NF	Assist physician in performing procedure.	30	20	CMS clinical review.
		L047A	MRI Technologist	NF	Other Clinical Activity: Escort patient from exam room due to magnetic sensitivity.	2	0	CMS clinical review.
70552	Mri brain stem w/dye	EL008	room, MRI	NF		47	45	Refined equipment time to conform to established policies for technical equipment.
		L047A	MRI Technologist	NF	Other Clinical Activity: Retrieve prior appropriate imaging exams and hang for MD review, verify orders, review the chart to incorporate relevant clinical information and confirm contrast protocol with interpreting MD.	8	5	CMS clinical review.
		L047A	MRI Technologist	NF	Obtain vital signs	0	3	CMS clinical review.
		L047A	MRI Technologist	NF	Provide preservice education/obtain consent.	9	7	CMS clinical review.
		L047A	MRI Technologist	NF	Other Clinical Activity: Escort patient from exam room due to magnetic sensitivity.	2	0	CMS clinical review.
		SG053	gauze, sterile 2in x 2in	NF		1	0	CMS clinical review.
		SG089	tape, phix strips (for nasal catheter).	NF		6	0	CMS clinical review.
		SJ043	povidone swabsticks (3 pack uou).	NF		1	0	CMS clinical review.
		SJ053	swab-pad, alcohol	NF		1	0	CMS clinical review.
70553	Mri brain stem w/o & w/dye.	EL008	room, MRI	NF		57	53	Refined equipment time to conform to established policies for technical equipment.

TABLE 29—CY 2014 INTERIM FINAL CODES WITH DIRECT PE INPUT RECOMMENDATIONS ACCEPTED WITH REFINEMENTS—Continued

HCPCS code	HCPCS code description	Input code	Input code description	Non-fac/ fac	Labor activity (if applicable)	RUC recommendation or current value (min or qty)	CMS Refinement (min or qty)	Comment
		L047A	MRI Technologist	NF	Other Clinical Activity: Retrieve prior appropriate imaging exams and hang for MD review, verify orders, review the chart to incorporate relevant clinical information and confirm contrast protocol with interpreting MD.	8	5	CMS clinical review.
		L047A	MRI Technologist	NF	Obtain vital signs	0	3	CMS clinical review.
		L047A	MRI Technologist	NF	Provide preservice education/obtain consent.	9	7	CMS clinical review.
		L047A	MRI Technologist	NF	Assist physician in performing procedure.	40	38	CMS clinical review.
		L047A	MRI Technologist	NF	Other Clinical Activity: Escort patient from exam room due to magnetic sensitivity.	2	0	CMS clinical review.
		SG053	gauze, sterile 2in x 2in	NF	.....	1	0	CMS clinical review.
		SG089	tape, phix strips (for nasal catheter).	NF	.....	6	0	CMS clinical review.
		SJ043	povidone swabsticks (3 pack uou).	NF	.....	1	0	CMS clinical review.
		SJ053	swab-pad, alcohol	NF	.....	1	0	CMS clinical review.
72141	Mri neck spine w/o dye	L047A	MRI Technologist	NF	Other Clinical Activity: Escort patient from exam room due to magnetic sensitivity.	2	0	CMS clinical review.
72142	Mri neck spine w/dye ..	L047A	MRI Technologist	NF	Other Clinical Activity: Escort patient from exam room due to magnetic sensitivity.	2	0	CMS clinical review.
72146	Mri chest spine w/o dye.	L047A	MRI Technologist	NF	Other Clinical Activity: Escort patient from exam room due to magnetic sensitivity.	2	0	CMS clinical review.
72147	Mri chest spine w/dye	L047A	MRI Technologist	NF	Other Clinical Activity: Escort patient from exam room due to magnetic sensitivity.	2	0	CMS clinical review.
72148	Mri lumbar spine w/o dye.	L047A	MRI Technologist	NF	Other Clinical Activity: Escort patient from exam room due to magnetic sensitivity.	2	0	CMS clinical review.
72149	Mri lumbar spine w/dye	L047A	MRI Technologist	NF	Other Clinical Activity: Escort patient from exam room due to magnetic sensitivity.	2	0	CMS clinical review.
72156	Mri neck spine w/o & w/dye.	L047A	MRI Technologist	NF	Other Clinical Activity: Escort patient from exam room due to magnetic sensitivity.	2	0	CMS clinical review.
72157	Mri chest spine w/o & w/dye.	L047A	MRI Technologist	NF	Other Clinical Activity: Escort patient from exam room due to magnetic sensitivity.	2	0	CMS clinical review.
72158	Mri lumbar spine w/o & w/dye.	L047A	MRI Technologist	NF	Other Clinical Activity: Escort patient from exam room due to magnetic sensitivity.	2	0	CMS clinical review.
74174	Ct angio abd & pelv w/ o & w/dye.	L046A	CT Technologist	NF	Other Clinical Activity: Process films, hang films and review study with interpreting MD prior to patient discharge.	25	20	CMS clinical review.
75726	Artery x-rays abdomen	L041A	Angio Technician	NF	Assist physician in performing procedure.	73	45	CMS clinical review.
77280	Set radiation therapy field.	E	Virtual Simulation Package.	NF	.....	27	0	CMS clinical review.

TABLE 29—CY 2014 INTERIM FINAL CODES WITH DIRECT PE INPUT RECOMMENDATIONS ACCEPTED WITH REFINEMENTS—Continued

HCPCS code	HCPCS code description	Input code	Input code description	Non-fac/ fac	Labor activity (if applicable)	RUC recommendation or current value (min or qty)	CMS Refinement (min or qty)	Comment
		ER057	radiation virtual simulation system.	NF		0	27	CMS clinical review; inadequate information to price new items; existing item used as a proxy.
77285	Set radiation therapy field.	E	Virtual Simulation Package.	NF		43	0	CMS clinical review.
		ER057	radiation virtual simulation system.	NF		0	43	CMS clinical review; inadequate information to price new items; existing item used as a proxy.
77290	Set radiation therapy field.	E	Virtual Simulation Package.	NF		50	0	CMS clinical review.
		ER057	radiation virtual simulation system.	NF		0	50	CMS clinical review; inadequate information to price new items; existing item used as a proxy.
77293	Respirator motion mgmt simul.	E	Virtual Simulation Package.	NF		40	0	CMS clinical review.
		E	4D Simulation Package	NF		40	0	CMS clinical review.
		ER057	radiation virtual simulation system.	NF		0	40	CMS clinical review; inadequate information to price new items; existing item used as a proxy.
77373	Sbrt delivery	EQ211	pulse oximeter w-printer.	NF		104	86	Refined equipment time to conform to established policies for technical equipment.
		ER056	radiation treatment vault.	NF		0	86	See discussion in section II.D.3.b. of this final rule.
		ER083	SRS system, SBRT, six systems, average.	NF		104	86	Refined equipment time to conform to established policies for technical equipment.
77600	Hyperthermia treatment.	EF015	mayo stand	NF		123	105	Refined equipment time to conform to established policies for technical equipment.
		ER035	hyperthermia system, ultrasound, external.	NF		123	105	Refined equipment time to conform to established policies for technical equipment.
		L037D	RN/LPN/MTA	NF	Clean Scope	10	0	CMS clinical review; catheters included are disposable supplies and time is already included for cleaning equipment.
77785	Hdr brachytx 1 channel	E	Emergency service container-safety kit.	NF		46	0	Indirect practice expense.
		EF021	table, brachytherapy treatment.	NF		46	42	Refined equipment time to conform to established policies for technical equipment.
		EQ292	Applicator Base Plate	NF		46	42	Refined equipment time to conform to established policies for technical equipment.
		ER003	HDR Afterload System, Nucletron—Oldelft.	NF		46	42	Refined equipment time to conform to established policies for technical equipment.

TABLE 29—CY 2014 INTERIM FINAL CODES WITH DIRECT PE INPUT RECOMMENDATIONS ACCEPTED WITH REFINEMENTS—Continued

HCPCS code	HCPCS code description	Input code	Input code description	Non-fac/ fac	Labor activity (if applicable)	RUC recommendation or current value (min or qty)	CMS Refinement (min or qty)	Comment
		ER028	electrometer, PC-based, dual channel.	NF		46	42	Refined equipment time to conform to established policies for technical equipment.
		ER054	radiation survey meter	NF		46	42	Refined equipment time to conform to established policies for technical equipment.
		ER060	source, 10 Ci Ir 192	NF		46	42	Refined equipment time to conform to established policies for technical equipment.
		ER062	stirrups (for brachytherapy table).	NF		46	42	Refined equipment time to conform to established policies for technical equipment.
		ER073	Area Radiation Monitor	NF		46	42	Refined equipment time to conform to established policies for technical equipment.
77786	Hdr brachytx 2–12 channel.	E	Emergency service container-safety kit.	NF		100	0	Indirect practice expense.
		EF021	table, brachytherapy treatment.	NF		100	86	Refined equipment time to conform to established policies for technical equipment.
		EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp).	NF		100	86	Refined equipment time to conform to established policies for technical equipment.
		EQ292	Applicator Base Plate	NF		100	86	Refined equipment time to conform to established policies for technical equipment.
		ER003	HDR Afterload System, Nucletron—Oldelft.	NF		100	86	Refined equipment time to conform to established policies for technical equipment.
		ER028	electrometer, PC-based, dual channel.	NF		100	86	Refined equipment time to conform to established policies for technical equipment.
		ER054	radiation survey meter	NF		100	86	Refined equipment time to conform to established policies for technical equipment.
		ER060	source, 10 Ci Ir 192	NF		100	86	Refined equipment time to conform to established policies for technical equipment.
		ER073	Area Radiation Monitor	NF		100	86	Refined equipment time to conform to established policies for technical equipment.
77787	Hdr brachytx over 12 chan.	E	Emergency service container-safety kit.	NF		162	0	Indirect practice expense.
		EF021	table, brachytherapy treatment.	NF		162	137	Refined equipment time to conform to established policies for technical equipment.

TABLE 29—CY 2014 INTERIM FINAL CODES WITH DIRECT PE INPUT RECOMMENDATIONS ACCEPTED WITH REFINEMENTS—Continued

HCPCS code	HCPCS code description	Input code	Input code description	Non-fac/ fac	Labor activity (if applicable)	RUC recommendation or current value (min or qty)	CMS Refinement (min or qty)	Comment
		EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp).	NF		162	137	Refined equipment time to conform to established policies for technical equipment.
		EQ292	Applicator Base Plate	NF		162	137	Refined equipment time to conform to established policies for technical equipment.
		ER003	HDR Afterload System, Nucletron—Oldelft.	NF		162	137	Refined equipment time to conform to established policies for technical equipment.
		ER028	electrometer, PC-based, dual channel.	NF		162	137	Refined equipment time to conform to established policies for technical equipment.
		ER054	radiation survey meter	NF		162	137	Refined equipment time to conform to established policies for technical equipment.
		ER060	source, 10 Ci Ir 192	NF		162	137	Refined equipment time to conform to established policies for technical equipment.
		ER062	stirrups (for brachytherapy table).	NF		162	137	Refined equipment time to conform to established policies for technical equipment.
		ER073	Area Radiation Monitor	NF		162	137	Refined equipment time to conform to established policies for technical equipment.
88112	Cytopath cell enhance tech.	E	Laboratory Information System with maintenance contract.	NF		2	0	Included in equipment cost per minute calculation.
		E	Copath System Software.	NF		2	0	Indirect practice expense.
		L035A	Lab Tech/ Histotechnologist.	NF	Order, restock, and distribute specimen containers with requisition forms..	0.5	0	CMS clinical review.
		L045A	Cytotechnologist	NF	Perform screening function (where applicable).	8	0	CMS clinical review.
		L045A	Cytotechnologist	NF	A. Confirm patient ID, organize work, verify and review history.	2	0	CMS clinical review.
		L045A	Cytotechnologist	NF	B: Enter screening diagnosis in laboratory information system, complete workload recording logs, manage any relevant utilization review/quality assurance activities and regulatory compliance documentation and assemble and deliver slides with paperwork to pathologist.	2	0	CMS clinical review.
		S	Courier transportation costs.	NF		2.02	0	Indirect practice expense.
		S	Specimen, solvent, and formalin disposal cost.	NF		0.18	0	Indirect practice expense.

TABLE 29—CY 2014 INTERIM FINAL CODES WITH DIRECT PE INPUT RECOMMENDATIONS ACCEPTED WITH REFINEMENTS—Continued

HCPCS code	HCPCS code description	Input code	Input code description	Non-fac/ fac	Labor activity (if applicable)	RUC recommendation or current value (min or qty)	CMS Refinement (min or qty)	Comment
93880	Extracranial bilat study	ED021	computer, desktop, w-monitor.	NF		68	51	Refined equipment time to conform to established policies for technical equipment.
		ED034	video SVHS VCR (medical grade).	NF		68	0	CMS clinical review; functionality of items redundant with other direct PE inputs.
		ED036	video printer, color (Sony medical grade).	NF		10	0	CMS clinical review; functionality of items redundant with other direct PE inputs.
		EL016	room, ultrasound, vascular.	NF		68	51	Refined equipment time to conform to established policies for technical equipment.
93882	Extracranial uni/ltd study.	ED021	computer, desktop, w-monitor.	NF		44	29	Refined equipment time to conform to established policies for technical equipment.
		ED034	video SVHS VCR (medical grade).	NF		44	0	CMS clinical review; functionality of items redundant with other direct PE inputs.
		ED036	video printer, color (Sony medical grade).	NF		10	0	CMS clinical review; functionality of items redundant with other direct PE inputs.
		EL016	room, ultrasound, vascular.	NF		44	29	Refined equipment time to conform to established policies for technical equipment.
94667	Chest wall manipulation.	EF023	table, exam	NF		1	35	Refined equipment time to conform to changes in clinical labor time.
94668	Chest wall manipulation.	EF023	table, exam	NF		1	33	Refined equipment time to conform to changes in clinical labor time.
94669	Mechanical chest wall oscill.	EF023	table, exam	NF		1	45	Refined equipment time to conform to changes in clinical labor time.
95816	Eeg awake and drowsy	EQ330	EEG, digital, testing system (computer hardware, software & camera).	NF		116	107	Refined equipment time to conform to established policies for technical equipment.
95819	Eeg awake and asleep	EQ330	EEG, digital, testing system (computer hardware, software & camera).	NF		148	139	Refined equipment time to conform to established policies for technical equipment.
95822	Eeg coma or sleep only.	EQ330	EEG, digital, testing system (computer hardware, software & camera).	NF		123	114	Refined equipment time to conform to established policies for technical equipment.
99170	Anogenital exam child w imag.	ED005	camera, digital system, 12 megapixel (medical grade).	NF		50	60	Refined equipment time to conform to established policies for technical equipment.
		ED021	computer, desktop, w-monitor.	NF		50	0	Indirect practice expense.
		EF015	mayo stand	NF		50	60	Refined equipment time to conform to established policies for technical equipment.

TABLE 29—CY 2014 INTERIM FINAL CODES WITH DIRECT PE INPUT RECOMMENDATIONS ACCEPTED WITH REFINEMENTS—Continued

HCPCS code	HCPCS code description	Input code	Input code description	Non-fac/ fac	Labor activity (if applicable)	RUC recommendation or current value (min or qty)	CMS Refinement (min or qty)	Comment
		EF031	table, power	NF		50	60	Refined equipment time to conform to established policies for technical equipment.
		EQ170	light fiberoptic headlight w-source.	NF		50	60	Refined equipment time to conform to established policies for technical equipment.
		ES004	colposcope	NF		50	67	Refined equipment time to conform to established policies for technical equipment.
		L051A	RN	NF	Coordinate pre-surgery services.	0	3	CMS clinical review.
		L051A	RN	NF	Other Clinical Activity (Preservice).	5	0	CMS clinical review.
		L051A	RN	NF	Other Clinical Activity (Post Service).	15	3	CMS clinical review.
		SA048	pack, minimum multi-specialty visit.	F		1	0	Service period supplies are not included in the facility setting.
		SB006	drape, non-sterile, sheet 40in x 60in.	F		1	0	Service period supplies are not included in the facility setting.
		SB022	gloves, non-sterile	F		1	0	Service period supplies are not included in the facility setting.
		SD118	specula, vaginal	F		1	0	Service period supplies are not included in the facility setting.
		SG008	applicator, cotton-tipped, non-sterile 6in.	F		2	0	Service period supplies are not included in the facility setting.
		SJ033	lubricating jelly (Surgilube).	F		1	0	Service period supplies are not included in the facility setting.
		SL146	tubed culture media	F		2	0	Service period supplies are not included in the facility setting.
		SL157	cup, sterile, 8 oz	F		1	0	Service period supplies are not included in the facility setting.
G0461	Immunohistochemistry, initial antibody.	E	Specimen, solvent, and formalin disposal cost.	NF		0.35	0	Indirect practice expense.
		E	Laboratory Information System with maintenance contract.	NF		2	0	Included in equipment cost per minute calculation.
		E	Copath System Software.	NF		2	0	Indirect practice expense.
		EP043	water bath, general purpose (lab).	NF		8	5	CMS clinical review.
		ER041	microtome	NF		8	5	CMS clinical review.
G0462	Immunohistochemistry, subsequent antibody.	EP112	Benchmark ULTRA automated slide preparation system.	NF		33	15	CMS clinical review.
		SL489	UtraView Universal Alkaline Phosphatase Red Detection Kit.	NF		0.2	2	CMS clinical review.

c. Establishing CY 2014 Interim Final Malpractice RVUs

According to our malpractice methodology discussed in section II.C. we are assigning malpractice RVUs for CY 2014 new, revised and potentially misvalued codes by utilizing a crosswalk to a source code with a similar malpractice risk. We have reviewed the AMA RUC recommended malpractice source code crosswalks for CY 2014 new, revised and potentially misvalued codes, and we are accepting all of them on an interim final basis for CY 2014.

For CY 2014, we created two HCPCS G-codes. HCPCS code G0461 (Immunohistochemistry or immunocytochemistry, per specimen; first stain with separately identifiable antibody(ies)) was created to replace CPT code 88342 (immunohistochemistry or immunocytochemistry, each separately identifiable antibody per block, cytologic preparation, or hematologic

smear; first separately identifiable antibody per slide), which is Invalid effective January 1, 2014. We believe CPT code 88342 has a similar malpractice risk-of-service as HCPCS code G0461. Therefore, we are assigning an interim final malpractice crosswalk of CPT code 88342 to HCPCS code G0461 on an interim final basis for CY 2014. HCPCS code G0462 (Immunohistochemistry or immunocytochemistry, per specimen; each additional stain with separately identifiable antibody(ies) (List separately in addition to code for primary procedure) was created to replace CPT code 88343 (immunohistochemistry or immunocytochemistry, each separately identifiable antibody per block, cytologic preparation, or hematologic smear; each additional separately identifiable antibody per slide (list separately in addition to code for primary procedure), which is invalid effective Janauary 1, 2014. We believe CPT code 88343 has a similar malpractice risk-of-service as HCPCS code G0462. Therefore, we are assigning an interim final malpractice crosswalk of CPT code 88343 to HCPCS code G0462 on an interim final basis for CY 2014.

Table 30 lists the adjusted CY 2013 and new/revised CY 2014 HCPCS codes and their respective source codes used to set the interim final CY 2014 malpractice RVUs. The malpractice RVUs for these services are reflected in Addendum B of this CY 2014 PFS final rule with comment period.

Consistent with past practice when the MEI has been rebased or revised we proposed to make adjustments to ensure that estimates of the aggregate CY 2014 PFS payments for work, PE and malpractice are in proportion to the weights for these categories in the revised MEI. As discussed in the II.B. and II.D., the MEI is being revised, the PE and malpractice RVUs, and the CF are being adjusted accordingly. For more information on this, see those sections. We received no comments specifically on the adjustment to malpractice RVUs.

TABLE 30—CROSSWALK FOR ESTABLISHING CY 2014 NEW/REVISED/POTENTIALLY MISVALUED CODES MALPRACTICE RVUS

CY 2014 new, revised, or potentially misvalued HCPCS code		Malpractice risk factor crosswalk HCPCS code	
10030	Guide cathet fluid drainage	37200	transcatheter biopsy.
13152	Cmplx rpr e/n/e/l 2.6–7.5 cm	13152	cmplx rpr e/n/e/l 2.6–7.5 cm.
17000	Destruct premalg lesion	17000	destruct premalg lesion.
17003	Destruct premalg les 2–14	17003	destruct premalg les 2–14.
17004	Destroy premal lesions 15/>	17004	destroy premal lesions 15/>.
17311	Mohs 1 stage h/n/hf/g	17311	mohs 1 stage h/n/hf/g.
17312	Mohs addl stage	17312	mohs addl stage.
17313	Mohs 1 stage t/a/l	17313	mohs 1 stage t/a/l.
17314	Mohs addl stage t/a/l	17314	mohs addl stage t/a/l.
17315	Mohs surg addl block	17315	mohs surg addl block.
19081	Bx breast 1st Lesion strtctc	32553	ins mark thor for rt perq.
19082	Bx breast add Lesion strtctc	64480	inj foramen epidural add-on.
19083	Bx breast 1st Lesion US imag	32551	insertion of chest tube.
19084	Bx breast add Lesion US imag	64480	inj foramen epidural add-on.
19085	Bx breast 1st lesion mr imag	36565	insert tunneled cv cath.
19086	Bx breast add lesion mr imag	76812	ob us detailed addl fetus.
19281	Perq device breast 1st imag	50387	change ext/int ureter stent.
19282	Perq device breast ea imag	76812	ob us detailed addl fetus.
19283	Perq dev breast 1st strtctc	50387	change ext/int ureter stent.
19284	Perq dev breast add strtctc	76812	ob us detailed addl fetus.
19285	Perq dev breast 1st us imag	36569	insert picc cath.
19286	Perq dev breast add us imag	76812	ob us detailed addl fetus.
19287	Perq dev breast 1st mr guide	32551	insertion of chest tube.
19288	Perq dev breast add mr guide	76812	ob us detailed addl fetus.
23333	Remove shoulder fb deep	23472	reconstruct shoulder joint.
23334	Shoulder prosthesis removal	23472	reconstruct shoulder joint.
23335	Shoulder prosthesis removal	23472	reconstruct shoulder joint.
24160	Remove elbow joint implant	24363	replace elbow joint.
24164	Remove radius head implant	23430	repair biceps tendon.
27130	Total hip arthroplasty	27130	total hip arthroplasty.
27236	Treat thigh fracture	27236	treat thigh fracture.
27446	Revision of knee joint	27446	revision of knee joint.
27447	Total knee arthroplasty	27447	total knee arthroplasty.
31237	Nasal/sinus endoscopy surg	31237	nasal/sinus endoscopy surg.
31238	Nasal/sinus endoscopy surg	31238	nasal/sinus endoscopy surg.
31239	Nasal/sinus endoscopy surg	31239	nasal/sinus endoscopy surg.
31240	Nasal/sinus endoscopy surg	31240	nasal/sinus endoscopy surg.
33282	Implant pat-active ht record	33282	implant pat-active ht record.
33284	Remove pat-active ht record	33284	remove pat-active ht record.
33366	Trcath replace aortic valve	33979	insert intracorporeal device.
35301	Rechanneling of artery	35301	rechanneling of artery.
35475	Repair arterial blockage	35475	repair arterial blockage.
35476	Repair venous blockage	35476	repair venous blockage.
36245	Ins cath abd/l-ext art 1st	36245	ins cath abd/l-ext art 1st.
37217	Stent placemt retro carotid	37660	revision of major vein.
37236	Open/perq place stent 1st	36247	ins cath abd/l-ext art 3rd.
37237	Open/perq place stent ea add	37223	iliac revasc w/stent add-on.
37238	Open/perq place stent same	36247	ins cath abd/l-ext art 3rd.
37239	Open/perq place stent ea add	37223	iliac revasc w/stent add-on.

TABLE 30—CROSSWALK FOR ESTABLISHING CY 2014 NEW/REVISED/POTENTIALLY MISVALUED CODES MALPRACTICE RVUS—Continued

37241	Vasc embolize/occlude venous	37204	transcatheter occlusion.
37242	Vasc embolize/occlude artery	37204	transcatheter occlusion.
37243	Vasc embolize/occlude organ	37204	transcatheter occlusion.
37244	Vasc embolize/occlude bleed	37204	transcatheter occlusion.
38240	Transplt allo hct/donor	38240	transplt allo hct/donor.
43191	Esophagoscopy rigid trnso dx	31575	diagnostic laryngoscopy.
43192	Esophagoscp rig trnso inject	31575	diagnostic laryngoscopy.
43193	Esophagoscp rig trnso biopsy	31575	diagnostic laryngoscopy.
43194	Esophagoscp rig trnso rem fb	31575	diagnostic laryngoscopy.
43195	Esophagoscopy rigid balloon	31575	diagnostic laryngoscopy.
43196	Esophagoscp guide wire dilat	31638	bronchoscopy revise stent.
43197	Esophagoscopy flex dx brush	31575	diagnostic laryngoscopy.
43198	Esophagosc flex trnsn biopsy	31575	diagnostic laryngoscopy.
43200	Esophagoscopy flexible brush	43200	esophagoscopy flexible brush.
43201	Esoph scope w/submucous inj	43201	esoph scope w/submucous inj.
43202	Esophagoscopy flex biopsy	43202	esophagoscopy flex biopsy.
43204	Esoph scope w/sclerosis inj	43204	esoph scope w/sclerosis inj.
43205	Esophagus endoscopy/ligation	43205	esophagus endoscopy/ligation.
43206	Esoph optical endomicroscopy	43200	esophagoscopy flexible brush.
43211	Esophagoscop mucosal resect	43201	esoph scope w/submucous inj.
43212	Esophagoscop stent placement	43219	esophagus endoscopy.
43213	Esophagoscopy retro balloon	43456	dilate esophagus.
43214	Esophagosc dilate balloon 30	43458	dilate esophagus.
43215	Esophagoscopy flex remove fb	43215	esophagoscopy flex remove fb.
43216	Esophagoscopy lesion removal	43216	esophagoscopy lesion removal.
43217	Esophagoscopy snare les remv	43217	esophagoscopy snare les remv.
43220	Esophagoscopy balloon <30mm	43220	esophagoscopy balloon <30mm.
43226	Esoph endoscopy dilation	43226	esoph endoscopy dilation.
43227	Esophagoscopy control bleed	43227	esophagoscopy control bleed.
43229	Esophagoscopy lesion ablate	43228	esoph endoscopy ablation.
43231	Esophagoscop ultrasound exam	43231	esophagoscop ultrasound exam.
43232	Esophagoscopy w/us needle bx	43232	esophagoscopy w/us needle bx.
43233	Egd balloon dil esoph30 mm/>	43271	endo cholangiopancreatograph.
43235	Egd diagnostic brush wash	43235	egd diagnostic brush wash.
43236	Uppr gi scope w/submuc inj	43236	uppr gi scope w/submuc inj.
43237	Endoscopic us exam esoph	43237	endoscopic us exam esoph.
43238	Egd us fine needle bx/aspir	43238	egd us fine needle bx/aspir.
43239	Egd biopsy single/multiple	43239	egd biopsy single/multiple.
43240	Egd w/transmural drain cyst	43240	egd w/transmural drain cyst.
43241	Egd tube/cath insertion	43241	egd tube/cath insertion.
43242	Egd us fine needle bx/aspir	43242	egd us fine needle bx/aspir.
43243	Egd injection varices	43243	egd injection varices.
43244	Egd varices ligation	43244	egd varices ligation.
43245	Egd dilate stricture	43245	egd dilate stricture.
43246	Egd place gastrostomy tube	43246	egd place gastrostomy tube.
43247	Egd remove foreign body	43247	egd remove foreign body.
43248	Egd guide wire insertion	43248	egd guide wire insertion.
43249	Esoph egd dilation <30 mm	43249	esoph egd dilation <30 mm.
43250	Egd cautery tumor polyp	43250	egd cautery tumor polyp.
43251	Egd remove lesion snare	43251	egd remove lesion snare.
43252	Egd optical endomicroscopy	43200	esophagoscopy flexible brush.
43253	Egd us transmural injxn/mark	43242	egd us fine needle bx/aspir.
43254	Egd endo mucosal resection	43251	egd remove lesion snare.
43255	Egd control bleeding any	43255	egd control bleeding any.
43257	Egd w/thrml txmnt gerd	43257	egd w/thrml txmnt gerd.
43259	Egd us exam duodenum/jejunum	43259	egd us exam duodenum/jejunum.
43260	Ercp w/specimen collection	43260	ercp w/specimen collection.
43261	Endo cholangiopancreatograph	43261	endo cholangiopancreatograph.
43262	Endo cholangiopancreatograph	43262	endo cholangiopancreatograph.
43263	Ercp sphincter pressure meas	43263	ercp sphincter pressure meas.
43264	Ercp remove duct calculi	43264	ercp remove duct calculi.
43265	Ercp lithotripsy calculi	43265	ercp lithotripsy calculi.
43266	Egd endoscopic stent place	43256	uppr gi endoscopy w/stent.
43270	Egd lesion ablation	43258	operative upper gi endoscopy.
43273	Endoscopic pancreatoscopy	43273	endoscopic pancreatoscopy.
43274	Ercp duct stent placement	43268	endo cholangiopancreatograph.
43275	Ercp remove forgn body duct	43269	endo cholangiopancreatograph.
43276	Ercp stent exchange w/dilate	43269	endo cholangiopancreatograph.
43277	Ercp ea duct/ampulla dilate	43271	endo cholangiopancreatograph.
43278	Ercp lesion ablate w/dilate	43272	endo cholangiopancreatograph.
43450	Dilate esophagus 1/mult pass	43450	dilate esophagus 1/mult pass.
43453	Dilate esophagus	43453	dilate esophagus.
49405	Image cath fluid colxn visc	37200	transcatheter biopsy.

TABLE 30—CROSSWALK FOR ESTABLISHING CY 2014 NEW/REVISED/POTENTIALLY MISVALUED CODES MALPRACTICE RVUs—Continued

49406	Image cath fluid peri/retro	37200	transcatheter biopsy.
49407	Image cath fluid trns/vgnl	37200	transcatheter biopsy.
50360	Transplantation of kidney	50360	transplantation of kidney.
52332	Cystoscopy and treatment	52332	cystoscopy and treatment.
52353	Cystouretero w/lithotripsy	52353	cystouretero w/lithotripsy.
52356	Cysto/uretero w/lithotripsy	52353	cystouretero w/lithotripsy.
62310	Inject spine cerv/thoracic	62310	inject spine cerv/thoracic.
62311	Inject spine lumbar/sacral	62311	inject spine lumbar/sacral.
62318	Inject spine w/cath crv/thrc	62318	inject spine w/cath crv/thrc.
62319	Inject spine w/cath lmb/scrl	62319	inject spine w/cath lmb/scrl.
63047	Remove spine lamina 1 lmbr	63047	remove spine lamina 1 lmbr.
63048	Remove spinal lamina add-on	63048	remove spinal lamina add-on.
63650	Implant neuroelectrodes	63650	implant neuroelectrodes.
64613	Destroy nerve neck muscle	64613	destroy nerve neck muscle.
64614	Destroy nerve extrem musc	64614	destroy nerve extrem musc.
64616	Chemodenerv musc neck dyston	64613	destroy nerve neck muscle.
64617	Chemodener muscle larynx emg	31513	injection into vocal cord.
64642	Chemodenerv 1 extremity 1–4	64614	destroy nerve extrem musc.
64643	Chemodenerv 1 extrem 1–4 ea	64614	destroy nerve extrem musc.
64644	Chemodenerv 1 extrem 5/> mus	64614	destroy nerve extrem musc.
64645	Chemodenerv 1 extrem 5/> ea	64614	destroy nerve extrem musc.
64646	Chemodenerv trunk musc 1–5	64614	destroy nerve extrem musc.
64647	Chemodenerv trunk musc 6/>	64614	destroy nerve extrem musc.
66180	Implant eye shunt	66180	implant eye shunt.
66183	Insert ant drainage device	65850	incision of eye.
66185	Revise eye shunt	66185	revise eye shunt.
67255	Reinforce/graft eye wall	67255	reinforce/graft eye wall.
67914	Repair eyelid defect	67914	repair eyelid defect.
67915	Repair eyelid defect	67915	repair eyelid defect.
67916	Repair eyelid defect	67916	repair eyelid defect.
67917	Repair eyelid defect	67917	repair eyelid defect.
67921	Repair eyelid defect	67921	repair eyelid defect.
67922	Repair eyelid defect	67922	repair eyelid defect.
67923	Repair eyelid defect	67923	repair eyelid defect.
67924	Repair eyelid defect	67924	repair eyelid defect.
69210	Remove impacted ear wax uni	69210	remove impacted ear wax uni.
70450	Ct head/brain w/o dye	70450	ct head/brain w/o dye.
70460	Ct head/brain w/dye	70460	ct head/brain w/dye.
70551	Mri brain stem w/o dye	70551	mri brain stem w/o dye.
70552	Mri brain stem w/dye	70552	mri brain stem w/dye.
70553	Mri brain stem w/o & w/dye	70553	mri brain stem w/o & w/dye.
72141	Mri neck spine w/o dye	72141	mri neck spine w/o dye.
72142	Mri neck spine w/dye	72142	mri neck spine w/dye.
72146	Mri chest spine w/o dye	72146	mri chest spine w/o dye.
72147	Mri chest spine w/dye	72147	mri chest spine w/dye.
72148	Mri lumbar spine w/o dye	72148	mri lumbar spine w/o dye.
72149	Mri lumbar spine w/dye	72149	mri lumbar spine w/dye.
72156	Mri neck spine w/o & w/dye	72156	mri neck spine w/o & w/dye.
72157	Mri chest spine w/o & w/dye	72157	mri chest spine w/o & w/dye.
72158	Mri lumbar spine w/o & w/dye	72158	mri lumbar spine w/o & w/dye.
72191	Ct angiograph pelv w/o&w/dye	72191	ct angiograph pelv w/o&w/dye.
74174	Ct angio abd&pelv w/o&w/dye	74174	ct angio abd&pelv w/o&w/dye.
74175	Ct angio abdom w/o & w/dye	74175	ct angio abdom w/o & w/dye.
77001	Fluoroguide for vein device	77001	fluoroguide for vein device.
77002	Needle localization by xray	77002	needle localization by xray.
77003	Fluoroguide for spine inject	77003	fluoroguide for spine inject.
77280	Set radiation therapy field	77280	set radiation therapy field.
77285	Set radiation therapy field	77285	set radiation therapy field.
77290	Set radiation therapy field	77290	set radiation therapy field.
77293	Respirator motion mgmt simul	77470	special radiation treatment.
77295	3-d radiotherapy plan	77295	3-d radiotherapy plan.
77301	Radiotherapy dose plan imrt	77301	radiotherapy dose plan imrt.
77336	Radiation physics consult	77336	radiation physics consult.
77338	Design mlc device for imrt	77338	design mlc device for imrt.
77372	Srs linear based	77372	srs linear based.
77373	Sbrt delivery	77373	sbrt delivery.
77402	Radiation treatment delivery	77402	radiation treatment delivery.
77403	Radiation treatment delivery	77403	radiation treatment delivery.
77404	Radiation treatment delivery	77404	radiation treatment delivery.
77406	Radiation treatment delivery	77406	radiation treatment delivery.
77407	Radiation treatment delivery	77407	radiation treatment delivery.
77408	Radiation treatment delivery	77408	radiation treatment delivery.
77409	Radiation treatment delivery	77409	radiation treatment delivery.

TABLE 30—CROSSWALK FOR ESTABLISHING CY 2014 NEW/REVISED/POTENTIALLY MISVALUED CODES MALPRACTICE RVUs—Continued

77411	Radiation treatment delivery	77411	radiation treatment delivery.
77412	Radiation treatment delivery	77412	radiation treatment delivery.
77413	Radiation treatment delivery	77413	radiation treatment delivery.
77414	Radiation treatment delivery	77414	radiation treatment delivery.
77416	Radiation treatment delivery	77416	radiation treatment delivery.
77417	Radiology port film(s)	77417	radiology port film(s).
77600	Hyperthermia treatment	77600	hyperthermia treatment.
77785	Hdr brachytx 1 channel	77785	hdr brachytx 1 channel.
77786	Hdr brachytx 2–12 channel	77786	hdr brachytx 2–12 channel.
77787	Hdr brachytx over 12 chan	77787	hdr brachytx over 12 chan.
78072	Parathyrd planar w/spect&ct	78452	ht muscle image spect mult.
88112	Cytopath cell enhance tech	88112	cytopath cell enhance tech.
88365	Insitu hybridization (fish)	88365	insitu hybridization (fish).
88367	Insitu hybridization auto	88367	insitu hybridization auto.
88368	Insitu hybridization manual	88368	insitu hybridization manual.
90785	Psytx complex interactive	90836	psytx pt&/fam w/e&m 45 min.
90791	Psych diagnostic evaluation	90846	family psytx w/o patient.
90792	Psych diag eval w/med srvcs	90846	family psytx w/o patient.
90832	Psytx pt&/family 30 minutes	90846	family psytx w/o patient.
90833	Psytx pt&/fam w/e&m 30 min	90846	family psytx w/o patient.
90834	Psytx pt&/family 45 minutes	90846	family psytx w/o patient.
90836	Psytx pt&/fam w/e&m 45 min	90846	family psytx w/o patient.
90837	Psytx pt&/family 60 minutes	90846	family psytx w/o patient.
90838	Psytx pt&/fam w/e&m 60 min	90846	family psytx w/o patient.
90839	Psytx crisis initial 60 min	90837	psytx pt&/family 60 minutes.
90840	Psytx crisis ea addl 30 min	90833	psytx pt&/fam w/e&m 30 min.
90845	Psychoanalysis	90845	psychoanalysis.
90846	Family psytx w/o patient	90846	family psytx w/o patient.
90847	Family psytx w/patient	90847	family psytx w/patient.
90853	Group psychotherapy	90853	group psychotherapy.
91065	Breath hydrogen/methane test	91065	breath hydrogen/methane test.
92521	Evaluation of speech fluency	96105	assessment of aphasia.
92522	Evaluate speech production	96105	assessment of aphasia.
92523	Speech sound lang comprehen	96105	assessment of aphasia.
92524	Behavral qualit analys voice	92520	laryngeal function studies.
93000	Electrocardiogram complete	93000	electrocardiogram complete.
93005	Electrocardiogram tracing	93005	electrocardiogram tracing.
93010	Electrocardiogram report	93010	electrocardiogram report.
93582	Perq transcath closure pda	93580	transcath closure of asd.
93583	Perq transcath septal reduxn	93580	transcath closure of asd.
93880	Extracranial bilat study	93880	extracranial bilat study.
93882	Extracranial uni/ltd study	93882	extracranial uni/ltd study.
94667	Chest wall manipulation	94667	chest wall manipulation.
94668	Chest wall manipulation	94668	chest wall manipulation.
94669	Mechanical chest wall oscill	94668	chest wall manipulation.
95816	Eeg awake and drowsy	95816	eeg awake and drowsy.
95819	Eeg awake and asleep	95819	eeg awake and asleep.
95822	Eeg coma or sleep only	95822	eeg coma or sleep only.
95886	Musc test done w/n test comp	95886	musc test done w/n test comp.
95887	Musc tst done w/n tst nonext	95887	musc tst done w/n tst nonext.
95928	C motor evoked uppr limbs	95928	c motor evoked uppr limbs.
95929	C motor evoked lwr limbs	95929	c motor evoked lwr limbs.
96365	Ther/proph/diag iv inf init	96365	ther/proph/diag iv inf init.
96366	Ther/proph/diag iv inf addon	96366	ther/proph/diag iv inf addon.
96367	Tx/proph/dg addl seq iv inf	96367	tx/proph/dg addl seq iv inf.
96368	Ther/diag concurrent inf	96368	ther/diag concurrent inf.
96413	Chemo iv infusion 1 hr	96413	chemo iv infusion 1 hr.
96415	Chemo iv infusion addl hr	96415	chemo iv infusion addl hr.
96417	Chemo iv infus each addl seq	96417	chemo iv infus each addl seq.
98940	Chiropract manj 1–2 regions	98940	chiropract manj 1–2 regions.
98941	Chiropract manj 3–4 regions	98941	chiropract manj 3–4 regions.
98942	Chiropractic manj 5 regions	98942	chiropractic manj 5 regions.
98943	Chiropract manj xtrspinl 1/>	98943	chiropract manj xtrspinl 1/>.
99170	Anogenital exam child w imag	99170	anogenital exam child w imag.
70450 26	Ct head/brain w/o dye	70450 26	ct head/brain w/o dye.
70450 TC	Ct head/brain w/o dye	70450 TC	ct head/brain w/o dye.
70460 26	Ct head/brain w/dye	70460 26	ct head/brain w/dye.
70460 TC	Ct head/brain w/dye	70460 TC	ct head/brain w/dye.
70551 26	Mri brain stem w/o dye	70551 26	mri brain stem w/o dye.
70551 TC	Mri brain stem w/o dye	70551 TC	mri brain stem w/o dye.
70552 26	Mri brain stem w/dye	70552 26	mri brain stem w/dye.
70552 TC	Mri brain stem w/dye	70552 TC	mri brain stem w/dye.
70553 26	Mri brain stem w/o & w/dye	70553 26	mri brain stem w/o & w/dye.

TABLE 30—CROSSWALK FOR ESTABLISHING CY 2014 NEW/REVISED/POTENTIALLY MISVALUED CODES MALPRACTICE RVUS—Continued

70553 TC	Mri brain stem w/o & w/dye	70553 tc	mri brain stem w/o & w/dye.
72141 26	Mri neck spine w/o dye	72141 26	mri neck spine w/o dye.
72141 TC	Mri neck spine w/o dye	72141 TC	mri neck spine w/o dye.
72142 26	Mri neck spine w/dye	72142 26	mri neck spine w/dye.
72142 TC	Mri neck spine w/dye	72142 TC	mri neck spine w/dye.
72146 26	Mri chest spine w/o dye	72146 26	mri chest spine w/o dye.
72146 TC	Mri chest spine w/o dye	72146 TC	mri chest spine w/o dye.
72147 26	Mri chest spine w/dye	72147 26	mri chest spine w/dye.
72147 TC	Mri chest spine w/dye	72147 TC	mri chest spine w/dye.
72148 26	Mri lumbar spine w/o dye	72148 26	mri lumbar spine w/o dye.
72148 TC	Mri lumbar spine w/o dye	72148 TC	mri lumbar spine w/o dye.
72149 26	Mri lumbar spine w/dye	72149 26	mri lumbar spine w/dye.
72149 TC	Mri lumbar spine w/dye	72149 TC	mri lumbar spine w/dye.
72156 26	Mri neck spine w/o & w/dye	72156 26	mri neck spine w/o & w/dye.
72156 TC	Mri neck spine w/o & w/dye	72156 TC	mri neck spine w/o & w/dye.
72157 26	Mri chest spine w/o & w/dye	72157 26	mri chest spine w/o & w/dye.
72157 TC	Mri chest spine w/o & w/dye	72157 TC	mri chest spine w/o & w/dye.
72158 26	Mri lumbar spine w/o & w/dye	72158 26	mri lumbar spine w/o & w/dye.
72158 TC	Mri lumbar spine w/o & w/dye	72158 TC	mri lumbar spine w/o & w/dye.
72191 26	Ct angiograph pelv w/o&w/dye	72191 26	ct angiograph pelv w/o&w/dye.
72191 TC	Ct angiograph pelv w/o&w/dye	72191 TC	ct angiograph pelv w/o&w/dye.
74174 26	Ct angio abd&pelv w/o&w/dye	74174 26	ct angio abd&pelv w/o&w/dye.
74174 TC	Ct angio abd&pelv w/o&w/dye	74174 TC	ct angio abd&pelv w/o&w/dye.
74175 26	Ct angio abdom w/o & w/dye	74175 26	ct angio abdom w/o & w/dye.
74175 TC	Ct angio abdom w/o & w/dye	74175 TC	ct angio abdom w/o & w/dye.
77001 26	Fluoroguide for vein device	77001 26	fluoroguide for vein device.
77001 TC	Fluoroguide for vein device	77001 TC	fluoroguide for vein device.
77002 26	Needle localization by xray	77002 26	needle localization by xray.
77002 TC	Needle localization by xray	77002 TC	needle localization by xray.
77003 26	Fluoroguide for spine inject	77003 26	fluoroguide for spine inject.
77003 TC	Fluoroguide for spine inject	77003 TC	fluoroguide for spine inject.
77280 26	Set radiation therapy field	77280 26	set radiation therapy field.
77280 TC	Set radiation therapy field	77280 TC	set radiation therapy field.
77285 26	Set radiation therapy field	77285 26	set radiation therapy field.
77285 TC	Set radiation therapy field	77285 TC	set radiation therapy field.
77290 26	Set radiation therapy field	77290 26	set radiation therapy field.
77290 TC	Set radiation therapy field	77290 TC	set radiation therapy field.
77293 26	Respirator motion mgmt simul	77470 26	special radiation treatment.
77293 TC	Respirator motion mgmt simul	77470 TC	special radiation treatment.
77295 26	3-d radiotherapy plan	77295 26	3-d radiotherapy plan.
77295 TC	3-d radiotherapy plan	77295 TC	3-d radiotherapy plan.
77301 26	Radiotherapy dose plan imrt	77301 26	radiotherapy dose plan imrt.
77301 TC	Radiotherapy dose plan imrt	77301 TC	radiotherapy dose plan imrt.
77338 26	Design mlc device for imrt	77338 26	design mlc device for imrt.
77338 TC	Design mlc device for imrt	77338 TC	design mlc device for imrt.
77600 26	Hyperthermia treatment	77600 26	hyperthermia treatment.
77600 TC	Hyperthermia treatment	77600 TC	hyperthermia treatment.
77785 26	Hdr brachytx 1 channel	77785 26	hdr brachytx 1 channel.
77785 TC	Hdr brachytx 1 channel	77785 TC	hdr brachytx 1 channel.
77786 26	Hdr brachytx 2–12 channel	77786 26	hdr brachytx 2–12 channel.
77786 TC	Hdr brachytx 2–12 channel	77786 TC	hdr brachytx 2–12 channel.
77787 26	Hdr brachytx over 12 chan	77787 26	hdr brachytx over 12 chan.
77787 TC	Hdr brachytx over 12 chan	77787 TC	hdr brachytx over 12 chan.
88112 26	Cytopath cell enhance tech	88112 26	cytopath cell enhance tech.
88112 TC	Cytopath cell enhance tech	88112 TC	cytopath cell enhance tech.
88365 26	Insitu hybridization (fish)	88365 26	insitu hybridization (fish).
88365 TC	Insitu hybridization (fish)	88365 TC	insitu hybridization (fish).
88367 26	Insitu hybridization auto	88367 26	insitu hybridization auto.
88367 TC	Insitu hybridization auto	88367 TC	insitu hybridization auto.
88368 26	Insitu hybridization manual	88368 26	insitu hybridization manual.
88368 TC	Insitu hybridization manual	88368 TC	insitu hybridization manual.
91065 26	Breath hydrogen/methane test	91065 26	breath hydrogen/methane test.
91065 TC	Breath hydrogen/methane test	91065 TC	breath hydrogen/methane test.
93880 26	Extracranial bilat study	93880 26	extracranial bilat study.
93880 TC	Extracranial bilat study	93880 TC	extracranial bilat study.
93882 26	Extracranial uni/ltd study	93882 26	extracranial uni/ltd study.
93882 TC	Extracranial uni/ltd study	93882 TC	extracranial uni/ltd study.
95816 26	Eeg awake and drowsy	95816 26	eeg awake and drowsy.
95816 TC	Eeg awake and drowsy	95816 TC	eeg awake and drowsy.
95819 26	Eeg awake and asleep	95819 26	eeg awake and asleep.
95819 TC	Eeg awake and asleep	95819 TC	eeg awake and asleep.
95822 26	Eeg coma or sleep only	95822 26	eeg coma or sleep only.
95822 TC	Eeg coma or sleep only	95822 TC	eeg coma or sleep only.

TABLE 30—CROSSWALK FOR ESTABLISHING CY 2014 NEW/REVISED/POTENTIALLY MISVALUED CODES MALPRACTICE RVUs—Continued

95928 26	C motor evoked uppr limbs	95928 26	c motor evoked uppr limbs.
95928 TC	C motor evoked uppr limbs	95928 TC	c motor evoked uppr limbs.
95929 26	C motor evoked lwr limbs	95929 26	c motor evoked lwr limbs.
95929 TC	C motor evoked lwr limbs	95929 TC	c motor evoked lwr limbs.
G0453	Cont intraop neuro monitor	95920	intraop nerve test add-on.
G0455	Fecal microbiota prep instil	91065	breath hydrogen/methane test.
G0461	Immunohistochemistry, init	88342	immunohisto antibody slide.
G0462	Immunohistochemistry, addl	88342	immunohisto antibody slide

F. Geographic Practice Cost Indices (GPCIs)

1. Background

Section 1848(e)(1)(A) of the Act requires us to develop separate Geographic Practice Cost Indices (GPCIs) to measure resource cost differences among localities compared to the national average for each of the three fee schedule components (that is, work, PE, and MP). The 89 total PFS localities are discussed in section II.F.3. of this final rule with comment period. Although requiring that the PE and MP GPCIs reflect the full relative cost differences, section 1848(e)(1)(A)(iii) of the Act requires that the work GPCIs reflect only one-quarter of the relative cost differences compared to the national average. In addition, section 1848(e)(1)(G) of the Act sets a permanent 1.5 work GPCI floor for services furnished in Alaska beginning January 1, 2009, and section 1848(e)(1)(I) of the Act sets a permanent 1.0 PE GPCI floor for services furnished in frontier states (as defined in section 1848(e)(1)(I) of the Act) beginning January 1, 2011. Additionally, section 1848(e)(1)(E) of the Act provided for a 1.0 floor for the work GPCIs, which was set to expire at the end of 2012. Section 602 of the ATRA amended the statute to extend the 1.0 floor for the work GPCIs through CY 2013 (that is, for services furnished no later than December 31, 2013).

Section 1848(e)(1)(C) of the Act requires us to review and, if necessary, adjust the GPCIs at least every 3 years. Section 1848(e)(1)(C) of the Act requires that "if more than 1 year has elapsed since the date of the last previous GPCI adjustment, the adjustment to be applied in the first year of the next adjustment shall be 1/2 of the adjustment that otherwise would be made." Therefore, since the previous GPCI update was implemented in CY 2011 and CY 2012, we proposed to phase in 1/2 of the latest GPCI adjustment in CY 2014.

We completed a review of the GPCIs and proposed new GPCIs, as well as a revision to the cost share weights that correspond to all three GPCIs in the CY 2014 proposed rule. We also calculated a corresponding geographic adjustment factor (GAF) for each PFS locality. The GAFs are a weighted composite of each area's work, PE and MP GPCIs using the national GPCI cost share weights. Although the GAFs are not used in computing the fee schedule payment for a specific service, we provide them because they are useful in comparing overall areas costs and payments. The actual effect on payment for any actual service will deviate from the GAF to the extent that the proportions of work, PE and MP RVUs for the service differ from those of the GAF.

As noted above, section 602 of the ATRA extended the 1.0 work GPCI floor only through December 31, 2013. Therefore, the proposed CY 2014 work GPCIs and summarized GAFs do not reflect the 1.0 work floor. However, as required by sections 1848(e)(1)(G) and 1848(e)(1)(I) of the Act, the 1.5 work GPCI floor for Alaska and the 1.0 PE GPCI floor for frontier states are permanent, and therefore, applicable in CY 2014

2. GPCI Update

As discussed in the CY 2014 PFS proposed rule (78 FR 43322), the proposed updated GPCI values were calculated by a contractor to CMS. There are three GPCIs (work, PE, and MP), and all GPCIs are calculated through comparison to a national average for each type. Additionally, each of the three GPCIs relies on its own data source(s) and methodology for calculating its value as described below. Additional information on the proposed CY 2014 GPCI update may be found in our contractor's draft report, "*Draft Report on the CY 2014 Update of the Geographic Practice Cost Index for the Medicare Physician Fee Schedule,*" which is available on the CMS Web site. It is located under the supporting documents section of the CY 2014 PFS proposed rule located at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html.* Note: Our contractor's final report and associated analysis will be posted on the CMS Web site after publication of this final rule with comment period (under the downloads section of the CY 2014 PFS final rule.

a. Work GPCIs

The physician work GPCIs are designed to reflect the relative costs of physician labor by Medicare PFS locality. As required by statute, the physician work GPCI reflects one quarter of the relative wage differences for each locality compared to the national average.

To calculate the physician work GPCIs, we use wage data for seven professional specialty occupation categories, adjusted to reflect one-quarter of the relative cost differences for each locality compared to the national average, as a proxy for physicians' wages. Physicians' wages are not included in the occupation categories used in calculating the work GPCI because Medicare payments are a key determinant of physicians' earnings. Including physician wage data in calculating the work GPCIs would potentially introduce some circularity to the adjustment since Medicare payments typically contribute to or influence physician wages. That is, including physicians' wages in the physician work GPCIs would, in effect, make the indices, to some extent, dependent upon Medicare payments.

The physician work GPCI updates in CYs 2001, 2003, 2005, and 2008 were based on professional earnings data from the 2000 Census. However, for the CY 2011 GPCI update (75 FR 73252), the 2000 data were outdated and wage and earnings data were not available from the more recent Census because the "long form" was discontinued. Therefore, we used the median hourly earnings from the 2006 through 2008 Bureau of Labor Statistics (BLS) Occupational Employment Statistics (OES) wage data as a replacement for the 2000 Census data. The BLS OES data meet several criteria that we consider to be important for selecting a data source for purposes of calculating

the GPCIs. For example, the BLS OES wage and employment data are derived from a large sample size of approximately 200,000 establishments of varying sizes nationwide from every metropolitan area and can be easily accessible to the public at no cost. Additionally, the BLS OES is updated regularly, and includes a comprehensive set of occupations and industries (for example, 800 occupations in 450 industries).

Because of its reliability, public availability, level of detail, and national scope, we believe the BLS OES continues to be the most appropriate source of wage and employment data for use in calculating the work GPCIs (and as discussed in section II.F.2.b the employee wage component and purchased services component of the PE GPCI). Therefore, for the proposed CY 2014 GPCI update, we used updated BLS OES data (2009 through 2011) as a replacement for the 2006 through 2008 data to compute the work GPCIs.

b. Practice Expense GPCIs

The PE GPCIs are designed to measure the relative cost difference in the mix of goods and services comprising practice expenses (not including malpractice expenses) among the PFS localities as compared to the national average of these costs. Whereas the physician work GPCIs (and as discussed later in this section, the MP GPCIs) are comprised of a single index, the PE GPCIs are comprised of four component indices (employee wages; purchased services; office rent; and equipment, supplies and other miscellaneous expenses). The employee wage index component measures geographic variation in the cost of the kinds of skilled and unskilled labor that would be directly employed by a physician practice. Although the employee wage index adjusts for geographic variation in the cost of labor employed directly by physician practices, it does not account for geographic variation in the cost of services that typically would be purchased from other entities, such as law firms, accounting firms, information technology consultants, building service managers, or any other third-party vendor. The purchased services index component of the PE GPCI (which is a separate index from employee wages) measures geographic variation in the cost of contracted services that physician practices would typically buy. (For more information on the development of the purchased service index, we refer readers to the CY 2012 PFS final rule with comment period (76 FR 73084 through 73085).) The office rent index component of the PE GPCI measures relative geographic variation in the cost of typical physician office rents. For the medical equipment, supplies, and miscellaneous expenses component, we believe there is a national market for these items such that there is not significant geographic variation in costs. Therefore, the "equipment, supplies and other miscellaneous expense" cost index component of the PE GPCI is given a value of 1.000 for each PFS locality.

For the previous update to the GPCIs (implemented in CY 2011 and CY 2012) we used 2006 through 2008 BLS OES data to calculate the employee wage and purchased services indices for the PE GPCI. As we discussed in the proposed rule because of its reliability, public availability, level of detail, and national scope, we continue to believe the BLS OES is the most appropriate data source for collecting wage and employment data. Therefore, in calculating the proposed CY 2014 GPCI update, we used updated BLS OES data (2009 through 2011) as a replacement for the 2006 through 2008 data for purposes of calculating the employee wage component and purchased service index of the PE GPCI.

Office Rent Index Discussion

Since the inception of the PFS, we have used residential rent data (primarily the two-bedroom residential apartment rent data produced by the Department of Housing and Urban Development (HUD) at the 50th percentile) as the proxy to measure the relative cost difference in physician office rents. As discussed in the CY 2012 PFS final rule with comment period (76 FR 73084), we had concerns with the continued use of the HUD rental data because the data were not updated frequently and the Census "long form," which was used to collect the necessary base year rents for the HUD Fair Market Rent (FMR) data, was discontinued in CY 2010 and would no longer be available for future updates. Therefore, we examined the suitability of using 3-year (2006–2008) U.S. Census Bureau American Community Survey (ACS) rental data as a proxy for physician office rents to replace the HUD data. We determined that the ACS is one of the largest nationally representative surveys of household rents in the United States conducted annually by the U.S. Census Bureau, sampling approximately 3 million addresses with a recent response rate above 97 percent, and that it reports rental information for residences at the county level. Given that the ACS rental data provided a sufficient degree of reliability, is updated annually, and was expected to be available for future updates, we used the 2006 through 2008 ACS 3-year residential rent data as a replacement for the HUD data to create the office rent index for the CY 2012 PFS final rule with comment (76 FR 73084). For all the same reasons that we used the ACS data for the last GPCI update, we proposed to use updated ACS residential rent data (2008 through 2010) to calculate the office rent component of the PE GPCI. We noted in the proposed rule that when responding to the ACS survey, individuals also report whether utilities are included in their rent. Thus, the cost of utilities cannot be separated from "gross rents" since some individuals monthly rent also covers the cost of utilities. As discussed in section II.F.2.d., we combined the cost weights for fixed capital and utilities when assigning a proposed weight to the office rent component of the PE GPCI.

For many years, we have received requests from stakeholders to use commercial rent data instead of residential rent data to measure the relative cost differences in physician office rent. Additionally, in a report entitled "*Geographic Adjustment in Medicare Payment, Phase I: Improving Accuracy,*" prepared for CMS under contract and released on September 28, 2011, the Institute of Medicine recommended that "a new source of data should be developed to determine the variation in the price of commercial office rent per square foot." The Institute of Medicine report did not identify any new data source and did not suggest how a new source of data might be developed. Because we could not identify a reliable commercial rental data source that is available on a national basis and includes data for non-metropolitan areas, we continued to use residential rent data for the CY 2012 GPCI update.

For the CY 2014 GPCI update, we continued our efforts to identify a reliable source of commercial rent data that could be used in calculating the rent index. We could not identify a nationally representative commercial rent data source that is available in the public sector. However, we identified a proprietary commercial rent data source that has potential for use in calculating the office rent indices in future years. To that end, we are attempting to negotiate an agreement with the proprietor to use the data for purposes of calculating the office rent component of the PE GPCI.

One of the challenges of using a proprietary data source is our ability to make information available to the public. When using government data,

we are able to release all data for public consideration. However, when using a proprietary data source, it is likely that restrictions will be imposed on its use and our ability to disclose data. In such a situation, those wishing to replicate our calculations based on detailed data would also need to purchase the underlying proprietary data. We also believe that, generally speaking, a proprietary "for profit" data source is more susceptible to periodic changes in the criteria used for data collection, including possible changes in the data collected, the frequency at which the data is updated, changes in ownership, and the potential for termination of the survey vehicle entirely as changes are made to address economic pressures or opportunities. As such, we cannot predict that a given proprietary data source will be available in the format needed to develop office rent indices in the future. Since we have not identified a nationally representative commercial rent data source that is available in the public sector, we believe it would be necessary to use a proprietary data source for commercial office rent data. That is, in the absence of using a proprietary data source, it is unlikely that we would be able to use commercial rent data to calculate the office rent index component of the PE GPCI. In the proposed rule we requested comments on the use of a proprietary commercial rent data source as well as whether there is a source for these data that is not proprietary.

c. Malpractice Expense (MP) GPCIs

The MP GPCIs measure the relative cost differences among PFS localities for the purchase of professional liability insurance (PLI). The MP GPCIs are calculated based on insurer rate filings of premium data for $1 million to $3 million mature claims-made policies (policies for claims made rather than services furnished during the policy term). For the CY 2011 GPCI update (sixth update) we used 2006 and 2007 malpractice premium data (75 FR 73256). The proposed CY 2014 MP GPCI update was developed using 2011 and 2012 premium data.

Additionally, for the past several GPCI updates, we were not able to collect MP premium data from insurer rate filings for the Puerto Rico payment locality. For the CY 2014 (seventh) GPCI update, we worked directly with the Puerto Rico Insurance Commissioner and Institute of Statistics to obtain data on MP insurance premiums that were used to calculate an updated MP GPCI for Puerto Rico. We noted in the proposed rule that using updated MP premium data would result in a 17 percent increase in MP GPCI for the Puerto Rico payment locality under the proposed fully phased-in seventh GPCI update, which would be effective CY 2015.

d. GPCI Cost Share Weights

To determine the cost share weights for the proposed CY 2014 GPCIs, we used the weights we proposed to use for the CY 2014 value for the revised 2006-based MEI as discussed in section II.D. of this final rule with comment period. As discussed in detail in that section, the MEI was rebased and revised in the CY 2011 PFS final rule with comment period (75 FR 73262 through 73277) to reflect the weighted-average annual price change for various inputs needed to provide physicians' services. We have historically updated the GPCI cost share weights to make them consistent with the most recent update to the MEI, and proposed to do so again for CY 2014. We would note that consistent with this approach, in the CY 2011 proposed rule, the last time the MEI was revised, we proposed to update the GPCI cost share weights to reflect these revisions to the MEI. However, in response to public comments we did not finalize the proposal in the CY 2011 PFS final rule with comment period (75 FR 73258 and 73260), so that we could explore public comments received suggesting the reallocation of labor related costs from the medical equipment, supplies and miscellaneous component to the employee compensation component and comments received on the cost share weight for the rent index of the PE GPCI as well as to continue our analysis of the cost share weights attributed to the PE GPCIs as required by section 1848(e)(1)(H)(iv) of the Act.

In the CY 2012 PFS final rule (76 FR 73085 through 73086) we addressed commenter concerns regarding the inclusion of the cost share weight assigned to utilities within the office rent component of the PE GPCI and to geographically adjust wage related industries contained within the medical equipment, supplies and miscellaneous component of the PE GPCI. As a result, to accurately capture the utility measurement present in the ACS two bedroom gross rent data, the cost share weight for utilities was combined with the fixed capital portion to form the office rent index. Additionally, we developed a purchased service index to geographically adjust the labor-related components of the "All Other Services" and "Other Professional Expenses" categories of the 2006-based MEI market basket. Upon completing our analysis of the GPCI cost share weights (as required by the Act) and addressing commenters' concerns regarding the office rent and labor related industries previously contained in the medical equipment, supplies and other miscellaneous components of the PE GCPI, we updated the GPCI cost share weights consistent with the weights established in the 2006-based MEI in the CY 2012 PFS final rule (76 FR 73086).

The proposed revised 2006-based MEI cost share weights reflect our actuaries' best estimate of the weights associated with each of the various inputs needed to provide physicians' services. Use of the current MEI cost share weights also provides consistency across the PFS in the use of this data. Given that we have addressed previous commenters' concerns about the allocation of labor related costs (as discussed earlier in this section) and that we have completed our analysis of the GPCI cost share weights (as required by the Act) we proposed to adopt the weights we proposed to use for the revised 2006-based MEI as the GPCI cost share weights for CY 2014.

Specifically, we proposed to change the cost share weights for the work GPCI (as a percentage of the total) from 48.266 percent to 50.866 percent, and the cost share weight for the PE GPCI from 47.439 percent to 44.839 percent. In addition we proposed to change the employee compensation component of the PE GPCI from 19.153 to 16.553 percentage points. The proposed cost share weights for the office rent component (10.223 percent), purchased services component (8.095 percent), and the medical equipment, supplies, and other miscellaneous expenses component (9.968 percent) of the PE GPCI and the cost share weight for the MP GPCI (4.295 percent) remained unchanged. A discussion of the specific MEI cost centers and the respective weights used to calculate each GPCI component (and subcomponent) is provided below.

(1) Work GPCIs

We proposed to adopt the proposed revised weight of 50.866 for the physician compensation cost category as the proposed work GPCI cost share weight.

(2) Practice Expense GPCIs

For the cost share weight for the PE GPCIs, we used the revised 2006-based MEI proposed weight for the PE category of 49.134 percent minus the PLI category weight of 4.295 percent (because the relative costs differences in malpractice expenses are measured by its own GPCI). Therefore, the proposed cost share weight for the PE GPCIs is 44.839 percent.

(a) Employee Compensation

For the employee compensation portion of the PE GPCIs, we used the proposed non-physician employee compensation category weight of 16.553 percent reflected in the revised 2006-based MEI.

(b) Office Rent

We set the PE GPCI office rent portion at 10.223 percent, which includes the proposed revised 2006-based MEI cost weights for fixed capital (reflecting the expenses for rent, depreciation on medical buildings and mortgage interest) and utilities. As discussed previously in this section, we proposed to use 2008–2010 ACS rental data as the proxy for physician office rent. As mentioned previously, these data represent a gross rent amount and include data on utility expenditures. Since it is not possible to separate the utilities component of rent for all ACS survey respondents, we combined these two components to calculate office rent values that were used to calculate the office rent index component of the proposed PE GPCI. For purposes of consistency, we combined those two cost categories when assigning a proposed weight to the office rent component.

(c) Purchased Services

As discussed in section II.A. of this final rule with comment period, to be consistent with the purchased services index, we proposed to combine the current MEI cost share weights for "All Other Services" and "Other Professional Expenses" into a component called "All Other Professional Services." The proposed weight for "All Other Professional Services" is 8.095. As noted in the CY 2012 PFS final rule with comment period (76 FR 73084), we only adjust for locality cost differences of the labor-related share of the purchased services index. We determined that only 5.011 percentage points of the total 8.095 proposed weight are labor-related and, thus, would be adjusted for locality cost differences (5.011 adjusted purchased service + 3.084 non-adjusted purchased services = 8.095 total cost share weight). Therefore, only 62 percent (5.011/8.095) of the purchased service index is adjusted for geographic cost differences while the remaining 38 percent (3.084/8.095) of the purchased service index is not adjusted for geographic variation.

(d) Equipment, Supplies, and Other Miscellaneous Expenses

To calculate the medical equipment, supplies, and other miscellaneous expenses component, we removed PLI (4.295 percentage points), non-physician employee compensation (16.553 percentage points), fixed capital/utilities (10.223 percentage points), and purchased services (8.095 percentage points) from the total proposed PE category weight (49.134 percent). Therefore, the proposed cost share weight for the medical equipment, supplies, and other miscellaneous expenses component is 9.968 percent (49.134 − (4.295 + 16.553 + 10.223 + 8.095) = 9.968). As explained above, because we believe there is a national market for these items, costs that fall within this component of the PE GPCI are not adjusted for geographic variation.

(3) Malpractice GPCIs

We proposed to use the PLI weight of 4.295 percent for the MP GPCI cost share weight. The proposed GPCI cost share weights for CY 2014 are displayed in Table 31.

TABLE 31—PROPOSED COST SHARE WEIGHTS FOR CY 2014 GPCI UPDATE

Expense category	Current cost share weight (percent)	Proposed CY 2014 cost share weight (percent)
Work	48.266	50.866
Practice Expense (less PLI)	47.439	44.839
- Employee Compensation	19.153	16.553
- Office Rent	10.223	10.223
- Purchased Services	8.095	8.095
- Equipment, Supplies, Other	9.968	9.968
Malpractice Insurance	4.295	4.295
Total	100.000	100.000

e. PE GPCI Floor for Frontier States

Section 10324(c) of the Affordable Care Act added a new subparagraph (I) under section 1848(e)(1) of the Act to establish a 1.0 PE GPCI floor for physicians' services furnished in frontier States effective January 1, 2011. In accordance with section 1848(e)(1)(I) of the Act, beginning in CY 2011, we applied a 1.0 PE GPCI floor for physicians' services furnished in states determined to be frontier states. In general, a frontier state is one in which at least 50 percent of the counties are "frontier counties," which are those that have a population per square mile of less than 6. For more information on the criteria used to define a frontier state, we refer readers to the FY 2011 Inpatient Prospective Payment System final rule (75 FR 50160 through 50161). There are no changes in the states identified as "frontier states" for CY 2014. The qualifying states are reflected in Table 32. In accordance with the Act, we will apply a 1.0 PE GPCI floor for these states in CY 2014.

TABLE 32—FRONTIER STATES UNDER SECTION 1848(E)(1)(I) OF THE ACT

[As added by section 10324(c) of the Affordable Care Act]

State	Total counties	Frontier counties	Percent frontier counties (relative to counties in the State) (percent)
Montana	56	45	80
Wyoming	23	17	74

TABLE 32—FRONTIER STATES UNDER SECTION 1848(E)(1)(I) OF THE ACT—Continued
[As added by section 10324(c) of the Affordable Care Act]

State	Total counties	Frontier counties	Percent frontier counties (relative to counties in the State) (percent)
North Dakota	53	36	68
Nevada	17	11	65
South Dakota	66	34	52

f. Proposed GPCI Update

As explained above, the periodic review and adjustment of GPCIs is mandated by section 1848(e)(1)(C) of the Act. At each update, the proposed GPCIs are published in the PFS proposed rule to provide an opportunity for public comment and further revisions in response to comments prior to implementation. The proposed CY 2014 updated GPCIs for the first and second year of the 2-year transition, along with the GAFs, were displayed in Addenda D and E to the CY 2014 proposed rule available on the CMS Web site under the supporting documents section of the CY 2014 PFS proposed rule Web page at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html.*

3. Payment Locality Discussion

a. Background

The current PFS locality structure was developed and implemented in 1997. There are currently 89 total PFS localities; 34 localities are statewide areas (that is, only one locality for the entire state). There are 52 localities in the other 16 states, with 10 states having 2 localities, 2 states having 3 localities, 1 state having 4 localities, and 3 states having 5 or more localities. The District of Columbia, Maryland, and Virginia suburbs, Puerto Rico, and the Virgin Islands are additional localities that make up the remainder of the total of 89 localities. The development of the current locality structure is described in detail in the CY 1997 PFS proposed rule (61 FR 34615) and the subsequent final rule with comment period (61 FR 59494).

Prior to 1992, Medicare payments for physicians' services were made under the reasonable charge system. Payments were based on the charging patterns of physicians. This resulted in large differences in payment for physicians' services among types of services, geographic payment areas, and physician specialties. Recognizing this, the Congress replaced the reasonable charge system with the Medicare PFS in the Omnibus Budget Reconciliation Act (OBRA) of 1989, and the PFS went into effect January 1, 1992. Payments under the PFS are based on the relative resources involved with furnishing services, and are adjusted to account for geographic variations in resource costs as measured by the GPCIs.

Payment localities originally were established under the reasonable charge system by local Medicare carriers based on their knowledge of local physician charging patterns and economic conditions. These localities changed little between the inception of Medicare in 1967 and the beginning of the PFS in 1992. Shortly after the PFS took effect, CMS undertook a study in 1994 that culminated in a comprehensive locality revision that was implemented in 1997 (61 FR 59494).

The revised locality structure reduced the number of localities from 210 to the current 89, and the number of statewide localities increased from 22 to 34. The revised localities were based on locality resource cost differences as reflected by the GPCIs. For a full discussion of the methodology, see the CY 1997 PFS final rule with comment period (61 FR 59494). The current 89 fee schedule areas are defined alternatively by state boundaries (for example, Wisconsin), metropolitan areas (for example, Metropolitan St. Louis, MO), portions of a metropolitan area (for example, Manhattan), or rest-of-state areas that exclude metropolitan areas (for example, rest of Missouri). This locality configuration is used to calculate the GPCIs that are in turn used to calculate payments for physicians' services under the PFS.

As stated in the CY 2011 PFS final rule with comment period (75 FR 73261), we require that changes to the PFS locality structure be done in a budget neutral manner within a state. For many years, before making any locality changes, we have sought consensus from among the professionals whose payments would be affected. In recent years, we have also considered more comprehensive changes to locality configuration. In 2008, we issued a draft comprehensive report detailing four different locality configuration options (*www.cms.gov/physicianfeesched/downloads/ReviewOfAltGPCIs.pdf*). The alternative locality configurations in the report are described below.

- *Option 1: CMS Core-Based Statistical Area (CBSA) Payment Locality Configuration:* CBSAs are a combination of Office of Management and Budget (OMB's) Metropolitan Statistical Areas (MSAs) and Micropolitan Statistical Areas. Under this option, MSAs would be considered as urban CBSAs. Micropolitan Statistical Areas (as defined by OMB) and rural areas would be considered as non-urban (rest of state) CBSAs. This approach would be consistent with the areas used in the Inpatient Prospective Payment System (IPPS) pre-reclassification wage index, which is the hospital wage index for a geographic area (CBSA or non-CBSA) calculated from submitted hospital cost report data before statutory adjustments reconfigure, or "reclassify" a hospital to an area other than its geographic location, to adjust payments for differences in local resource costs in other Medicare payment systems. Based on data used in the 2008 locality report, this option would increase the number of PFS localities from 89 to 439.
- *Option 2: Separate High-Cost Counties from Existing Localities (Separate Counties):* Under this approach, higher cost counties are removed from their existing locality structure, and they would each be placed into their own locality. This option would increase the number of PFS localities from 89 to 214, using a 5 percent GAF differential to separate high-cost counties.
- *Option 3: Separate MSAs from Statewide Localities (Separate MSAs):* This option begins with statewide localities and creates separate localities for higher cost MSAs (rather than removing higher cost counties from their existing locality as described in Option 2). This option would increase the number of PFS localities from 89 to 130, using a 5 percent GAF differential to separate high-cost MSAs.

• *Option 4: Group Counties Within a State Into Locality Tiers Based on Costs (Statewide Tiers):* This option creates tiers of counties (within each state) that may or may not be contiguous but share similar practice costs. This option would increase the number of PFS localities from 89 to 140, using a 5 percent GAF differential to group similar counties into statewide tiers.

For a detailed discussion of the public comments on the contractor's 2008 draft report detailing four different locality configurations, we refer readers to the CY 2010 PFS proposed rule (74 FR 33534) and subsequent final rule with comment period (74 FR 61757). There was no public consensus on the options, although a number of commenters expressed support for Option 3 (separate MSAs from statewide localities) because the commenters believed this alternative would improve payment accuracy and could mitigate potential reductions to rural areas compared to Option 1 (CMS CBSAs).

In response to some public comments regarding the third of the four locality options, we had our contractor conduct an analysis of the impacts that would result from the application of Option 3. Those results were displayed in the final locality report released in 2011. The final report, entitled "*Review of Alternative GPCI Payment Locality Structures—Final Report,*" may be accessed directly from the CMS Web site at *www.cms.gov/PhysicianFeeSched/downloads/Alt_GPCI_Payment_Locality_Structures_Review.pdf.*

Moreover, at our request, the Institute of Medicine conducted a comprehensive empirical study of the Medicare GAFs established under sections 1848(e) (PFS GPCI) and 1886(d)(3)(E) (IPPS hospital wage index) of the Act. These adjustments are designed to ensure Medicare payments reflect differences in input costs across geographic areas. The first of the Institute of Medicine's two reports entitled, "*Geographic Adjustment in Medicare Payment, Phase I: Improving Accuracy*" recommended that the same labor market definition should be used for both the hospital wage index and the physician geographic adjustment factor. Further, the Institute of Medicine recommended that MSAs and statewide non-metropolitan statistical areas should serve as the basis for defining these labor markets.

Under the Institute of Medicine's recommendations, MSAs would be considered as urban CBSAs. Micropolitan Areas (as defined by the OMB) and rural areas would be considered as non-urban (rest of state) CBSAs. This approach would be consistent with the areas used in the IPPS pre-reclassification wage index to make geographic payment adjustments in other Medicare payment systems. For more information on the Institute of Medicine's recommendations on the PFS locality structure, see the CY 2013 PFS final rule with comment period (77 FR 68949). We also provided our technical analyses of the Institute of Medicine Phase I recommendations in a report released on the PFS Web site at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html.*

Additionally, the Phase I report can be accessed on the Institute of Medicine's Web site at *http://www.iom.edu/Reports/2011/Geographic-Adjustment-in-Medicare-Payment-Phase-I-Improving-Accuracy.aspx.*

b. Institute of Medicine Phase II Report Discussion

The Institute of Medicine's second report, entitled "*Geographic Adjustment in Medicare Payment—Phase II: Implications for Access, Quality, and Efficiency*" was released July 17, 2012 and can be accessed on the Institute of Medicine's Web site at *http://www.iom.edu/Reports/2011/Geographic-Adjustment-in-Medicare-Payment-Phase-I-Improving-Accuracy.aspx.*

The Phase II report evaluated the effects of geographic adjustment factors (hospital wage index and GPCIs) on the distribution of the health care workforce, quality of care, population health, and the ability to provide efficient, high value care. The Institute of Medicine's Phase II report also included an analysis of the impacts of implementing its recommendations for accuracy in geographic adjustments which include a CBSA-based locality structure under the PFS. The Institute of Medicine analysis found that adopting a CBSA-based locality structure under the PFS creates large changes in county GAF values; for example, approximately half of all U.S. counties would experience a payment reduction. The Institute of Medicine also found that GPCIs calculated under a CBSA-based locality structure would result in lower GAFs in rural areas (relative to the national average) because the GPCI values for rural areas would no longer include metropolitan practice costs within the current "rest-of-state" or "statewide" localities.

(1) Institute of Medicine Phase II Report Recommendations

The Institute of Medicine developed recommendations for improving access to and quality of medical care. The recommendations included in the Institute of Medicine's Phase II report are summarized as follows:

• *Recommendation 1;* The Medicare program should develop and apply policies that promote access to primary care services in geographic areas where Medicare beneficiaries experience persistent access problems.

• *Recommendation 2:* The Medicare program should pay for services that improve access to primary and specialty care for beneficiaries in medically underserved urban and rural areas, particularly telehealth technologies.

• *Recommendation 3:* To promote access to appropriate and efficient primary care services, the Medicare program should support policies that would allow all qualified practitioners to practice to the full extent of their educational preparation.

• *Recommendation 4:* The Medicare program should reexamine its policies that provide location-based adjustments for specific groups of hospitals, and modify or discontinue them based on their effectiveness in ensuring adequate access to appropriate care.

• *Recommendation 5:* Congress should fund an independent ongoing entity, such as the National Health Care Workforce Commission, to support data collection, research, evaluations, and strategy development, and make actionable recommendations about workforce distribution, supply, and scope of practice.

• *Recommendation 6:* Federal support should facilitate independent external evaluations of ongoing workforce programs intended to provide access to adequate health services for underserved populations and Medicare beneficiaries. These programs include the National Health Services Corps, Title VII and VIII programs under the Public Health Service Act, and related programs intended to achieve these goals.

(2) Institute of Medicine Phase II Report Conclusions

The Institute of Medicine committee concluded that geographic payment adjustments under the PFS are not a strong determinant of access problems and not an appropriate mechanism for improving the distribution of the healthcare workforce, quality of care, population health, and the ability to provide efficient, high value care. Specifically, the Institute of Medicine

committee stated "that there are wide discrepancies in access to and quality of care across geographic areas particularly for racial and ethnic minorities. However, the variations do not appear to be strongly related to differences in or potential changes to fee for service payment" (Page. 6). The committee also concluded "that Medicare beneficiaries in some geographic pockets face persistent access and quality problems, and many of these pockets are in medically underserved rural and inner-city areas. However, geographic adjustment of Medicare payment is not an appropriate approach for addressing problems in the supply and distribution of the health care workforce. The geographic variations in the distribution of physicians, nurses and physician assistants, and local shortages that create access problems for beneficiaries should be addressed through other means" (Page 7). Moreover, the committee concluded that "geographic [payment] adjustment is not an appropriate tool for achieving policy goals such as improving quality of expanding the pool of providers available to see Medicare beneficiaries" (Page 9).

(3) CMS Summary Response to Institute of Medicine Phase II Report

The Institute of Medicine's Phase II report recommendations are broad in scope, do not propose specific recommendations for making changes to the GPCIs or PFS locality structure, or are beyond the statutory authority of CMS.

We agree with the Institute of Medicine's assessment that many counties would experience a payment reduction and that large payment shifts would occur as a result of implementing a CBSA-based locality configuration under the PFS. Based on our contractor's analysis, there would be significant redistributive impacts if we were to implement a policy that would reconfigure the PFS localities based on the Institute of Medicine's CBSA-based locality recommendation. Many rural areas would see substantial decreases in their corresponding GAF and GPCI values as higher cost counties are removed from current "rest of state" payment areas. Conversely, many urban areas, especially those areas that are currently designated as "rest of state" but are located within higher cost MSAs, would experience increases in their applicable GPCIs and GAFs. That is, given that urban and rural areas would no longer be grouped together (for example, as in the current 34 statewide localities), many rural areas would see a reduction in payment under a CBSA-based locality configuration.

As noted earlier in this section, we are assessing a variety of approaches to changing the locality structure under the PFS and will continue to study options for revising the locality structure. However, to fully assess the implications of proposing a nationwide locality reconfiguration under the PFS, we must also assess and analyze the operational changes necessary to implement a revised locality structure. Given that all options under consideration (including the Institute of Medicine's CBSA-based approach) would expand the number of current localities and result in payment reductions to primarily rural areas, presumably any nationwide locality reconfiguration could potentially be transitioned over a number of years (to phase-in the impact of payment reductions gradually, from year-to-year, instead of all at once). As such, transitioning from the current locality structure to a nationwide reconfigured locality structure would present operational and administrative challenges that need to be identified and addressed. Therefore, we have begun to assess the broad operational changes that would be involved in implementing a nationwide locality reconfiguration under the PFS. Accordingly, we believe that it would be premature to make any statements about potential changes we would consider making to the PFS localities at this time. Any changes to PFS fee schedule areas would be made through future notice and comment rulemaking.

The following is a summary of the comments we received regarding our proposed CY 2014 GPCI update and summary response to the Institute of Medicine's Phase II report recommendations.

Comment: A few commenters including a national medical association and state medical society expressed support for using more current data in calculating the GPCIs. Another commenter stated that the BLS OES provides the best data for calculating the work GPCI and the employee wage component and purchased service component of the PE GPCI.

Response: For the reasons outlined in the proposed rule, we agree with the commenters.

Comment: One state medical association expressed support for our proposal to use BLS OES data for calculating the geographic variation in physician work. The commenter stated that the BLS OES includes a large sample of data on wages and should be very reliable. However, the commenter raised concerns about using multi-year averages of wages in years that large demographic and economic changes may have occurred. The commenter contends that because the BLS OES data are so robust, using three-year averages is not necessary or appropriate. The commenter suggested that GPCI updates based on BLS OES data should be based on the most recent annual data available, rather than multi-year averages.

Response: We agree with the commenter that the BLS OES data are a reliable and robust source of wage and earnings data. The BLS OES wage and earnings data released in any given year are aggregated using 6 semi-annual panels of data collected over 3 years (2 panels per year). The BLS does not produce 1-year wage and earnings data. According to the Occupational Employment Statistics Frequently Asked Questions: "Significant reductions in sampling error can be achieved by taking advantage of a full 3 years of data, covering 1.2 million establishments and about 62 percent of the employment in the United States. This feature is particularly important in improving the reliability of estimates for detailed occupations in small geographical areas. Combining multiple years of data is also necessary to obtain full coverage of the largest establishments. In order to reduce respondent burden, the OES survey samples these establishments with virtual certainty only once every three years." We also note that the BLS recognizes that labor costs change over time. To make the data from all 6 semi-annual panels comparable, the OES program uses the Employment Cost Index (ECI) to translate the occupation-level wages from previous years into a wage number for the most recent year. The Occupational Employment Statistics Frequently Asked Questions may be accessed from the Bureau of Labor Statistics Web site at: *http://www.bls.gov/oes/oes_ques.htm.* As discussed above, the OES FAQs explain that the use of multi-year averages improves reliability of the data and reduces sampling error. We agree with this assessment, and therefore, we will continue to use the BLS OES wage and earnings data that reflect multi-year averaging.

Comment: A few commenters stated that the proposed GPCI update results in lowering payment amounts to rural areas, which threatens patient access to physician services, including treatments for complex conditions such as cancer and lupus. Another commenter expressed support for the elimination of all geographic adjustment factors under

the PFS. The commenter believes that lower GPCIs discourage physicians and practitioners from practicing in rural and underserved areas.

Response: As discussed previously, section 1848(e)(1)(A) of the Act requires us to develop separate GPCIs to measure resource cost differences among localities compared to the national average for each of the three fee schedule components. We do not have the authority to eliminate geographic payment adjustments under the PFS. We note that the GPCI values for many rural PFS areas, including many single state localities (and rest of state localities), will increase as a result of the CY 2014 GPCI update. However, because the statutory 1.0 work GPCI floor expires at the end of CY 2013, beginning January 1, 2014, PFS payment amounts will be calculated based upon the actual work GPCI for the locality rather than using the 1.0 work GPCI floor (except in Alaska where the statutory 1.5 work GPCI floor will continue to apply). Accordingly, the summarized GAFs, provided as noted above for purposes of illustration and comparison, demonstrate decreases in the work GPCIs for these same PFS localities.

Comment: A few commenters requested an extension of the statutorily-mandated 1.0 work GPCI floor, which expires on December 31, 2013.

Response: As discussed above, the 1.0 work GPCI floor is established by statute and expires on December 31, 2013. We do not have authority to extend the 1.0 work GPCI floor beyond December 31, 2013.

Comment: A few commenters urged us to reassess the professional occupational categories used to determine the relative cost differences in physician earnings for purposes of calculating the work GPCI. The commenters believe that the current inputs do not adequately measure the relative cost differences in physician salary across PFS localities. The commenters also mentioned a recent report published by MedPAC on the work GPCI, which recommended changes to the proxy occupations used in calculating the work GPCI. The commenters stated that the MedPAC study found that the data sources we currently rely upon for determining the work GPCI bear no correlation to physician earnings and that rural primary care physicians have higher wages than their urban counterparts. One commenter suggested that we use actual physician salaries (instead of proxy occupations) to determine the relative differences in physician wages. Another commenter urged us to modify the work GPCI to include "reference occupations that will accurately reflect the higher input costs of rural physician earnings."

Response: We appreciate the comments regarding the professional occupations used to determine the relative cost differences in physician earnings for purposes of calculating the work GPCI. As noted previously in this section, physicians' wages are not included in the occupation categories used in calculating the work GPCI because Medicare payments are a key determinant of physicians' earnings. Including physician wage data in calculating the work GPCIs would potentially introduce some circularity to the adjustment since Medicare payments typically contribute to or influence physician wages. In other words, including physicians' wages in the physician work GPCIs would, in effect, make the indices, to some extent, dependent upon Medicare payments, which in turn are affected by the indices. Additionally, as noted in the proposed rule the MedPAC was required by section 3004 of the MCTRJCA to submit a report to the Congress by June 15, 2013, assessing whether any adjustment under section 1848 of the Act to distinguish the difference in work effort by geographic area is appropriate and, if so, what that level should be and where it should be applied. In the report, MedPAC was required to also assess the impact of the work geographic adjustment under the Act, including the extent to which the floor on such adjustment impacts access to care. We also noted in the proposed rule that we did not have sufficient time to review this report, which was issued on June 14, 2013, in order to take the report into consideration for the proposed rule. We will be assessing the findings and recommendations from the MedPAC report and, and we will consider whether to make recommendations or proposals for changes in future rulemaking.

Comment: Several commenters noted that they appreciated our efforts to obtain more recent malpractice premium data from Puerto Rico for purposes of calculating the MP GPCIs. The commenters stated that a MP GPCI update for the Puerto Rico payment locality is long overdue.

Response: We agree with the commenters. By obtaining more recent malpractice premium insurance data, we were able to calculate an updated MP GPCI for the Puerto Rico payment locality using recent market share and rate filings data, as we were able to do for most other PFS localities.

Comment: One commenter stated that we did not use the most recent ACS residential rent data available (2009 through 2011) when calculating the rent index and encouraged us to use the most recent ACS residential rent data if it does not decrease the PE GPCI for Puerto Rico.

Response: We appreciate the commenter's suggestion to use 2009 through 2011 ACS data for the CY 2014 GPCI update. We note that there was insufficient time between the release of the 2009 through 2011 ACS data and the CY 2014 PFS proposed rule to allow us to use these data for the calculation of the proposed office rent component of the PE GPCI.

Comment: Many commenters requested an increase to the PE GPCI values for the Puerto Rico payment locality. The commenters believe it is necessary to increase payments to Puerto Rico to prevent the continued exodus of physicians to the U.S. mainland, as well as to maintain the quality of care, reflect inflation, and modernize equipment and supplies in Puerto Rico. The commenters also argue that doctors in Puerto Rico are required to provide the same services for lower reimbursement than those practicing in the U.S. mainland).

One commenter acknowledged that the work, PE and malpractice GPCIs for the Puerto Rico locality were increased as a result of the CY 2014 GPCI update, but noted that, even with the increases, Puerto Rico continues to be the lowest paid PFS locality and that its "neighboring locality," the Virgin Islands, unjustifiably receives a MP GPCI and PE GPCI of 1.0. The commenter also requested specific increases to the proposed PE GPCI for the Puerto Rico locality, most notably the rent component and medical equipment and supplies component, and referenced a previous study entitled "Cost of Medical Services in Puerto Rico," which included physician survey information on the costs of operating a medical practice in Puerto Rico.

In addition, the same commenter stated that the methodology used to determine the equipment and supplies component of the PE GPCI is unfair to Puerto Rico. For example, the commenter noted that the medical equipment and supplies component of the PE GPCI is currently not adjusted for geographic cost differences; therefore all PFS localities receive an index of 1.0 for the equipment and supplies component. The commenter stated that medical equipment and supplies cost more in Puerto Rico because of the higher cost of shipping, noting, for example, that air and maritime shipping is more

expensive than ground shipping. Because Puerto Rico is dependent on air and maritime shipping, the commenter believes that our presumption that most medical equipment and supplies are sold through a national market does not adequately capture the higher cost of shipping medical equipment and medical supplies to the Puerto Rico locality. The commenter urged us to increase the PE GPCI calculated for the Puerto Rico locality, "so that it is equal to, or more closely approximates, the PE GPCI calculated for the state with the lowest PE GPCI (in this case, West Virginia)."

Response: As noted previously in this section, we are required by section 1848(e)(1)(A) of the Act to develop separate GPCIs to measure relative resource cost differences among localities compared to the national average for each of the three fee schedule components: work, PE and MP expense and to update the GPCIs at least every 3 years. In the CY 2014 PFS proposed rule, we proposed to update the GPCIs for each Medicare PFS locality using updated data. For the CY 2014 GPCI update, we calculated updated GPCIs for the Puerto Rico locality using the same data sources and methodology as used for other PFS localities. To calculate the work GPCI and the employee compensation and purchased service components of the PE GPCI, we used 2009 through 2011 BLS OES data. To calculate the office rent component of the PE GPCI we used updated ACS data (2008 through 2010) as replacement for 2006 through 2008. With respect to the comment suggesting we assign the PE GPCI calculated for West Virginia to the Puerto Rico payment locality, we note that we are required to calculate GPCIs based upon the geographic cost differences between a specific PFS payment locality and the national average. As noted above, we have sufficient cost data to calculate GPCI values specific to the Puerto Rico payment locality. It would not be appropriate to assign a PE GPCI calculated for the West Virginia payment locality (based on data specific to West Virginia) to the Puerto Rico payment locality. Additionally, with respect to the comment on the differential between the GPCI values assigned to the Virgin Islands payment locality (as compared to the calculated GPCI values for the Puerto Rico payment locality), we note that when a locality has sufficient locality-specific data, we use those data to calculate GPCI values according to the established methodology. Given that there are sufficient locality-specific data for Puerto Rico, we calculated the GPCI values for the Puerto Rico payment locality based upon data from Puerto Rico.

As previously mentioned, we continue to believe that the BLS OES and ACS are reliable data sources for measuring the relative cost differences in wages and rents. In preparation for the CY 2014 GPCI update, we reviewed the study previously submitted by stakeholders entitled "Cost of Medical Services in Puerto Rico." The study aimed to analyze medical practice costs as well as physicians' perceptions of cost trends in Puerto Rico. Broadly, many of the study's findings are not directly relevant to the GPCIs because the study largely measured increases in the cost of practicing medicine in the Puerto Rico locality over time, but did not compare Puerto Rico cost trends to those across other PFS localities. We note that updates to the GPCIs are based upon changes in the relative costs of operating a medical practice among all PFS localities and not changes in the costs within a specific locality. Further, the survey methodology did not claim to be representative of all physicians furnishing services in the Puerto Rico payment locality. The physician responses do not appear to be weighted to represent the population of physicians across the Puerto Rico payment locality.

Moreover, the study claimed (as did many of the commenters) that shipping and transportation expenses increase the cost of medical equipment and supplies in Puerto Rico relative to the U.S. mainland. In developing the proposed CY 2014 GPCI update, we evaluated the premise that Puerto Rico physicians incur higher shipping costs when purchasing medical equipment and supplies that should be reflected in the GPCIs. At our request, our contractor attempted to locate data sources specific to geographic variation in shipping costs for medical equipment and supplies. However, there does not appear to be a comprehensive national data source available. In light of the comment that shipping costs are more expensive for the Puerto Rico payment locality (and rural areas, as discussed later in this section by other commenters) we are requesting specific information regarding potential data sources for shipping costs for medical equipment and supplies that are accessible to the public, available on a national basis for both urban and rural areas, and updated regularly.

Comment: One commenter asserted that residential rents are an inaccurate proxy for commercial (office) rents in Puerto Rico because the residential rental market is less developed in Puerto Rico as compared to the commercial rental market. The commenter noted that Puerto Rico's residential rental market is largely skewed towards the very low (and extremely low) end of the income scale. For example, the commenter stated that 30 percent of renters in Puerto Rico are subsidized by a HUD program, compared to a national average of about 12 percent. The commenter also mentioned that the ACS residential rent data (which are used to calculate the office rent index) includes utilities. The commenter stated that the cost of one utility, electricity, in Puerto Rico, is more than double the national average. However, the commenter believes the high cost of electricity and other utilities that physicians in Puerto Rico incur is not adequately captured in the ACS residential rental data, because nearly one third of all the renters in Puerto Rico receive utility allowances and therefore are not responsible for their utility costs.

Response: The ACS is designed to capture the total actual costs of both rent and utilities (i.e. gross rent) regardless of whether either or both are subsidized and regardless of whether utility costs are included in rent or paid separately. According to the American Community Survey and Puerto Rico Community Survey (PRCS) 2010 Subject Definitions: "Gross rent is the contract rent plus the estimated average monthly cost of utilities (electricity, gas, and water and sewer) and fuels (oils, coal, kerosene, wood, etc.) if these are paid by the renter (or paid for the renter by someone else)." (Page 17.) The rent portion of gross rent is "the monthly rent agreed to or contracted for, regardless of any furnishings, utilities, fees, meals, or services that may be included." (Page 15.) Contract rent data were obtained from Housing Question 15a of the 2010 American Community Survey and Puerto Rico Community Survey. Utility costs included in the rent payment were also captured in this question while utility costs paid separately from contract rent were obtained from a different set of questions in the survey. For instance, according to the American Community Survey and Puerto Rico Community Survey 2010 Subject Definitions: "The data on utility costs were obtained from Housing Questions 11a through 11d in the 2010 American Community Survey. The questions were asked of occupied housing units. The questions about electricity and gas asked for the monthly costs, and the questions about water/sewer and other fuels (oil, coal, wood,

kerosene, etc.) asked for the yearly costs. Costs are recorded if paid by or billed to occupants, *a welfare agency, relatives, or friends* [emphasis added]. Costs that are paid by landlords, included in the rent payment, or included in condominium or cooperative fees are excluded" (Page 37). Therefore, it is correct to say the ACS estimates of residential rent and utility costs account for subsidized utilities. The American Community Survey and Puerto Rico Community Survey 2010 Subject Definitions publication may be accessed from the Bureau of Census Web site at *http://www.census.gov/acs/www/Downloads/data_documentation/SubjectDefinitions/2010_ACSSubjectDefinitions.pdf.*

Comment: One commenter stated that "our region's office rental rates are, by GPCI measurement, supposedly only one-third of the highest (cost) regions" and that Medical Group Management Association (MGMA) survey data do not support these findings. The commenter requested that relative cost differences be accurately determined before making any adjustment to the PE GPCI.

Response: We do not believe the MGMA rental information on physician office rent is an adequate source for calculating the office rent index component of the PE GPCI for the following reasons. First, although MGMA invites about 11,000 medical practices to complete each of the two surveys it conducts (cost survey and compensation survey), the response rates for these surveys are typically below 20 percent and responses primarily capture information for physician practices operating in metropolitan areas. Second, in addition to the low response rates, MGMA has uneven response rates across regions due to the fact that MGMA relies on a convenience sample rather than a random sample. For example, almost twice as many Colorado practices completed the surveys compared to those in California; the survey also includes more provider responses from Minnesota (ranked 21st in population) than any other state. Finally, there are few observations for many small states; in fact, ten states have fewer than 10 observations each.

For the reasons discussed above, we do not believe the MGMA survey is a viable data source for determining the relative cost differences in rents across PFS localities. As discussed previously in this section, given its national representation, reliability, high response rate and frequent updates we continue to believe that the ACS residential rent data is the most appropriate data source available at this time for purposes of calculating the rent index of the PE GPCI.

Comment: We received mixed comments regarding the potential use of a proprietary commercial rent data source for purposes of calculating the rent index of the PE GPCI. For instance, a few commenters stated that we should continue to explore the possibility of using a commercial rent data source (but did not comment specifically on the potential use of proprietary data). One medical association stated that it would be helpful if we could "elucidate how incorporating the commercial rent data would impact the practice expense GPCI and payment rates in each Medicare payment locality." In contrast, three other commenters did not support the use of a proprietary commercial rent data source and urged us to continue using publicly available data. One association suggested that we "should use the most accurate publicly available datasets to set the GPCI adjustments . . . because . . . it is important for the public to have an opportunity to comment on proposed changes, and they need access to information to provide meaningful comments." Another commenter stated that there is not a more reliable source of data for calculating physician office rents (than the ACS residential rent data) and that the ACS data serve as a reasonable proxy for the relative differences in rents across PFS localities. The same commenter expressed concern about the cost to the public of purchasing proprietary data and suggested that a commercial rent data source might be used to validate relative cost differences calculated from the ACS data (but not replace the ACS data).

Response: We appreciate the comments received on the potential use of a proprietary commercial rent data source. In the event we make a specific proposal to incorporate a commercial rent data source (either proprietary or publicly available) for calculating the office rent index of the PE GPCI, we would provide locality level impacts of such proposal and the opportunity for public comment as afforded through the rulemaking process.

Comment: A few commenters supported the continuation of the 1.0 PE GPCI floor for frontier states.

Response: The 1.0 PE GPCI floor will continue to be applied for states identified as "frontier states" in accordance with 1848(e)(1)(I) of the Act.

Comment: Two commenters stated that many rural areas that do not fall within the statutory definition of a frontier state also face challenges associated with patient access to "physician-furnished services." The commenters stated that, even if the 1.0 work GPCI floor is extended, the updates to the PE GPCIs disadvantage rural providers, most notably in the provision of drugs and biologicals administered in a physician's office. The commenters assert that rural practices have "low purchasing power" (because of lower patient volumes) and higher shipping costs (in comparison to urban areas). The same commenters urged us to take into account the "unique challenges faced by rural physicians in non-designated frontier states" and to fully recognize the significant costs of providing health care in rural communities when updating the GPCIs.

Response: We appreciate the comments received on the PE GPCI for rural areas. As discussed previously in this section, we are required to update the GPCIs at least every 3 years to reflect the relative cost differences of operating a medical practice in each locality compared to the national average costs. We do not have authority to apply the 1.0 PE GPCI floor to states that do not meet the statutory definition of a frontier state. As discussed above in response to another commenter, we are requesting specific information regarding potential data sources for shipping costs for medical equipment and supplies—especially sources that are publicly available, collect data nationally with sufficient coverage in both urban and rural areas, and are updated at regular intervals.

Comment: Several state medical associations strongly opposed the proposed revised 2006-based MEI that moved compensation for nonphysician practitioners from the practice expense category to the physician compensation category, and the implications of that proposed change for the GPCIs. Because of those concerns, the commenters strongly objected to our proposal to update the GPCI cost share weights to make them consistent with the most recent update to the MEI. Additionally, the commenters expressed concern that the proposed changes in cost share weights used in calculating updated GPCIs would alone cause significant changes in CY 2014 PFS payment amounts.

Response: As discussed in section II.B. revisions to the MEI are used to adjust the RVUs under the PFS so that the work RVUs and PE RVUs (in the aggregate) are in the same proportions as in the MEI. We also make the necessary adjustments to achieve budget neutrality for the year under the PFS. A discussion of how our adoption of the proposed MEI cost weight revisions affects the

adjustment of work RVUs and PE RVUs is provided in section II.B. of this final rule with comment period.

With regard to the GPCIs, as noted in section II.F.2.d., we historically have updated the GPCI cost share weights (and more generally, as noted above, the RVUs under the PFS) to make them consistent with the most recent update to the MEI because the MEI cost share weights reflect our actuaries' best estimate of the weights associated with each of the various inputs needed to provide physician services. Use of the revised MEI weights for purposes of the GPCIs does not represent a change to the data sources or methodology used to calculate the GPCIs. For purposes of calculating GPCI values, the revised MEI weights only result in changes to the relative weighting within the PE GPCI (because there are no subcomponent cost share weights for the work GPCI or malpractice GPCI). Since the MEI weight only changed for the employee compensation subcomponent (for instance, the MEI weights for office rent, purchased services and equipment and supplies remained unchanged), the revised MEI affected the relative weight of all PE subcomponents (as a percentage of total PE GPCI). In other words, using the revised MEI cost share weights results in a lower weight for the employee compensation component as a percentage of the total PE GPCI and higher weights for office rents, purchased services, and medical equipment and supplies as a percentage of the total PE GPCI. Use of the revised MEI cost share weights has no implications for calculating the work GPCI values or malpractice GPCI values. Thus, we believe the comments on our proposal to adopt the revised 2006-based MEI weights predominately reflect concerns about the impact of the revised weights in terms of RVU redistribution and conversion factor adjustment, which is discussed in section II.B.2.f., rather than on their use in the calculation of GPCI values. An analysis isolating the impact of the changes in the subcomponent weighting of the PE GPCIs is available on the CMS Web site under the supporting documents section of the CY 2014 PFS final rule Web page at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html.*

We note that the MEI cost share weights are also used to calculate a geographic adjustment factor (GAF) for each PFS locality, weighting each locality's GPCIs (work, PE, and MP) by the corresponding national MEI cost share weight. However, as mentioned previously, we calculate the GAFs for purposes of comparing the approximate aggregate geographic payment adjustments among localities. The GAF is not used to calculate the geographically adjusted payment amount for individual services. Rather, the geographically adjusted payment amount is calculated by applying the actual GPCI values (for work, PE and malpractice) for the particular PFS locality to adjust the RVUs (for work, PE and MP) for a specific service.

Comment: A few national medical associations requested that CMS respond to the Institute of Medicine's "Recommendation 3" as contained in its Phase II report. The commenters noted that the Institute of Medicine recommended that the Medicare program should support policies that would allow all qualified practitioners to practice to the full extent of their educational preparation. The commenters believe "that there are numerous barriers in Medicare regulations, procedures, and instructions that prevent nurse practitioners and other health care providers from performing the full range of services they are educated and clinically prepared to deliver." However, the commenter did not provide specific examples as part of their submitted comments on the CY 2014 PFS proposed rule. Moreover, the commenter urged us to develop proposals to revise Medicare regulations and policies to address the need for primary care, including women's health and pediatric services, in underserved areas.

Response: The Institute of Medicine's Phase II report summary analysis indicates: "There are many inconsistencies in state laws regarding scope of practice and many NPs are more likely to locate in rural areas in states with more progressive, less restrictive regulations." Additionally, the Institute of Medicine recommended that "given the shortage of primary care providers in the United States and specifically in rural areas, the committee agrees that it would be reasonable to remove barriers in Medicare and state licensing language so all qualified practitioners are able to practice to the full extent of their educational preparation in providing needed services for Medicare beneficiaries" (Page 10). We did not include any proposals based on this Institute of Medicine recommendation in the CY 2014 PFS proposed rule. Therefore, we believe the comments relating to this recommendation are beyond the scope of the CY 2014 PFS proposed rule.

Comment: We received several comments on the PFS locality structure that were not within the scope of the CY 2014 proposed rule. For example, several commenters requested a locality change for a specific county. Another commenter requested that we consider the operational impact of a locality reconfiguration on the provider community, including non-physician practitioners, before making changes to the PFS locality structure. Two state medical associations emphasized the need to reform PFS localities, preferring an MSA-based approach. One national association was opposed to locality changes resulting in payment reductions to rural areas and a rural physician clinic recommended that we do not make any changes to the PFS locality structure because increasing the number of localities would lower payments to rural physicians.

Response: We appreciate the suggestions for making revisions to the PFS locality structure. As discussed above, we did not propose changes to the PFS locality structure.

Result of Evaluation of Comments

After consideration of the public comments received on the CY 2014 GPCI update, we are finalizing the CY 2014 GPCI update as proposed. Specifically, we are using updated BLS OES data (2009 through 2011) as a replacement for 2006 through 2008 data for purposes of calculating the work GPCI and the employee compensation component and purchased services component of the PE GPCI. We are also using updated ACS data (2008 through 2010) as a replacement for 2006 through 2008 data for calculating the office rent component of the PE GPCI, and updated malpractice premium data (2011 and 2012) as a replacement for 2006 through 2007 data to calculate the MP GPCI. We also note that we do not adjust the medical equipment, supplies and other miscellaneous expenses component of the PE GPCI because we continue to believe there is a national market for these items such that there is not a significant geographic variation in costs. However, in light of comments suggesting that there are geographic differences in shipping costs for medical equipment and supplies, we are requesting specific information regarding potential data sources for these shipping costs—especially sources that are publicly available, nationally representative with sufficient coverage in both urban and rural areas, and updated at regular intervals. Additionally, we are finalizing our proposal to update the GPCI cost share weights consistent with the revised

2006-based MEI cost share weights finalized in section II.D. of this final rule with comment period. As discussed above in response to comments, use of the revised GPCI cost share weights changed the weighting of the subcomponents within the PE GPCI (employee wages, office rent, purchased services, and medical equipment and supplies).

The CY 2014 updated GPCIs and summarized GAFs by Medicare PFS locality may be found in Addenda D and E to the CY 2014 final rule available on the CMS Web site under the supporting documents section of the CY 2014 proposed rule Web page at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html.*

Additional information on the CY 2014 GPCI update may be found in our contractor's report, "*Report on the CY 2014 Update of the Geographic Practice Cost Index for the Medicare Physician Fee Schedule,*" which is available on the CMS Web site. It is located under the supporting documents section of the CY 2014 PFS final rule with comment period located at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html.*

G. Allowed Expenditures for Physicians' Services and the Sustainable Growth Rate

1. Medicare Sustainable Growth Rate (SGR)

The SGR is an annual growth rate that applies to physicians' services paid by Medicare. The use of the SGR is intended to control growth in aggregate Medicare expenditures for physicians' services. Payments for services are not withheld if the percentage increase in actual expenditures exceeds the SGR. Rather, the PFS update, as specified in section 1848(d)(4) of the Act, is adjusted based on a comparison of allowed expenditures (determined using the SGR) and actual expenditures. If actual expenditures exceed allowed expenditures, the update is reduced. If actual expenditures are less than allowed expenditures, the update is increased.

Section 1848(f)(2) of the Act specifies that the SGR for a year (beginning with CY 2001) is equal to the product of the following four factors:

(1) The estimated change in fees for physicians' services;

(2) The estimated change in the average number of Medicare fee-for-service beneficiaries;

(3) The estimated projected growth in real Gross Domestic Product per capita; and

(4) The estimated change in expenditures due to changes in statute or regulations.

In general, section 1848(f)(3) of the Act requires us to determine the SGRs for 3 different time periods], using the best data available as of September 1 of each year. Under section 1848(f)(3) of the Act, (beginning with the FY and CY 2000 SGRs) the SGR is estimated and subsequently revised twice based on later data. (The Act also provides for adjustments to be made to the SGRs for FY 1998 and FY 1999. See the February 28, 2003 **Federal Register** (68 FR 9567) for a discussion of these SGRs). Under section 1848(f)(3)(C)(ii) of the Act, there are no further revisions to the SGR once it has been estimated and subsequently revised in each of the 2 years following the preliminary estimate. In this final rule with comment, we are making our preliminary estimate of the CY 2014 SGR, a revision to the CY 2013 SGR, and our final revision to the CY 2012 SGR.

a. Physicians' Services

Section 1848(f)(4)(A) of the Act defines the scope of physicians' services covered by the SGR. The statute indicates that "the term 'physicians' services' includes other items and services (such as clinical diagnostic laboratory tests and radiology services), specified by the Secretary, that are commonly performed or furnished by a physician or in a physician's office, but does not include services furnished to a Medicare+Choice plan enrollee."

We published a definition of physicians' services for use in the SGR in the November 1, 2001 **Federal Register** (66 FR 55316). We defined physicians' services to include many of the medical and other health services listed in section 1861(s) of the Act. Since that time, the statute has been amended to add new Medicare benefits. As the statute changed, we modified the definition of physicians' services for the SGR to include the additional benefits added to the statute that meet the criteria specified in section 1848(f)(4)(A).

As discussed in the CY 2010 PFS final rule with comment period (74 FR 61961), the statute provides the Secretary with clear discretion to decide whether physician-administered drugs should be included or excluded from the definition of "physicians' services." Exercising this discretion, we removed physician-administered drugs from the definition of physicians' services in section 1848(f)(4)(A) of the Act for purposes of computing the SGR and the levels of allowed expenditures and actual expenditures beginning with CY 2010, and for all subsequent years. Furthermore, in order to effectuate fully the Secretary's policy decision to remove drugs from the definition of physicians' services, we removed physician-administered drugs from the calculation of allowed and actual expenditures for all prior years.

Thus, for purposes of determining allowed expenditures, actual expenditures for all years, and SGRs beginning with CY 2010 and for all subsequent years, we specified that physicians' services include the following medical and other health services if bills for the items and services are processed and paid by Medicare carriers (and those paid through intermediaries where specified) or the equivalent services processed by the Medicare Administrative Contractors:

- Physicians' services.
- Services and supplies furnished incident to physicians' services, except for the expenditures for "drugs and biologicals which are not usually self-administered by the patient."
- Outpatient physical therapy services and outpatient occupational therapy services,
- Services of PAs, certified registered nurse anesthetists, certified nurse midwives, clinical psychologists, clinical social workers, nurse practitioners, and certified nurse specialists.
- Screening tests for prostate cancer, colorectal cancer, and glaucoma.
- Screening mammography, screening pap smears, and screening pelvic exams.
- Diabetes outpatient self-management training (DSMT) services.
- Medical Nutrition Therapy (MNT) services.
- Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests (including outpatient diagnostic laboratory tests paid through intermediaries).
- X-ray, radium, and radioactive isotope therapy.
- Surgical dressings, splints, casts, and other devices used for the reduction of fractures and dislocations.
- Bone mass measurements.
- An initial preventive physical exam.
- Cardiovascular screening blood tests.
- Diabetes screening tests.
- Telehealth services.
- Physician work and resources to establish and document the need for a power mobility device.
- Additional preventive services.

- Pulmonary rehabilitation.
- Cardiac rehabilitation.
- Intensive cardiac rehabilitation.
- Kidney disease education (KDE) services.
- Personalized prevention plan services

b. Preliminary Estimate of the SGR for 2014

Our preliminary estimate of the CY 2014 SGR is −16.7 percent. We first estimated the CY 2014 SGR in March 2013, and we made the estimate available to the MedPAC and on our Web site. Table 33 shows the March 2013 estimate and our current estimates of the factors included in the 2014 SGR. The majority of the difference between the March estimate and our current estimate of the CY 2014 SGR is explained by changes in estimated enrollment after our March estimate was prepared. Estimates of 2014 real per capita GDP are also higher than were included in our March 2013 estimate of the SGR.

TABLE 33—CY 2014 SGR CALCULATION

Statutory factors	March estimate	Current estimate
Fees	0.5 percent (1.005)	0.6 percent (1.006).
Enrollment	4.5 percent (1.045)	2.2 percent (1.022).
Real per Capita GDP	0.6 percent (1.006)	0.8 percent (1.008).
Law and Regulation	−19.7 percent (0.803)	−19.6 percent (0.804).
Total	−15.2 percent (0.848)	−16.7 percent (0.833).

Note: Consistent with section 1848(f)(2) of the Act, the statutory factors are multiplied, not added, to produce the total (that is, 1.006 x 1.022 x 1.008 x 0.804 = 0.833). A more detailed explanation of each figure is provided in section II.G.1.e. of this final rule with comment period.

c. Revised Sustainable Growth Rate for CY 2013

Our current estimate of the CY 2013 SGR is 1.8 percent. Table 34 shows our preliminary estimate of the CY 2013 SGR, which was published in the CY 2013 PFS final rule with comment period, and our current estimate. The majority of the difference between the preliminary estimate and our current estimate of the CY 2013 SGR is explained by adjustments to reflect intervening legislative changes that have occurred since publication of the CY 2013 final rule with comment period.

TABLE 34—CY 2013 SGR CALCULATION

Statutory factors	Estimate from CY 2013 final rule	Current estimate
Fees	0.3 percent (1.003)	0.4 Percent (1.004).
Enrollment	3.6 percent (1.036)	1.0 Percent (1.01).
Real per Capita GDP	0.7 percent (1.007)	0.9 Percent (1.009).
Law and Regulation	−23.3 percent (0.767)	−0.5 Percent (0.995).
Total	−19.7 percent (0.803)	1.8 Percent (1.018).

Note: Consistent with section 1848(f)(2) of the Act, the statutory factors are multiplied, not added, to produce the total (that is, 1.004 x 1.01 x 1.009 x 0.995 = 1.018). A more detailed explanation of each figure is provided in section II.G.1.e. of this final rule with comment period.

d. Final Sustainable Growth Rate for CY 2012

The SGR for CY 2012 is 5.1 percent. Table 35 shows our preliminary estimate of the CY 2012 SGR from the CY 2012 PFS final rule with comment period, our revised estimate from the CY 2013 PFS final rule with comment period, and the final figures determined using the best available data as of September 1, 2013.

TABLE 35—CY 2012 SGR CALCULATION

Statutory factors	Estimate from CY 2012 final rule	Estimate from CY 2013 final rule	Final
Fees	0.6 percent (1.006)	0.6 percent (1.006)	0.6 Percent (1.006).
Enrollment	3.5 percent (1.035)	1.6 percent (1.016)	0.9 Percent (1.009).
Real per Capita GDP	0.6 percent (1.006)	0.7 percent (1.007)	0.9 Percent (1.009).
Law and Regulation	−20.7 percent (0.793)	0.0 percent (1.000)	2.6 Percent (1.026).
Total	−16.9 percent (0.831)	2.3 percent (1.023)	5.1 Percent (1.051).

Note: Consistent with section 1848(f)(2) of the Act, the statutory factors are multiplied, not added, to produce the total (that is, 1.006 x 1.009 x 1.009 x 1.026 = 1.051). A more detailed explanation of each figure is provided in section II.G.1.e. of this final rule with comment period.

e. Calculation of CYs 2014, 2013, and 2012 SGRs

(1) Detail on the CY 2014 SGR

All of the figures used to determine the CY 2014 SGR are estimates that will be revised based on subsequent data. Any differences between these estimates and the actual measurement of these figures will be included in future revisions of the SGR and allowed expenditures and incorporated into subsequent PFS updates.

(a) Factor 1– Changes in Fees for Physicians' Services (Before Applying Legislative Adjustments) for CY 2014

This factor is calculated as a weighted average of the CY 2014 changes in fees for the different types of services included in the definition of physicians' services for the SGR. Medical and other health services paid using the PFS are estimated to account for approximately 87.7 percent of total allowed charges included in the SGR in CY 2014 and are updated using the percent change in the MEI. As discussed in section A of this final rule with comment period, the percent change in the MEI for CY 2014 is 0.8 percent. Diagnostic laboratory tests are estimated to represent approximately 12.3 percent of Medicare allowed charges included in the SGR for CY 2014. Medicare payments for these tests are updated by the Consumer Price Index for Urban Areas (CPI–U), which is 1.8 percent for CY 2014. Section 1833(h)(2)(A)(iv) of the Act requires that the CPI–U update applied to clinical laboratory tests be reduced by a multi-factor productivity adjustment (MFP adjustment) and, for each of years 2011 through 2015, by 1.75 percentage points (percentage adjustment). The MFP adjustment will not apply in a year where the CPI–U is zero or a percentage decrease for a year. Further, the application of the MFP adjustment shall not result in an adjustment to the fee schedule of less than zero for a year. However, the application of the percentage adjustment may result in an adjustment to the fee schedule being less than zero for a year and may result in payment rates for a year being less than such payment rates for the preceding year. The applicable productivity adjustment for CY 2014 is −0.8 percent. Adjusting the CPI–U update by the productivity adjustment results in a 1.0 percent (1.8 percent (CPI–U) minus 0.8 percent (MFP adjustment)) update for CY 2014. Additionally, the percentage reduction of 1.75 percent is applied for CYs 2011 through 2015, as discussed previously. Therefore, for CY 2014, diagnostic laboratory tests will receive an update of −0.8 percent (rounded). Table 36 shows the weighted average of the MEI and laboratory price changes for CY 2014.

TABLE 36—WEIGHTED-AVERAGE OF THE MEI AND LABORATORY PRICE CHANGES FOR CY 2014

	Weight	Update (%)
Physician	0.877	0.8
Laboratory	0.123	−0.8
Weighted-average	1.000	0.6

We estimate that the weighted average increase in fees for physicians' services in CY 2014 under the SGR (before applying any legislative adjustments) will be 0.6 percent.

(b) Factor 2—Percentage Change in the Average Number of Part B Enrollees From CY 2013 to CY 2014

This factor is our estimate of the percent change in the average number of fee-for-service enrollees from CY 2013 to CY 2014. Services provided to Medicare Advantage (MA) plan enrollees are outside the scope of the SGR and are excluded from this estimate. We estimate that the average number of Medicare Part B fee-for-service enrollees will increase by 2.2 percent from CY 2013 to CY 2014. Table 37 illustrates how this figure was determined.

TABLE 37—AVERAGE NUMBER OF MEDICARE PART B FEE-FOR-SERVICE ENROLLEES FROM CY 2013 TO CY 2014

[Excluding beneficiaries enrolled in MA plans]

	CY 2013	CY 2014
Overall	47.982 million	49.459 million.
Medicare Advantage (MA)	14.837 million	15.569 million.
Net	33.144 million	33.890 million.
Percent Increase	1 percent	2.2 percent.

An important factor affecting fee-for-service enrollment is beneficiary enrollment in MA plans. Because it is difficult to estimate the size of the MA enrollee population before the start of a CY, at this time we do not know how actual enrollment in MA plans will compare to current estimates. For this reason, the estimate may change substantially as actual Medicare fee-for-service enrollment for CY 2014 becomes known.

(c) Factor 3—Estimated Real Gross Domestic Product per Capita Growth in CY 2014

We estimate that the growth in real GDP per capita from CY 2013 to CY 2014 will be 0.8 percent (based on the annual growth in the 10 year moving average of real GDP per capita 2005 through 2014). Our past experience indicates that there have also been changes in estimates of real GDP per capita growth made before the year begins and the actual change in real GDP per capita growth computed after the year is complete. Thus, it is possible that this figure will change as actual information on economic performance becomes available to us in CY 2014.

(d) Factor 4—Percentage Change in Expenditures for Physicians' Services Resulting From Changes in Statute or Regulations in CY 2014 Compared With CY 2013

The statutory and regulatory provisions that will affect expenditures in CY 2014 relative to CY 2013 are estimated to have an impact on expenditures of −19.6 percent. The impact is primarily due to the expiration of the physician fee schedule update specified in statute for CY 2013 only.

(2) Detail on the CY 2013 SGR

A more detailed discussion of our revised estimates of the four elements of the CY 2013 SGR follows.

(a) Factor 1—Changes in Fees for Physicians' Services (Before Applying Legislative Adjustments) for CY 2013

This factor was calculated as a weighted-average of the CY 2013 changes in fees that apply for the different types of services included in the definition of physicians' services for the SGR in CY 2013.

We estimate that services paid using the PFS account for approximately 90.1 percent of total allowed charges included in the SGR in CY 2013. These services were updated using the CY 2013 percent change in the MEI of 0.8 percent. We estimate that diagnostic laboratory tests represent approximately 9.9 percent of total allowed charges

included in the SGR in CY 2013. For CY 2013, diagnostic laboratory tests received an update of −3.0 percent.

Table 38 shows the weighted-average of the MEI and laboratory price changes for CY 2013.

TABLE 38—WEIGHTED-AVERAGE OF THE MEI, AND LABORATORY PRICE CHANGES FOR CY 2013

	Weight	Update
Physician	0.901	0.8
Laboratory	0.099	−3.0
Weighted-average	1.000	0.4

After considering the elements described in Table 38, we estimate that the weighted-average increase in fees for physicians' services in CY 2013 under the SGR was 0.4 percent. Our estimate of this factor in the CY 2013 PFS final rule with comment period was 0.3 percent (77 FR 69133).

(b) Factor 2—Percentage Change in the Average Number of Part B Enrollees From CY 2012 to CY 2013

We estimate that the average number of Medicare Part B fee-for-service enrollees (excluding beneficiaries enrolled in Medicare Advantage plans) increased by 1.0 percent in CY 2013. Table 39 illustrates how we determined this figure.

TABLE 39—AVERAGE NUMBER OF MEDICARE PART B FEE-FOR-SERVICE ENROLLEES FROM CY 2012 TO CY 2013

[Excluding beneficiaries enrolled in MA plans]

	CY 2012	CY 2013
Overall	46.405 million	47.982 million.
Medicare Advantage (MA)	13.586 million	14.837 million.
Net	32.818 million	33.144 million.
Percent Increase	0.9 percent	1.0 percent.

Our estimate of the 1.0 percent change in the number of fee-for-service enrollees, net of Medicare Advantage enrollment for CY 2013 compared to CY 2012, is different than our original estimate of an increase of 3.6 percent in the CY 2013 PFS final rule with comment period (77 FR 69133). While our current projection based on data from 8 months of CY 2013 differs from our original estimate of 0.4 percent when we had no actual data, it is still possible that our final estimate of this figure will be different once we have complete information on CY 2013 fee-for-service enrollment.

(c) Factor 3—Estimated Real GDP per Capita Growth in CY 2013

We estimate that the growth in real GDP per capita will be 0.9 percent for CY 2013 (based on the annual growth in the 10-year moving average of real GDP per capita (2004 through 2013)). Our past experience indicates that there have also been differences between our estimates of real per capita GDP growth made prior to the year's end and the actual change in this factor. Thus, it is possible that this figure will change further as complete actual information on CY 2013 economic performance becomes available to us in CY 2014.

(d) Factor 4—Percentage Change in Expenditures for Physicians' Services Resulting From Changes in Statute or Regulations in CY 2013 Compared With CY 2012

The statutory and regulatory provisions that affected expenditures in CY 2013 relative to CY 2012 are estimated to have an impact on expenditures of −0.5 percent. This impact is primarily due to the expiration of the PFS update specified in statute for CY 2013 only.

(3) Detail on the CY 2012 SGR

A more detailed discussion of our final revised estimates of the four elements of the CY 2012 SGR follows.

(a) Factor 1—Changes in Fees for Physicians' Services for CY 2012

This factor was calculated as a weighted average of the CY 2012 changes in fees that apply for the different types of services included in the definition of physicians' services for the SGR in CY 2012.

We estimate that services paid under the PFS account for approximately 90 percent of total allowed charges included in the SGR in CY 2012. These services were updated using the CY 2012 percent change in the MEI of 0.6 percent. We estimate that diagnostic laboratory tests represent approximately 10 percent of total allowed charges included in the SGR in CY 2012. For CY 2012, diagnostic laboratory tests received an update of 0.7 percent.

Table 40 shows the weighted-average of the MEI and laboratory price changes for CY 2012.

TABLE 40—WEIGHTED-AVERAGE OF THE MEI, LABORATORY, AND DRUG PRICE CHANGES FOR 2012

	Weight	Update
Physician	0.900	0.6
Laboratory	0.100	0.7
Weighted-average	1.00	0.6

After considering the elements described in Table 40, we estimate that the weighted-average increase in fees for physicians' services in CY 2012 under the SGR (before applying any legislative adjustments) was 0.6 percent. This figure is a final one based on complete data for CY 2012.

(b) Factor 2—Percentage Change in the Average Number of Part B Enrollees From CY 2011 to CY 2012

We estimate the change in the number of fee-for-service enrollees (excluding beneficiaries enrolled in MA plans) from CY 2011 to CY 2012 was 0.9 percent. Our calculation of this factor is based on complete data from CY 2012. Table 41 illustrates the calculation of this factor.

TABLE 41—AVERAGE NUMBER OF MEDICARE PART B FEE-FOR-SERVICE ENROLLEES FROM CY 2011 TO CY 2012

[Excluding beneficiaries enrolled in MA Plans]

	CY 2011	CY 2012
Overall	44.906	46.405
Medicare Advantage (MA)	12.382	13.586
Net	32.524	32.818

TABLE 41—AVERAGE NUMBER OF MEDICARE PART B FEE-FOR-SERVICE ENROLLEES FROM CY 2011 TO CY 2012—Continued

[Excluding beneficiaries enrolled in MA Plans]

	CY 2011	CY 2012
Percent Change		0.9%

(c) Factor 3—Estimated Real GDP per Capita Growth in CY 2012

We estimate that the growth in real per capita GDP was 0.9 percent in CY 2012 (based on the annual growth in the 10-year moving average of real GDP per capita (2003 through 2012)). This figure is a final one based on complete data for CY 2012.

(d) Factor 4—Percentage Change in Expenditures for Physicians' Services Resulting From Changes in Statute or Regulations in CY 2012 Compared With CY 2011

Our final estimate for the net impact on expenditures from the statutory and regulatory provisions that affect expenditures in CY 2012 relative to CY 2011 is 2.6 percent. This is primarily an effect of the statutory requirements surrounding the temporary physician fee schedule update in CY 2012.

2. The Update Adjustment Factor (UAF)

Section 1848(d) of the Act provides that the PFS update is equal to the product of the MEI and the UAF. The UAF is applied to make actual and target expenditures (referred to in the statute as "allowed expenditures") equal. As discussed previously, allowed expenditures are equal to actual expenditures in a base period updated each year by the SGR. The SGR sets the annual rate of growth in allowed expenditures and is determined by a formula specified in section 1848(f) of the Act.

The calculation of the UAF is not affected by sequestration. Pursuant to 2 U.S.C. 906(d)(6), "The Secretary of Health and Human Services shall not take into account any reductions in payment amounts which have been or may be effected under [sequestration], for purposes of computing any adjustments to payment rates under such title XVIII". Therefore, allowed charges, which are unaffected by sequestration, were used to calculate physician expenditures in lieu of Medicare payments plus beneficiary cost-sharing. As a result, neither actual expenditures or allowed expenditures were adjusted to reflect the impact of sequestration.

a. Calculation Under Current Law

Under section 1848(d)(4)(B) of the Act, the UAF for a year beginning with CY 2001 is equal to the sum of the following—

• *Prior Year Adjustment Component.* An amount determined by—

++ Computing the difference (which may be positive or negative) between the amount of the allowed expenditures for physicians' services for the prior year (the year prior to the year for which the update is being determined) and the amount of the actual expenditures for those services for that year;

++ Dividing that difference by the amount of the actual expenditures for those services for that year; and

++ Multiplying that quotient by 0.75.

• *Cumulative Adjustment Component.* An amount determined by—

++ Computing the difference (which may be positive or negative) between the amount of the allowed expenditures for physicians' services from April 1, 1996, through the end of the prior year and the amount of the actual expenditures for those services during that period;

++ Dividing that difference by actual expenditures for those services for the prior year as increased by the SGR for the year for which the UAF is to be determined; and

++ Multiplying that quotient by 0.33.

Section 1848(d)(4)(E) of the Act requires the Secretary to recalculate allowed expenditures consistent with section 1848(f)(3) of the Act. As discussed previously, section 1848(f)(3) specifies that the SGR (and, in turn, allowed expenditures) for the upcoming CY (CY 2014 in this case), the current CY (that is, CY 2013) and the preceding CY (that is, CY 2012) are to be determined on the basis of the best data available as of September 1 of the current year. Allowed expenditures for a year generally are estimated initially and subsequently revised twice. The second revision occurs after the CY has ended (that is, we are making the second revision to CY 2012 allowed expenditures in this final rule with comment).

Table 42 shows the historical SGRs corresponding to each period through CY 2014.

TABLE 42—ANNUAL AND CUMULATIVE ALLOWED AND ACTUAL EXPENDITURES FOR PHYSICIANS' SERVICES FROM APRIL 1, 1996 THROUGH THE END OF THE UPCOMING CALENDAR YEAR

Period	Annual allowed expenditures ($ in billions)	Annual actual expenditures ($ in billions)	Cumulative allowed expenditures ($ in billions)	Cumulative actual expenditures ($ in billions)	FY/CY SGR
4/1/96–3/31/97	47.0	47.0	47.0	47.0	
4/1/97–3/31/98	48.5	47.2	95.6	94.3	3.2
4/1/98–3/31/99	50.6	48.1	146.2	142.4	4.2
1/1/99–3/31/99	12.7	12.5	146.2	142.4	
4/1/99–12/31/99	40.5	37.2	186.7	179.6	6.9
1/1/99–12/31/99	53.2	49.7	186.7	179.6	
1/1/00–12/31/00	57.1	54.4	243.7	234.0	7.3
1/1/01–12/31/01	59.7	61.5	303.4	295.5	4.5
1/1/02–12/31/02	64.6	64.8	368.0	360.3	8.3
1/1/03–12/31/03	69.3	70.4	437.3	430.7	7.3
1/1/04–12/31/04	73.9	78.5	511.2	509.1	6.6
1/1/05–12/31/05	77.0	83.8	588.2	593.0	4.2
1/1/06–12/31/06	78.2	85.1	666.4	678.1	1.5
1/1/07–12/31/07	80.9	85.1	747.2	763.1	3.5
1/1/08–12/31/08	84.5	87.3	831.8	850.4	4.5
1/1/09–12/31/09	89.9	91.1	921.7	941.5	6.4
1/1/10–12/31/10	97.9	96	1,019.60	1,037.40	8.9
1/1/11–12/31/11	102.5	99.6	1,122.20	1,137.10	4.7
1/1/12–12/31/12	107.8	99.5	1,230.00	1,236.60	5.1

TABLE 42—ANNUAL AND CUMULATIVE ALLOWED AND ACTUAL EXPENDITURES FOR PHYSICIANS' SERVICES FROM APRIL 1, 1996 THROUGH THE END OF THE UPCOMING CALENDAR YEAR—Continued

Period	Annual allowed expenditures ($ in billions)	Annual actual expenditures ($ in billions)	Cumulative allowed expenditures ($ in billions)	Cumulative actual expenditures ($ in billions)	FY/CY SGR
1/1/13–12/31/13	109.7	102.2	1,339.70	1,338.80	1.8
1/1/14–12/31/14	91.4	N/A	1,431.10	N/A	−16.7

[1] Allowed expenditures in the first year (April 1, 1996–March 31, 1997) are equal to actual expenditures. All subsequent figures are equal to quarterly allowed expenditure figures increased by the applicable SGR. Cumulative allowed expenditures are equal to the sum of annual allowed expenditures. We provide more detailed quarterly allowed and actual expenditure data on our Web site at the following address: *http://www.cms.hhs.gov/SustainableGRatesConFact/*. We expect to update the Web site with the most current information later this month.

[2] Allowed expenditures for the first quarter of 1999 are based on the FY 1999 SGR.

[3] Allowed expenditures for the last three quarters of 1999 are based on the FY 2000 SGR.

Consistent with section 1848(d)(4)(E) of the Act, Table 42 includes our second revision of allowed expenditures for CY 2012, a recalculation of allowed expenditures for CY 2013, and our initial estimate of allowed expenditures for CY 2014. To determine the UAF for CY 2014, the statute requires that we use allowed and actual expenditures from April 1, 1996 through December 31, 2013 and the CY 2014 SGR. Consistent with section 1848(d)(4)(E) of the Act, we will be making revisions to the CY 2013 and CY 2014 SGRs and CY 2013 and CY 2014 allowed expenditures. Because we have incomplete actual expenditure data for CY 2013, we are using an estimate for this period. Any difference between current estimates and final figures will be taken into account in determining the UAF for future years.

We are using figures from Table 42 in the following statutory formula:

$$UAF_{14} = \frac{Target_{13} - Actual_{13}}{Actual_{13}} \times 0.75 + \frac{Target_{4/96-12/13} - Actual_{4/96-12/13}}{Actual_{13} \times SGR_{14}} \times 0.33$$

UAF_{14} = Update Adjustment Factor for CY 2014 = 3.0 percent

$Target_{13}$ = Allowed Expenditures for CY 2013 = $109.7 billion

$Actual_{13}$ = Estimated Actual Expenditures for CY 2013 = $102.2 billion

$Target_{4/96-12/13}$ = Allowed Expenditures from 4/1/1996–12/31/2013 = $1,339.70 billion

$Actual_{4/96-12/13}$ = Estimated Actual Expenditures from 4/1/1996–12/31/2013 = $1,338.80 billion

SGR_{14} = −16.7 percent (0.833)

$$\frac{\$109.7 - \$102.2}{\$102.2} \times 0.75 + \frac{\$1339.70 - \$1338.80}{\$102.2 \times .833} \times 0.33 = 5.9\%$$

Section 1848(d)(4)(D) of the Act indicates that the UAF determined under section 1848(d)(4)(B) of the Act for a year may not be less than −0.07 or greater than 0.03. Since 0.059 (5.9 percent) is greater than 0.03, the UAF for CY 2014 will be 3 percent.

Section 1848(d)(4)(A)(ii) of the Act indicates that 1.0 should be added to the UAF determined under section 1848(d)(4)(B) of the Act. Thus, adding 1.0 to 0.03 makes the UAF equal to 1.03.

3. Percentage Change in the MEI for CY 2014

MEI is required by section 1842(b)(3) of the Act, which states that prevailing charge levels beginning after June 30, 1973 may not exceed the level from the previous year except to the extent that the Secretary finds, on the basis of appropriate economic index data, that the higher level is justified by year-to-year economic changes. The current form of the MEI was detailed in the CY 2010 PFS final rule (75 FR 73262), which updated the cost structure of the index from a base year of 2000 to 2006. Additional updates to the MEI are discussed in section II.D of this final rule with comment period.

The MEI measures the weighted-average annual price change for various inputs needed to produce physicians' services. The MEI is a fixed-weight input price index, with an adjustment for the change in economy-wide multifactor productivity. This index, which has CY 2006 base year weights, is comprised of two broad categories: (1) Physician's own time; and (2) physician's practice expense (PE).

The physician's compensation (own time) component represents the net income portion of business receipts and primarily reflects the input of the physician's own time into the production of physicians' services in physicians' offices. This category consists of two subcomponents: (1) Wages and salaries; and (2) fringe benefits.

The physician's practice expense (PE) category represents nonphysician inputs used in the production of services in physicians' offices. This category consists of wages and salaries and fringe benefits for nonphysician staff (who cannot bill independently) and other nonlabor inputs. The physician's PE component also includes the following categories of nonlabor inputs: Office expenses; medical materials and supplies; professional liability insurance; medical equipment; medical materials and supplies; and other professional expenses.

Table 43 lists the MEI cost categories with associated weights and percent changes for price proxies for the CY 2014 update. The CY 2014 final MEI update is 0.8 percent and reflects a 1.9 percent increase in physician's own time and a 1.4 percent increase in physician's PE. Within the physician's PE, the largest increase occurred in postage, which increased 4.9 percent.

For CY 2014, the increase in the MEI is 0.8 percent, which reflects an increase in the non-productivity adjusted MEI of 1.7 percent and a productivity adjustment of 0.9 percent (which is based on the 10-year moving average of economy-wide private nonfarm business

multifactor productivity). The BLS is the agency that publishes the official measure of private non-farm business MFP. Please see *http://www.bls.gov/mfp*, which is the link to the BLS historical published data on the measure of MFP.

TABLE 43—INCREASE IN THE MEDICARE ECONOMIC INDEX UPDATE FOR CY 2014 [1]

Revised cost category	2006 revised cost weight [2] (percent)	CY14 Update (percent)
MEI Total, productivity adjusted	100.000	0.8
Productivity: 10-year moving average of MFP [1]	[5] N/A	0.9
MEI Total, without productivity adjustment	100.000	1.7
Physician Compensation [3]	50.866	1.9
Wages and Salaries	43.641	1.9
Benefits	7.225	2.2
Practice Expense	49.134	1.4
Non-physician compensation	16.553	1.7
Non-physician wages	11.885	1.7
Non-health, non-physician wages	7.249	1.8
Professional & Related	0.800	1.9
Management	1.529	1.8
Clerical	4.720	1.8
Services	0.200	1.5
Health related, non-physician wages	4.636	1.4
Non-physician benefits	4.668	1.9
Other Practice Expense	32.581	1.2
Utilities	1.266	0.7
Miscellaneous Office Expenses	2.478	0.3
Chemicals	0.723	−1.2
Paper	0.656	1.1
Rubber & Plastics	0.598	0.5
All other products	0.500	1.9
Telephone	1.501	0.0
Postage	0.898	4.9
All Other Professional Services	8.095	1.8
Professional, Scientific, and Tech. Services	2.592	1.7
Administrative and support & waste	3.052	1.9
All Other Services	2.451	1.6
Capital	10.310	0.7
Fixed	8.957	0.7
Moveable	1.353	0.7
Professional Liability Insurance [4]	4.295	1.5
Medical Equipment	1.978	1.2
Medical supplies	1.760	1.0

[1] The forecasts are based upon the latest available Bureau of Labor Statistics data on the 10-year average of BLS private nonfarm business multifactor productivity published on June 28, 2013. (*http://www.bls.gov/news.release/prod3.nr0.htm.*)

[2] The weights shown for the MEI components are the 2006 base-year weights, which may not sum to subtotals or totals because of rounding. The MEI is a fixed-weight, Laspeyres-type input price index whose category weights indicate the distribution of expenditures among the inputs to physicians' services for CY 2006. To determine the MEI level for a given year, the price proxy level for each component is multiplied by its 2006 weight. The sum of these products (weights multiplied by the price index levels) overall cost categories yields the composite MEI level for a given year. The annual percent change in the MEI levels is an estimate of price change over time for a fixed market basket of inputs to physicians' services.

[3] The measures of productivity, average hourly earnings, Employment Cost Indexes, as well as the various Producer and Consumer Price Indexes can be found on the Bureau of Labor Statistics Web site at *http://stats.bls.gov.*

[4] Derived from a CMS survey of several major commercial insurers.

[5] Productivity is factored into the MEI categories as an adjustment; therefore, no explicit weight exists for productivity in the MEI.

4. Physician and Anesthesia Fee Schedule Conversion Factors for CY 2014

The CY 2014 PFS CF is $27.2006. The CY 2014 national average anesthesia CF is $17.2283.

a. Physician Fee Schedule Update and Conversion Factor

(1) CY 2014 PFS Update

The formula for calculating the PFS update is set forth in section 1848(d)(4)(A) of the Act. In general, the PFS update is determined by multiplying the CF for the previous year by the percentage increase in the MEI less productivity times the UAF, which is calculated as specified under section 1848(d)(4)(B) of the Act.

(2) CY 2014 PFS Conversion Factor

Generally, the PFS CF for a year is calculated in accordance with section 1848(d)(1)(A) of the Act by multiplying the previous year's CF by the PFS update.

We note section 101 of the Medicare Improvements and Extension Act, Division B of the Tax Relief and Health Care Act of 2006 (MIEA–TRHCA) provided a 1-year increase in the CY 2007 CF and specified that the CF for CY 2008 must be computed as if the 1-year increase had never applied.

Section 101 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) provided a 6-month increase in the CY 2008 CF, from January 1, 2008, through June 30, 2008, and specified that the CF for the remaining portion of CY 2008 and the CFs for CY 2009 and subsequent years must be computed as if the 6-month increase had never applied.

Section 131 of the MIPPA extended the increase in the CY 2008 CF that applied during the first half of the year to the entire year, provided for a 1.1 percent increase to the CY 2009 CF, and specified that the CFs for CY 2010 and subsequent years must be computed as if the increases for CYs 2007, 2008, and 2009 had never applied.

Section 1011(a) of the DODAA and section 5 of the TEA specified a zero percent update for CY 2010, effective January 1, 2010 through March 31, 2010.

Section 4 of the Continuing Extension Act of 2010 (CEA) extended the zero percent update for CY 2010 through May 31, 2010.

Subsequently, section 101(a)(2) of the PACMBPRA provided for a 2.2 percent update to the CF, effective from June 1, 2010 to November 30, 2010.

Section 2 of the Physician Payment and Therapy Relief Act of 2010 (Pub. L. No. 111–286) extended the 2.2 percent through the end of CY 2010.

Section 101 of the MMEA provided a zero percent update for CY 2011, effective January 1, 2011 through December 31, 2011, and specified that the CFs for CY 2012 and subsequent years must be computed as if the increases in previous years had never applied.

Section 301 of the Temporary Payroll Tax Cut Continuation Act of 2011 (TPTCCA) provided a zero percent update effective January 1, 2012 through February 29, 2012, and specified that the CFs for subsequent time periods must be computed as if the increases in previous years had never applied.

Section 3003 of the Middle Class Tax Relief and Job Creation Act of 2012 (Job Creation Act) provided a zero percent update effective March 1, 2012 through December 31, 2012, and specified that the CFs for subsequent time periods must be computed as if the increases in previous years had never applied.

Section 601 of the American Taxpayer Relief Act (ATRA) of 2012 (Pub. L. 112–240) provided a zero percent update for CY 2013, effective January 1, 2013 through December 31, 2013, and specified that the CFs for subsequent time periods must be computed as if the increases in previous years had not been applied.

Therefore, under current law, the CF that would be in effect in CY 2013 had the prior increases specified above not applied is $25.0070.

In addition, when calculating the PFS CF for a year, section 1848(c)(2)(B)(ii)(II) of the Act requires that increases or decreases in RVUs may not cause the amount of expenditures for the year to differ more than $20 million from what it would have been in the absence of these changes. If this threshold is exceeded, we must make adjustments to preserve budget neutrality. We estimate that CY 2014 RVU changes would result in a decrease in Medicare physician expenditures of more than $20 million. Accordingly, we are increasing the CF by 0.046 percent to offset this estimated decrease in Medicare physician expenditures due to the CY 2014 RVU changes. Furthermore, as discussed in section A of this final rule with comment period, we are increasing the CF by 4.72 percent in order to offset the decrease in Medicare physician payments due to the CY 2014 rescaling of the RVUs so that the proportions of total payments for the work, PE, and malpractice RVUs match the proportions in the final revised MEI for CY 2014. Accordingly, we calculate the CY 2014 PFS CF to be $27.2006. This final rule with comment period announces a reduction to payment rates for physicians' services in CY 2014 under the SGR formula. These payment rates are currently scheduled to be reduced under the SGR system on January 1, 2014. The total reduction in the MPFS conversion factor between CY 2013 and CY 2014 under the SGR system will be 20.1 percent. By law, we are required to make these reductions in accordance with section 1848(d) and (f) of the Act, and these reductions can only be averted by an Act of Congress. While Congress has provided temporary relief from these reductions every year since 2003, a long-term solution is critical. We will continue to work with Congress to fix this untenable situation so doctors and beneficiaries no longer have to worry about the stability and adequacy of payments from Medicare under the Physician Fee Schedule.

We illustrate the calculation of the CY 2014 PFS CF in Table 44.

TABLE 44—CALCULATION OF THE CY 2014 PFS CF

Conversion Factor in effect in CY 2013		$34.0230
CY 2013 Conversion Factor had statutory increases not applied		$25.0070
CY 2014 Medicare Economic Index	0.8 percent (1.008)	
CY 2014 Update Adjustment Factor	3.0 percent (1.03)	
CY 2014 RVU Budget Neutrality Adjustment	0.046 percent (1.00046)	
CY 2014 Rescaling to Match MEI Weights Budget Neutrality Adjustment	4.718 percent (1.04718)	
CY 2014 Conversion Factor		$27.2006
Percent Change from Conversion Factor in effect in CY 2013 to CY 2014 Conversion Factor.		−20.1%

We note payment for services under the PFS will be calculated as follows:

Payment = [(Work RVU × Work GPCI) + (PE RVU × PE GPCI) + (Malpractice RVU × Malpractice GPCI)] × CF.

b. Anesthesia Conversion Factor

We calculate the anesthesia CF as indicated in Table 45. Anesthesia services do not have RVUs like other PFS services. Therefore, we account for any necessary RVU adjustments through an adjustment to the anesthesia CF to simulate changes to RVUs. More specifically, if there is an adjustment to the work, PE, or malpractice RVUs, these adjustments are applied to the respective shares of the anesthesia CF as these shares are proxies for the work, PE, and malpractice RVUs for anesthesia services. Information regarding the anesthesia work, PE, and malpractice shares can be found at the following: *https://www.cms.gov/center/anesth.asp.*

The anesthesia CF in effect in CY 2013 is $ 21.9243. As explained previously, in order to calculate the CY 2014 PFS CF, the statute requires us to calculate the CFs for all previous years as if the various legislative changes to the CFs for those years had not occurred. Accordingly, under current law, the anesthesia CF in effect in CY 2013 had statutory increases not applied is $16.1236. The percent change from the anesthesia CF in effect in CY 2013 to the CF for CY 2014 is −21.4 percent. We illustrate the calculation of the CY 2014 anesthesia CF in Table 45.

TABLE 45—CALCULATION OF THE CY 2014 ANESTHESIA CF

2013 National Average Anesthesia Conversion Factor in effect in CY 2013		$21.9243
2013 National Anesthesia Conversion Factor had Statutory Increases Not Applied		$16.1236
CY 2014 Medicare Economic Index	0.8 (1.008)	
CY 2014 Update Adjustment Factor	3.0 (1.003)	
CY 2014 Budget Neutrality Work and Malpractice Adjustment	0.046 (1.00046)	
CY 2014 Rescaling to Match MEI Weights Budget Neutrality Adjustment	4.718 percent (1.4718)	
CY 2014 Anesthesia Fee Schedule Practice Expense Adjustment	.9823 (.9823)	
CY 2014 Anesthesia Conversion Factor		$17.2283
Percent Change from 2013 to 2014		−21.4%

H. Medicare Telehealth Services for the Physician Fee Schedule

1. Billing and Payment for Telehealth Services

a. History

Prior to January 1, 1999, Medicare coverage for services delivered via a telecommunications system was limited to services that did not require a face-to-face encounter under the traditional model of medical care. Examples of these services included interpretation of an x-ray, electroencephalogram tracing, and cardiac pacemaker analysis.

Section 4206 of the BBA provided for coverage of, and payment for, consultation services delivered via a telecommunications system to Medicare beneficiaries residing in rural health professional shortage areas (HPSAs) as defined by the Public Health Service Act. Additionally, the BBA required that a Medicare practitioner (telepresenter) be with the patient at the time of a teleconsultation. Further, the BBA specified that payment for a teleconsultation had to be shared between the consulting practitioner and the referring practitioner and could not exceed the fee schedule payment that would have been made to the consultant for the service furnished. The BBA prohibited payment for any telephone line charges or facility fees associated with the teleconsultation. We implemented this provision in the CY 1999 PFS final rule with comment period (63 FR 58814).

Effective October 1, 2001, section 223 of the Medicare, Medicaid and SCHIP Benefits Improvement Protection Act of 2000 (BIPA) (Pub. L. 106–554) added section 1834(m) to the Act, which significantly expanded Medicare telehealth services. Section 1834(m)(4)(F)(i) of the Act defines Medicare telehealth services to include consultations, office visits, office psychiatry services, and any additional service specified by the Secretary, when delivered via a telecommunications system. We first implemented this provision in the CY 2002 PFS final rule with comment period (66 FR 55246). Section 1834(m)(4)(F)(ii) of the Act required the Secretary to establish a process that provides for annual updates to the list of Medicare telehealth services. We established this process in the CY 2003 PFS final rule with comment period (67 FR 79988).

As specified in regulations at § 410.78(b), we generally require that a telehealth service be furnished via an interactive telecommunications system. Under § 410.78(a)(3), an interactive telecommunications system is defined as, "multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner. Telephones, facsimile machines, and electronic mail systems do not meet the definition of an interactive telecommunications system." An interactive telecommunications system is generally required as a condition of payment; however, section 1834(m)(1) of the Act allows the use of asynchronous "store-and-forward" technology when the originating site is a federal telemedicine demonstration program in Alaska or Hawaii. As specified in regulations at § 410.78(a)(1), store-and-forward means the asynchronous transmission of medical information from an originating site to be reviewed at a later time by the practitioner at the distant site.

Medicare telehealth services may be furnished to an eligible telehealth individual notwithstanding the fact that the practitioner furnishing the telehealth service is not at the same location as the beneficiary. An eligible telehealth individual means an individual enrolled under Part B who receives a telehealth service furnished at an originating site. Under the BIPA, originating sites were limited under section 1834(m)(3)(C) of the Act to specified medical facilities located in specific geographic areas. The initial list of telehealth originating sites included the office of a practitioner, CAH, a rural health clinic (RHC), a federally qualified health center (FQHC) and a hospital (as defined in section 1861(e) of the Act). More recently, section 149 of the Medicare Improvements for Patients and Providers Act of 2008 (Pub. L. 110–275) (MIPPA) expanded the list of telehealth originating sites to include a hospital-based renal dialysis center, a skilled nursing facility (SNF), and a community mental health center (CMHC). To serve as a telehealth originating site, the Act requires that a site must also be located in an area designated as a rural HPSA, in a county that is not in a MSA, or must be an entity that participates in a federal telemedicine demonstration project that has been approved by (or receives funding from) the Secretary as of December 31, 2000. Finally, section 1834(m) of the Act does not require the eligible telehealth individual to be with a telepresenter at the originating site.

b. Current Telehealth Billing and Payment Policies

As noted previously, Medicare telehealth services can only be furnished to an eligible telehealth beneficiary in a qualifying originating site. An originating site is defined as one of the specified sites where an eligible telehealth individual is located at the time the service is being furnished via a telecommunications system. The originating sites authorized by the statute are as follows:

- Offices of a physician or practitioner;
- Hospitals;
- CAHs;
- RHCs;
- FQHCs;
- Hospital-Based or Critical Access Hospital-Based Renal Dialysis Centers (including Satellites);
- SNFs;
- CMHCs.

Currently approved Medicare telehealth services include the following:

- Initial inpatient consultations;
- Follow-up inpatient consultations;
- Office or other outpatient visits;
- Individual psychotherapy;
- Pharmacologic management;
- Psychiatric diagnostic interview examination;
- End-stage renal disease (ESRD) related services;

- Individual and group medical nutrition therapy (MNT);
- Neurobehavioral status exam;
- Individual and group health and behavior assessment and intervention (HBAI);
- Subsequent hospital care;
- Subsequent nursing facility care;
- Individual and group kidney disease education (KDE);
- Individual and group diabetes self-management training (DSMT);
- Smoking cessation services;
- Alcohol and/or substance abuse and brief intervention services;
- Screening and behavioral counseling interventions in primary care to reduce alcohol misuse;
- Screening for depression in adults;
- Screening for sexually transmitted infections (STIs) and high intensity behavioral counseling (HIBC) to prevent STIs;
- Intensive behavioral therapy for cardiovascular disease; and
- Behavioral counseling for obesity.

In general, the practitioner at the distant site may be any of the following, provided that the practitioner is licensed under state law to furnish the service via a telecommunications system:

- Physician;
- Physician assistant (PA);
- Nurse practitioner (NP);
- Clinical nurse specialist (CNS);
- Nurse-midwife;
- Clinical psychologist;
- Clinical social worker;
- Registered dietitian or nutrition professional.

Practitioners furnishing Medicare telehealth services submit claims for telehealth services to the Medicare contractors that process claims for the service area where their distant site is located. Section 1834(m)(2)(A) of the Act requires that a practitioner who furnishes a telehealth service to an eligible telehealth individual be paid an amount equal to the amount that the practitioner would have been paid if the service had been furnished without the use of a telecommunications system. Distant site practitioners must submit the appropriate HCPCS procedure code for a covered professional telehealth service, appended with the –GT (via interactive audio and video telecommunications system) or –GQ (via asynchronous telecommunications system) modifier. By reporting the –GT or –GQ modifier with a covered telehealth procedure code, the distant site practitioner certifies that the beneficiary was present at a telehealth originating site when the telehealth service was furnished. The usual Medicare deductible and coinsurance policies apply to the telehealth services reported by distant site practitioners.

Section 1834(m)(2)(B) of the Act provides for payment of a facility fee to the originating site. To be paid the originating site facility fee, the provider or supplier where the eligible telehealth individual is located must submit a claim with HCPCS code Q3014 (telehealth originating site facility fee), and the provider or supplier is paid according to the applicable payment methodology for that facility or location. The usual Medicare deductible and coinsurance policies apply to HCPCS code Q3014. By submitting HCPCS code Q3014, the originating site certifies that it is located in either a rural HPSA or non-MSA county or is an entity that participates in a federal telemedicine demonstration project that has been approved by (or receives funding from) the Secretary as of December 31, 2000 as specified in section 1834(m)(4)(C)(i)(III) of the Act.

As previously described, certain professional services that are commonly furnished remotely using telecommunications technology, but that do not require the patient to be present in-person with the practitioner when they are furnished, are covered and paid in the same way as services delivered without the use of telecommunications technology when the practitioner is in-person at the medical facility furnishing care to the patient. Such services typically involve circumstances where a practitioner is able to visualize some aspect of the patient's condition without the patient being present and without the interposition of a third person's judgment. Visualization by the practitioner can be possible by means of x-rays, electrocardiogram or electroencephalogram tracings, tissue samples, etc. For example, the interpretation by a physician of an actual electrocardiogram or electroencephalogram tracing that has been transmitted via telephone (that is, electronically, rather than by means of a verbal description) is a covered physician's service. These remote services are not Medicare telehealth services as defined under section 1834(m) of the Act. Rather, these remote services that utilize telecommunications technology are considered physicians' services in the same way as services that are furnished in-person without the use of telecommunications technology; they are paid under the same conditions as in-person physicians' services (with no requirements regarding permissible originating sites), and should be reported in the same way (that is, without the –GT or –GQ modifier appended).

c. Geographic Criteria for Originating Site Eligibility

Section 1834(m)(4)(C)(i)(I)–(III) of the Act specifies three criteria for the location of eligible telehealth originating sites. One of these is for entities participating in federal telemedicine demonstration projects as of December 31, 2000, and the other two are geographic. One of the geographic criteria is that the site is located in a county that is not in an MSA and the other is that the site is located in an area that is designated as a rural HPSA under section 332(a)(1)(A) of the Public Health Service Act (PHSA) (42 U.S.C. 254e(a)(1)(A)). Section 332(a)(1)(A) of the PHSA provides for the designation of various types of HPSAs, but does not provide for "rural" HPSAs. In the absence of guidance in the PHSA, CMS has in the past interpreted the term "rural" under section 1834(m)(4)(C)(i)(I) to mean an area that is not located in an MSA. As such, the current geographic criteria for telehealth originating sites limits eligible sites to those that are not in an MSA.

To determine rural designations with more precision for other purposes, HHS and CMS have sometimes used methods that do not rely solely on MSA designations. For example, the Office of Rural Health Policy (ORHP) uses the Rural Urban Commuting Areas (RUCAs) to determine rural areas within MSAs. RUCAs are a census tract-based classification scheme that utilizes the standard Bureau of Census Urbanized Area and Urban Cluster definitions in combination with work commuting information to characterize all of the nation's census tracts regarding their rural and urban status and relationships. They were developed under a collaborative project between ORHP, the U.S. Department of Agriculture's Economic Research Service (ERS), and the WWAMI Rural Health Research Center (RHRC). A more comprehensive description is available at the USDA ERS Web site at: *www.ers.usda.gov/data-products/rural-urban-commuting-area-codes/documentation.aspx#.UcsKfZwzZKE*. The RUCA classification scheme contains 10 primary and 30 secondary codes. The primary code numbers (1 through 10) refer to the primary, or single largest, commuting share. Census tracts with RUCA codes of 4 through 10 refer to areas with a primary commuting share outside of a metropolitan area. In addition to counties that are not in an MSA, ORHP considers some census tracts in MSA counties to be rural.

Specifically, census tracts with RUCA codes 4 through 10 are considered to be rural, as well as census tracts with RUCA codes 2 and 3 that are also at least 400 square miles and have a population density of less than 35 people per square mile.

We proposed to modify our regulations regarding originating sites to define rural HPSAs as those located in rural census tracts as determined by ORHP stating that by defining "rural" to include geographic areas located in rural census tracts within MSAs we would allow for the appropriate inclusion of additional HPSAs as areas for telehealth originating sites. We also noted that by adopting the more precise definition of "rural" for this purpose we would expand access to health care services for Medicare beneficiaries located in rural areas.

We also proposed to change our policy so that geographic eligibility for an originating site would be established and maintained on an annual basis, consistent with other telehealth payment policies. Absent this proposed change, the status of a geographic area's eligibility for telehealth originating site payment is effective at the same time as the effective date for changes in designations that are made outside of CMS. This proposed change would reduce the likelihood that mid-year changes to geographic designations would result in sudden disruptions to beneficiaries' access to services, unexpected changes in eligibility for established telehealth originating sites, and avoid the operational difficulties associated with administering mid-year Medicare telehealth payment changes. We proposed to establish geographic eligibility for Medicare telehealth originating sites for each calendar year based upon the status of the area as of December 31st of the prior calendar year.

Accordingly, we proposed to revise our regulations at § 410.78(b)(4) to conform with both of these proposed policies.

The following is a summary of the comments we received regarding our proposed changes regarding geographic eligibility for serving as a Medicare telehealth originating site.

Comment: Commenters supported our proposal to modify the geographic criteria for originating site eligibility to define rural HPSAs as those located in rural census tracts, as determined by ORHP. In addition, commenters supported our proposal to establish and maintain geographic eligibility on an annual basis. Commenters noted that these modifications will:

- Expand access to health care services for Medicare beneficiaries by allowing some rural areas within MSAs to be eligible for Medicare telehealth services.
- Provide greater clarity and consistency for those involved in telehealth.
- Allow for better continuity of care in rural areas by avoiding sudden disruptions to beneficiaries' access to telehealth services.
- Restore eligibility for some counties that were affected by the updated MSAs based on the 2010 census.

Response: We appreciate the broad support for revising the geographic criteria for originating site eligibility and for establishing and maintaining geographic eligibility for an originating site on an annual basis. We are finalizing our CY 2014 proposals (1) to define rural HPSAs as those located in rural census tracts as determined by ORHP, and (2) to establish and maintain geographic eligibility for an originating site on an annual basis. Consistent with these proposals, we are also revising our regulations at § 410.78(b)(4) to conform to these policies.

Comment: Commenters expressed concern that our proposed definition of a rural HPSA does not conform to the definition of a rural HPSA used for rural health clinic qualification, that is, a federally designated shortage area or a non-urbanized area, as defined by the U.S. Census Bureau. As a result, existing RHCs may be excluded from providing telehealth services to Medicare beneficiaries. To avoid this discrepancy, the commenters requested further expansion of the geographic criteria for originating site eligibility to include both non-urbanized areas, as defined by the U.S. Census Bureau, and those rural HPSAs located in rural census tracts, as determined by ORHP. A commenter also recommended that CMS work with the Health Resources and Services Administration (HRSA) to update all data with 2010 census information.

Other commenters recommended expansion of the geographic criteria for originating site to urban and suburban areas. A commenter recommended including sites that are located in (1) areas other than rural HPSAs and (2) counties that are included in MSAs. The commenter noted that beneficiaries in both urban and rural areas face significant barriers in accessing care, including access to certain specialists, such as gerontologists, and access to transportation.

A commenter noted that urban and suburban areas do not have appropriate access to acute stroke care, noting that 77 percent of U.S. counties did not have a hospital with neurological services. As a result of these and other barriers; only a small fraction of patients receive the treatment recommended by the latest scientific guidelines for acute stroke. The commenter concluded that our policy of limiting payment for telehealth services to those originating in rural areas has hampered the development of sufficient stroke consultation coverage and recommend eliminating the rural originating site requirement. Another commenter made similar points concerning cancer patients living in small urban areas without access to complex subspecialty care. A commenter proposed using RUCAs to determine eligible originating sites, to ensure greater access to telemedicine services.

Response: Telehealth originating sites are defined in section 1834(m)(4)(C) of the Act. Only a site that meets one of these requirements can qualify as an originating site:

(1) Located in an area that is designated as a rural health professional shortage area under section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A));

(2) Located in a county that is not included in a Metropolitan Statistical Area; or

(3) From an entity that participates in a Federal telemedicine demonstration project that has been approved by (or receives funding from) the Secretary of Health and Human Services as of December 31, 2000.

Although RHCs are among the types of locations that are statutorily authorized to serve as originating sites for telehealth services, they also must meet the geographic requirements specified in the statute in order to serve as a telehealth originating site. While most RHCs would meet at least one of the geographic requirements to serve as a telehealth originating site, the separate statutory provisions that establish geographic requirements for telehealth originating sites and for RHCs are sufficiently different that they do not necessarily overlap. We do not have the authority to waive the geographic telehealth requirements for those RHCs that do not meet any of the requirements to serve as an originating site.

Accordingly, we are not modifying our proposal to expand the scope of telehealth originating sites to include all RHCs, and we are finalizing our proposed regulation without change. We agree with the commenter that the data that are used to determine which areas are rural should be updated to reflect the 2010 census information.

Comment: Several commenters expressed that the complexity involved

in determining geographic eligibility to serve as an originating site to provide telehealth services may deter providers from offering telehealth services. Commenters indicated that due to recent changes in the 2010 census there have been numerous changes in all rural designations. Commenters noted that RUCAs are a census tract-based classification scheme and there is no single source to determine one's census tract. Commenters recommended that CMS provide an online tool to allow beneficiaries and providers to determine what specific geographic areas are eligible as telehealth originating sites. One commenter suggested simplifying the process in future years by considering using postal ZIP codes or ZIP+4.

Response: We share the commenters' concern that expanding the geographic definition of "rural" to include more telehealth originating sites has increased the complexity in determining the eligibility of a particular location to serve as an originating site. We are working with HRSA to develop a Web site tool to provide assistance to potential originating sites to determine their eligibility. As it becomes available, we will post further information about this on the CMS Web site at *www.cms.gov/teleheath/*.

Comment: A commenter expressed concern about the annual changes in coverage within census tracts that may occur under the proposal. The commenter recommended that CMS use its authority under the statute to avoid annual on/off/on/off coverage to reduce constant fluctuations in coverage of telehealth services. The commenter concluded that once covered for telehealth services, a beneficiary should not lose coverage because of accidental circumstances of geographic location and administrative designation.

Response: This regulation addresses which providers can qualify to be an originating site to furnish telehealth services. Beneficiaries do not have to meet specialized criteria for telehealth services. Beneficiaries who are covered under Medicare Part B can receive services on the list of Medicare telehealth services from providers that meet the criteria to serve as an originating site (and other criteria to furnish telehealth services). We recognize that beneficiaries may experience disruptions in service or challenges in accessing services when a provider that has been an originating site is not eligible in a future year. As discussed above, we believe our proposed policy mitigates the disruptions caused by mid-year changes in geographic status and expands the scope of providers eligible to serve as telehealth originating sites. However, as noted above, we believe it is necessary to use updated information regarding whether a site meets the statutory criteria for originating site eligibility. We do not believe we have authority to continue treating a site as a telehealth originating site if it ceases to meet the statutory criteria. Thus, we are finalizing the regulations regarding originating sites, as proposed to define rural HPSAs as those located in rural census tracts as determined by ORHP and to establish and maintain geographic eligibility for an originating site on an annual basis.

2. Adding Services to the List of Medicare Telehealth Services

As noted previously, in the December 31, 2002 **Federal Register** (67 FR 79988), we established a process for adding services to or deleting services from the list of Medicare telehealth services. This process provides the public with an ongoing opportunity to submit requests for adding services. We assign any request to make additions to the list of telehealth services to one of two categories. In the November 28, 2011 **Federal Register** (76 FR 73102), we finalized revisions to criteria that we use to review requests in the second category. The two categories are:

- *Category 1:* Services that are similar to professional consultations, office visits, and office psychiatry services that are currently on the list of telehealth services. In reviewing these requests, we look for similarities between the requested and existing telehealth services for the roles of, and interactions among, the beneficiary, the physician (or other practitioner) at the distant site and, if necessary, the telepresenter. We also look for similarities in the telecommunications system used to deliver the proposed service; for example, the use of interactive audio and video equipment.
- *Category 2:* Services that are not similar to the current list of telehealth services. Our review of these requests includes an assessment of whether the service is accurately described by the corresponding code when delivered via telehealth and whether the use of a telecommunications system to deliver the service produces demonstrated clinical benefit to the patient. In reviewing these requests, we look for evidence indicating that the use of a telecommunications system in delivering the candidate telehealth service produces clinical benefit to the patient. Submitted evidence should include both a description of relevant clinical studies that demonstrate the service furnished by telehealth to a Medicare beneficiary improves the diagnosis or treatment of an illness or injury or improves the functioning of a malformed body part, including dates and findings, and a list and copies of published peer reviewed articles relevant to the service when furnished via telehealth. Our evidentiary standard of clinical benefit does not include minor or incidental benefits.

Some examples of clinical benefit include the following:

- Ability to diagnose a medical condition in a patient population without access to clinically appropriate in-person diagnostic services.
- Treatment option for a patient population without access to clinically appropriate in-person treatment options.
- Reduced rate of complications.
- Decreased rate of subsequent diagnostic or therapeutic interventions (for example, due to reduced rate of recurrence of the disease process).
- Decreased number of future hospitalizations or physician visits.
- More rapid beneficial resolution of the disease process treatment.
- Decreased pain, bleeding, or other quantifiable symptom.
- Reduced recovery time.

Since establishing the process to add or remove services from the list of approved telehealth services, we have added the following to the list of Medicare telehealth services: individual and group HBAI services; psychiatric diagnostic interview examination; ESRD services with 2 to 3 visits per month and 4 or more visits per month (although we require at least 1 visit a month to be furnished in-person by a physician, CNS, NP, or PA to examine the vascular access site); individual and group MNT; neurobehavioral status exam; initial and follow-up inpatient telehealth consultations for beneficiaries in hospitals and SNFs; subsequent hospital care (with the limitation of one telehealth visit every 3 days); subsequent nursing facility care (with the limitation of one telehealth visit every 30 days); individual and group KDE; and individual and group DSMT (with a minimum of 1 hour of in-person instruction to ensure effective injection training), smoking cessation services; alcohol and/or substance abuse and brief intervention services; screening and behavioral counseling interventions in primary care to reduce alcohol misuse; screening for depression in adults; screening for sexually transmitted infections (STIs) and high intensity behavioral counseling (HIBC) to prevent STIs; intensive behavioral therapy for cardiovascular disease; and behavioral counseling for obesity.

Requests to add services to the list of Medicare telehealth services must be submitted and received no later than December 31 of each calendar year to be considered for the next rulemaking cycle. For example, requests submitted before the end of CY 2013 will be considered for the CY 2015 proposed rule. Each request for adding a service to the list of Medicare telehealth services must include any supporting documentation the requester wishes us to consider as we review the request. Because we use the annual PFS rulemaking process as a vehicle for making changes to the list of Medicare telehealth services, requestors should be advised that any information submitted is subject to public disclosure for this purpose. For more information on submitting a request for an addition to the list of Medicare telehealth services, including where to mail these requests, we refer readers to the CMS Web site at *www.cms.gov/telehealth/*.

3. Submitted Requests and Other Additions to the List of Telehealth Services for CY 2014

We received a request in CY 2012 to add online assessment and E/M services as Medicare telehealth services effective for CY 2014. The following presents a discussion of this request, and our proposals for additions to the CY 2014 telehealth list.

a. Submitted Requests

The American Telemedicine Association (ATA) submitted a request to add CPT codes 98969 (Online assessment and management service provided by a qualified nonphysician health care professional to an established patient, guardian, or health care provider not originating from a related assessment and management service provided within the previous 7 days, using the Internet or similar electronic communications network) and 99444 (Online evaluation and management service provided by a physician to an established patient, guardian, or health care provider not originating from a related E/M service provided within the previous 7 days, using the Internet or similar electronic communications network) to the list of Medicare telehealth services.

As we explained in the CY 2008 PFS final rule with comment period (72 FR 66371), we assigned a status indicator of "N" (Non-covered service) to these services because: (1) these services are non-face-to-face; and (2) the code descriptor includes language that recognizes the provision of services to parties other than the beneficiary and for whom Medicare does not provide coverage (for example, a guardian). Under section 1834(m)(2)(A) of the Act, Medicare pays the physician or practitioner furnishing a telehealth service an amount equal to the amount that would have been paid if the service was furnished without the use of a telecommunications system. Because CPT codes 98969 and 99444 are currently noncovered, there would be no Medicare payment if these services were furnished without the use of a telecommunications system. Since these codes are noncovered services for which no payment may be made under Medicare, we did not propose to add online evaluation and management services to the list of Medicare Telehealth Services for CY 2014.

b. Other Additions

Under our existing policy, we add services to the telehealth list on a category 1 basis when we determine that they are similar to services on the existing telehealth list with respect to the roles of, and interactions among, the beneficiary, physician (or other practitioner) at the distant site and, if necessary, the telepresenter. As we stated in the CY 2012 proposed rule (76 FR 42826), we believe that the category 1 criteria not only streamline our review process for publically requested services that fall into this category, the criteria also expedite our ability to identify codes for the telehealth list that resemble those services already on this list.

For CY 2013, CMS finalized a payment policy for new CPT code 99495 (Transitional care management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge medical decision making of at least moderate complexity during the service period face-to-face visit, within 14 calendar days of discharge) and CPT code 99496 (Transitional care management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge medical decision making of high complexity during the service period face-to-face visit, within 7 calendar days of discharge). These services are for a patient whose medical and/or psychosocial problems require moderate or high complexity medical decision making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospitalization, observation status in a hospital, or skilled nursing facility/nursing facility, to the patient's community setting (home, domiciliary, rest home, or assisted living). Transitional care management is comprised of one face-to-face visit within the specified time frames following a discharge, in combination with non-face-to-face services that may be performed by the physician or other qualified health care professional and/or licensed clinical staff under his or her direction.

We believe that the interactions between the furnishing practitioner and the beneficiary described by the required face-to-face visit component of the transitional care management (TCM) services are sufficiently similar to services currently on the list of Medicare telehealth services for these services to be added under category 1. Specifically, we believe that the required face-to-face visit component of TCM services is similar to the office/outpatient evaluation and management visits described by CPT codes 99201–99205 and 99211–99215. We note that like certain other non-face-to-face PFS services, the other components of the TCM service are commonly furnished remotely using telecommunications technology, and do not require the patient to be present in-person with the practitioner when they are furnished. As such, we do not need to consider whether the non-face-to-face aspects of the TCM service are similar to other telehealth services. Were these components of the TCM services separately billable, they would not need to be on the telehealth list to be covered and paid in the same way as services delivered without the use of telecommunications technology. Therefore, we proposed to add CPT codes 99495 and 99496 to the list of telehealth services for CY 2014 on a category 1 basis. Consistent with this proposal, we revised our regulations at § 410.78(b) and § 414.65(a)(1) to include TCM services as Medicare telehealth services.

4. Telehealth Frequency Limitations

The ATA asked that we remove the telehealth frequency limitation for subsequent nursing facility services reported by CPT codes 99307 through 99310. Subsequent nursing facility services were added to the list of Medicare telehealth services in the CY 2011 PFS final rule (75 FR 73317 through 73318), with a limitation of one telehealth subsequent nursing facility care service every 30 days. In the CY 2011 PFS final rule (75 FR 73615) we noted that, as specified in our regulation at § 410.78(e)(2), the federally mandated periodic SNF visits required under

§ 483.40(c) could not be furnished through telehealth.

The ATA requested that the frequency limitation be removed due to "recent federal telecommunications policy changes" and newly available information from recent studies. Specifically, the ATA pointed to the Federal Communications Commission (FCC) pilot funding of a program to facilitate the creation of a nationwide broadband network dedicated to health care, connecting public and private non-profit health care providers in rural and urban locations, and a series of studies that demonstrated the value to patients of telehealth technology.

In considering this request, we began with the analysis contained in the CY 2011 proposed rule (75 FR 73318), when we proposed to add SNF subsequent care, to the list of Medicare telehealth services. We discussed our complementary commitments to ensuring that SNF residents, given their potential clinical acuity, continue to receive in-person visits as appropriate to manage their complex care and to make sure that Medicare pays only for medically reasonable and necessary care. To meet these commitments, we believed it was appropriate to limit the provision of subsequent nursing facility care services furnished through telehealth to once every 30 days.

We then reviewed the publicly available information regarding both the FCC pilot program and the ATA-referenced studies in light of the previously stated commitments to assess whether these developments warrant a change in 30-day frequency limitation policy. Based on our review of the FCC demonstration project and the studies referenced in the request, we found no information regarding the relative clinical benefits of SNF subsequent care when furnished via telehealth more frequently than once every 30 days. We did note that the FCC information reflected an aim to improve access to medical specialists in urban areas for rural health care providers, and that medical specialists in urban areas can continue to use the inpatient telehealth consultation HCPCS G-codes (specifically G0406, G0407, G0408, G0425, G0426, or G0427) when reporting medically reasonable and necessary consultations furnished to SNF residents via telehealth without any frequency limitation.

We also reviewed the studies referenced by the ATA to assess whether they provided evidence that more frequent telehealth visits would appropriately serve this particular population given the potential medical acuity and complexity of patient needs. We did not find any such evidence in the studies. Three of the studies identified by the ATA were not directly relevant to SNF subsequent care services. One of these focused on using telehealth technology to treat patients with pressure ulcers after spinal cord injuries. The second focused on the usefulness of telehealth technology for patients receiving home health care services. A third study addressed the use of interactive communication technology to facilitate the coordination of care between hospital and SNF personnel on the day of hospital discharge. The ATA also mentioned a peer-reviewed presentation delivered at its annual meeting related to SNF patient care, suggesting that the presentation demonstrated that telehealth visits are better for SNF patients than in-person visits to emergency departments or, in some cases, visits to physician offices. Although we did not have access to the full presentation it does not appear to address subsequent nursing facility services, so we do not believe this is directly relevant to the clinical benefit of SNF subsequent care furnished via telehealth. More importantly, none of these studies addresses the concerns we have expressed about the possibility that nursing facility subsequent care visits furnished too frequently through telehealth rather than in-person could compromise care for this potentially acute and complex patient population.

We remain committed to ensuring that SNF inpatients receive appropriate in-person visits and that Medicare pays only for medically reasonable and necessary care. We are not persuaded by the information submitted by the ATA that it would be beneficial or advisable to remove the frequency limitation we established for SNF subsequent care when furnished via telehealth. Because we want to ensure that nursing facility patients with complex medical conditions have appropriately frequent, medically reasonable and necessary encounters with their admitting practitioner, we continue to believe that it is appropriate for some subsequent nursing facility care services to be furnished through telehealth. At the same time, because of the potential acuity and complexity of SNF inpatients, we remain committed to ensuring that these patients continue to receive in-person, hands-on visits as appropriate to manage their care. Therefore, we did not propose any changes to the limitations regarding SNF subsequent care services furnished via telehealth for CY 2014.

The following is summary of the comments we received regarding adding services to the list of Medicare telehealth services.

Comment: All commenters expressed support for our proposals to add transitional care management (CPT codes 99495 and 99496) to the list of Medicare telehealth services for CY 2014. A commenter suggested that CMS allow the required E/M visit component of the two CPT codes to be delivered via telehealth.

Response: We appreciate the support for the proposed additions to the list of Medicare telehealth services. In response to the commenter asking that the required E/M visit component be allowed to be furnished via telehealth, adding TCM CPT codes 99495 and 99496 to the list of Medicare telehealth services allows the E/M portion of these services to be furnished via telehealth. After consideration of the public comments received, we are finalizing our CY 2014 proposal to add TCM CPT codes 99495 and 99496 to the list of telehealth services for CY 2014 on a category 1 basis.

Comment: Another commenter recommended that the originating site be required to conduct a physical examination of a patient's mental and physical condition following a care transaction, and transmit the results to the consulting physician before or during the telehealth session, as a condition for coverage of transitional care management services provided via telehealth.

Response: Concerning the conduct of a physical examination, nothing would preclude such an in person, face-to-face examination from occurring at the originating site; and the TCM codes describe communication between practitioners, when appropriate. We are not adopting this recommendation as we do not believe there is a reason to treat these new additions to the list of telehealth services differently than services already on the list.

Comment: A commenter asked whether providing transitional care management via telehealth applies to services furnished in private homes and assisted living facilities.

Response: No, in furnishing TCM services as telehealth services, all other conditions for telehealth services still apply. In addition to geographic criteria, the statutory criteria for eligible originating sites include only certain types of locations specified in section 1834(m)(4)(C)(ii) of the Act, and those do not include private homes and assisted living facilities.

Comment: A commenter supported our decision not to remove the telehealth frequency limitation for subsequent nursing facility services

reported by CPT codes 99307 through 99310. The commenter noted that telehealth occupational therapy services are just beginning to be provided and evaluated, and indicated that it is important to ensure that care for the acute and complex patients found in SNFs is not compromised, regardless of the mode used to provide services.

Another commenter disagreed with our determination that there is no relative clinical benefit from allowing SNF services to be provided via telehealth more than once every 30 days. The commenter indicated that CMS recently issued Survey and Certification Memo 13–35–NH, which put additional emphasis on the survey process for managing behavioral or psychological symptoms of dementia and limiting the use of antipsychotic medications in SNFs. The commenter concluded that having this medical/behavioral evaluation performed by the primary care provider or a psychiatrist using telehealth could help reduce the need to transfer the patient to the emergency department, which could possibly exacerbate dementia symptoms.

A commenter stated that the frequency limitation can result in additional unnecessary transports for office or emergency department visits, additional opportunities for patient injury, and significant transportation costs especially for the immobile and disabled patient. In light of the evolving mobile health technologies, robotics, and miniaturization of telecommunications tools and medical devices, as well as the increasing complexity and co-morbidities of SNF patients, the commenter recommended setting the limit at one visit per 10 days.

A commenter suggested that subsequent nursing facility care services furnished through telehealth should not be limited to one service every 30 days, as long as the federally mandated SNF visits are conducted on an in-person basis.

Response: We appreciate the comment in support of maintaining the 30-day limit. Commenters opposed to the 30-day limit offered no clinically persuasive evidence to support their positions. Survey and Certification Memo 13–35–NH addresses dementia care in nursing homes and unnecessary drug use. The memo does not address telehealth services, and does not represent clinical evidence supporting removal of the telehealth frequency limitation for subsequent nursing facility services. Therefore, we are maintaining the 30-day frequency limitation for subsequent nursing facility services due to the absence of evidence regarding the relative clinical benefits of SNF subsequent care when furnished via telehealth more frequently than once every 30 days, and to ensure that SNF patients continue to receive in-person, hands-on visits as appropriate to manage their care.

Comment: A commenter urged CMS to reconsider its decision to not include CPT codes 98969 (Online assessment and management service provided by a qualified nonphysician health care professional to an established patient, guardian, or health care provider not originating from a related assessment and management service provided within the previous 7 days, using the Internet or similar electronic communications network) and 99444 (Online evaluation and management service provided by a physician to an established patient, guardian, or health care provider not originating from a related E/M service provided within the previous 7 days, using the Internet or similar electronic communications network) on the list of Medicare telehealth services. The commenter noted that such services can serve as a valuable preventive benefit in the treatment and care of Medicare beneficiaries; that such services are often are unavailable to beneficiaries who reside in very rural areas; and that telehealth services should be expanded in view of the increasing number of beneficiaries and the projected physician shortage.

Response: As noted previously, we did not propose to add the subject codes to the list of telehealth services because they are noncovered services for which no payment may be made under Medicare. Accordingly we are finalizing our proposal.

In summary, after consideration of the comments we received we are finalizing the changes to our regulation at § 410.78 to add "transitional care management" to the list of services in paragraph (b) as proposed.

We remind all interested stakeholders that we are currently soliciting public requests to add services to the list of Medicare telehealth services. To be considered during PFS rulemaking for CY 2015, these requests must be submitted and received by December 31, 2013, or the close of the comment period for this final rule with comment period. Each request to add a service to the list of Medicare telehealth services must include any supporting documentation the requester wishes us to consider as we review the request. For more information on submitting a request for an addition to the list of Medicare telehealth services, including where to mail these requests, we refer readers to the CMS Web site at *www.cms.gov/telehealth/*.

5. Telehealth Originating Site Facility Fee Payment Amount Update

Section 1834(m)(2)(B) of the Act establishes the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001, through December 31 2002, at $20.00. For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased by the percentage increase in the MEI as defined in section 1842(i)(3) of the Act. The MEI increase for 2014 is 0.8 percent. Therefore, for CY 2014, the payment amount for HCPCS code Q3014 (Telehealth originating site facility fee) is 80 percent of the lesser of the actual charge or $24.63. The Medicare telehealth originating site facility fee and MEI increase by the applicable time period is shown in Table 46.

TABLE 46—THE MEDICARE TELEHEALTH ORIGINATING SITE FACILITY FEE AND MEI INCREASE BY THE APPLICABLE TIME PERIOD

Facility fee	MEI increase (%)	Period
$20.00	N/A	10/01/2001–12/31/2002
$20.60	3.0	01/01/2003–12/31/2003
$21.20	2.9	01/01/2004–12/31/2004
$21.86	3.1	01/01/2005–12/31/2005
$22.47	2.8	01/01/2006–12/31/2006
$22.94	2.1	01/01/2007–12/31/2007
$23.35	1.8	01/01/2008–12/31/2008
$23.72	1.6	01/01/2009–12/31/2009
$24.00	1.2	01/01/2010–12/31/2010
$24.10	0.4	01/01/2011–12/31/2011
$24.24	0.6	01/01/2012–12/31/2012
$24.43	0.8	01/01/2013–12/31/2013
$24.63	0.8	01/01/2014–12/31/2014

I. Therapy Caps

1. Outpatient Therapy Caps for CY 2014

Section 1833(g) of the Act applies annual, per beneficiary, limitations on expenses that can be considered as incurred expenses for outpatient therapy services under Medicare Part B, commonly referred to as "therapy caps."

There is one therapy cap for outpatient occupational therapy (OT) services and another separate therapy cap for physical therapy (PT) and speech-language pathology (SLP) services combined.

Until October 1, 2012, the therapy caps applied to all outpatient therapy services except those under section 1833(a)(8)(B) of the Act, which describes services furnished by a hospital or another entity under an arrangement with a hospital. For convenience, we will refer to the exemption from the caps for services described under section 1833(a)(8)(B) of the Act as the "outpatient hospital services exemption." Section 3005(b) of the MCTRJCA added section 1833(g)(6) of the Act to temporarily suspend the outpatient hospital services exemption, thereby requiring that the therapy caps apply to services described under section 1833(a)(8)(B) of the Act from October 1, 2012 to December 31, 2012 for services furnished beginning January 1, 2012. This broadened application of the therapy caps was extended through December 31, 2013, by section 603(a) of the ATRA. In addition, section 603(b) of the ATRA amended section 1833(g)(6) of the Act to specify that during CY 2013, for outpatient therapy services paid under section 1834(g) of the Act (those furnished by a CAH), we must count towards the therapy caps the amount that would be payable for the services under Medicare Part B if the services were paid as outpatient therapy services under section 1834(k)(1)(B) of the Act, which describes payment for outpatient therapy services furnished by hospitals and certain other entities, instead of as CAH outpatient therapy services under section 1834(g) of the Act. Payment for outpatient therapy services under section 1834(k)(1)(B) of the Act is made at 80 percent of the lesser of the actual charge for the services or the applicable fee schedule amount as defined in section 1834(k)(3) of the Act. Section 1834(k)(3) of the Act defines applicable fee schedule to mean the payment amount determined under a fee schedule established under section 1848 of the Act, which refers to the PFS, or an amount under a fee schedule for comparable services as the Secretary specifies. The PFS is the applicable fee schedule to be used as the payment basis under section 1834(k)(3) of the Act. Section 603(b) of the ATRA specified that nothing in the amendments to section 1833(g)(6) of the Act "shall be construed as changing the method of payment for outpatient therapy services under 1834(g) of the Act."

Since CY 2011, a therapy multiple procedure payment reduction (MPPR) policy has applied to the second and subsequent "always therapy" services billed on the same date of service for one patient by the same practitioner or facility under the same NPI. Prior to April 1, 2013, the therapy MPPR reduced the practice expense portion of office-based services by 20 percent and reduced the practice expense portion of institutional-based services by 25 percent. As of April 1, 2013, section 633(a) of the ATRA amended sections 1848(b)(7) and 1834(k) of the Act to increase the therapy MPPR to 50 percent for all outpatient therapy services furnished in office-based and institutional settings. (For more information on the MPPR and its history, see section II.C.4 of this final rule with comment period.)

Section 1833(g) of the Act applies the therapy caps to incurred expenses for outpatient therapy services on a calendar year basis, and section 603(b) of the ATRA requires that we accrue toward the therapy caps a proxy value for a beneficiary's incurred expenses for outpatient therapy services furnished by a CAH during CY 2013. Since payment for outpatient therapy services under section 1834(k)(1)(B) of the Act is made at the PFS rate and includes any applicable therapy MPPR, the proxy amounts accrued toward the caps for therapy services furnished by a CAH also reflect any applicable therapy MPPR.

We believe that this is consistent with the statutory amendments made by the ATRA. Including the therapy MPPR in calculating incurred expenses for therapy services furnished by CAHs treats CAH services consistently with services furnished in other applicable settings. Therefore, therapy services furnished by CAHs during CY 2013 count towards the therapy caps using the amount that would be payable under section 1834(k)(1)(B) of the Act, which includes an applicable MPPR. For a list of the "always therapy" codes subject to the therapy MPPR policy, see Addendum H of this final rule with comment period.

The therapy cap amounts under section 1833(g) of the Act are updated each year based on the MEI. Specifically, the annual caps are calculated by updating the previous year's cap by the MEI for the upcoming calendar year and rounding to the nearest $10 as specified in section 1833(g)(2)(B) of the Act. Increasing the CY 2013 therapy cap of $1,900 by the CY 2014 MEI of 0.8 percent, results in a therapy cap amount for CY 2014 of $1,920.

An exceptions process for the therapy caps has been in effect since January 1, 2006. Originally required by section 5107 of the Deficit Reduction Act of 2005 (DRA), which amended section 1833(g)(5) of the Act, the exceptions process for the therapy caps has been continuously extended several times through subsequent legislation (MIEA–TRHCA, MMSEA, MIPPA, the Affordable Care Act, MMEA, TPTCCA, and MCTRJCA). Last amended by section 603(a) of the ATRA, the Agency's current authority to provide an exceptions process for therapy caps expires on December 31, 2013. After expenses incurred for the beneficiary's services for the year have exceeded the therapy caps, therapy suppliers and providers use the KX modifier on claims for services to request an exception to the therapy caps. By use of the KX modifier, the therapist is attesting that the services above the therapy caps are reasonable and necessary and that there is documentation of medical necessity for the services in the beneficiary's medical record.

Under section 1833(g)(5)(C) of the Act, which was added by the MCTRJCA and extended through 2013 by the ATRA, we are required to apply a manual medical review process to therapy claims when a beneficiary's incurred expenses exceed a threshold amount of $3,700. There are two separate thresholds of $3,700, just as there are two therapy caps, and incurred expenses are counted towards the thresholds in the same manner as the caps. Under the statute, the required application of the manual medical review process expires December 31, 2013. For information on the manual medical review process, go to *www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medical-Review/TherapyCap.html.*

2. Application of Therapy Caps to Services Furnished by CAHs

Section 4541 of the BBA amended section 1833(g) of the Act to create the therapy caps discussed above. This BBA provision applied the therapy caps to outpatient therapy services described at section 1861(p) of the Act except for the outpatient therapy services described in section 1833(a)(8)(B) of the Act. Section 1833(a)(8)(B) of the Act refers to therapy services furnished by a hospital to an outpatient; to services furnished to a hospital inpatient who has exhausted, or is not entitled to, benefits under Part A; and to these same services when furnished by an entity under arrangements with a hospital. Payment for the services described under section

1833(a)(8)(B) of the Act is made under section 1834(k)(1)(B) of the Act.

Section 4201 of the BBA amended section 1820 of the Act to require a process for establishment of CAHs. Payment for CAH outpatient services is described under section 1834(g) of the Act.

When we proposed language to implement the BBA provision establishing therapy caps in the CY 1999 PFS proposed rule, we indicated in the preamble that the therapy caps do not apply to therapy services furnished directly or under arrangements by a hospital or CAH to an outpatient or to an inpatient who is not in a covered Part A stay (63 FR 30818, 30858). We included a similar statement in the preamble to the final rule; however, we did not include the same reference to CAHs in that sentence in the CY 1999 PFS final rule with comment period (63 FR 58814, 58865). In the CY 1999 PFS final rule with comment period, we also stated generally that the therapy caps apply only to items and services furnished by nonhospital providers and therapists (63 FR 58865). In the CY 1999 proposed rule, we proposed to include provisions at § 410.59(e)(3) and § 410.60(e)(3) to describe, respectively, the outpatient therapy services that are exempt from the statutory therapy caps for outpatient OT services, and for outpatient PT and SLP services combined. Specifically, in the CY 1999 PFS proposed rule, we proposed to add the following regulatory language for OT and for PT at § 410.59(e)(3) and § 410.60(e)(3): "For purposes of applying the limitation, outpatient [occupational therapy/physical therapy] excludes services furnished by a hospital or CAH directly or under arrangements" (63 FR 30880). However, in the CY 1999 PFS final rule with comment period, the phrase "or CAH" was omitted from the final regulation text for OT in § 410.59(e)(3), but was included in the final regulation text for PT in § 410.60(e)(3). We note that for purposes of the therapy cap, outpatient PT services under our regulation at § 410.60 include outpatient SLP services described under § 410.62. As such, SLP services are included in the references to PT under § 410.60. Although the rulemaking history and regulations appear inconclusive as to whether outpatient therapy services furnished by CAHs were intended to be subject to the therapy caps between January 1, 1999 and October 1, 2012, we believe that we inadvertently omitted the phrase "or CAH" in the CY 1999 final regulation for the occupational therapy cap. Moreover, we have consistently excluded all outpatient therapy services furnished by CAHs from the therapy caps over this time frame, whether the services were PT, SLP, or OT.

Accordingly, from the outset of the therapy caps under section 1833(g) of the Act, therapy services furnished by CAHs have not been subject to the therapy caps. Thus, CAHs have not been required to use the exceptions process (including the KX modifier and other requirements) when furnishing medically necessary therapy services above the therapy caps; and therapy services furnished by CAHs above the threshold amounts have not been subject to the manual medical review process. Similarly, until section 603(b) of the ATRA amended the statute to specify the amount that must be counted towards the therapy caps and thresholds for outpatient therapy services furnished by CAHs in CY 2013, we did not apply towards the therapy caps or thresholds any amounts for therapy services furnished by CAHs. Therefore, we have consistently interpreted the statutory exclusion for outpatient therapy services furnished by hospital outpatient departments also to apply to CAHs and implemented the therapy caps accordingly.

As noted above, section 3005(b) of the MCTRJCA temporarily suspended the outpatient hospital services exemption from October 1, 2012 through December 31, 2012 (which has subsequently been extended through December 31, 2013 by the ATRA). As a result, from October 1, 2012 to the present, CAH services have been treated differently than services furnished in other outpatient hospital settings. In implementing this change required by the MCTRJCA, we had reason to assess whether, as a result of the amendment, the therapy caps should be applied to outpatient therapy services furnished by CAHs. We concluded that the MCTRJCA amendment did not make the therapy caps applicable to services furnished by CAHs for which payment is made under section 1834(g) of the Act because it affected only the outpatient hospital services described under section 1833(a)(8)(B) of the Act for which payment is made under section 1834(k)(1)(B) of the Act. With the enactment in section 603(b) of the ATRA of specific language requiring us to count amounts towards the therapy caps and thresholds for services furnished by CAHs, we again had reason to assess whether the therapy caps apply to services furnished by CAHs. We concluded that the ATRA amendment did not explicitly make the therapy caps applicable to services furnished by CAHs, but directed us to count CAH services towards the caps. However, after reflecting on the language of section 1833(g) of the Act, we have concluded based upon the language of the Act that the therapy caps should be applied to outpatient therapy services furnished by CAHs.

To explain further, under section 1833(g)(1) and (3) of the Act, the therapy caps are made applicable to all services described under section 1861(p) of the Act except those described under the outpatient hospital services exemption. Section 1861(p) of the Act establishes the benefit category for outpatient PT, SLP and OT services, (expressly for PT services and, through section 1861(ll)(2) of the Act, for outpatient SLP services and, through section 1861(g) of the Act, for outpatient OT services). Section 1861(p) of the Act defines outpatient therapy services in the three disciplines as those furnished by a provider of services, a clinic, rehabilitation agency, or a public health agency, or by others under an arrangement with, and under the supervision of, such provider, clinic, rehabilitation agency, or public health agency to an individual as an outpatient; and those furnished by a therapist not under arrangements with a provider of services, clinic, rehabilitation agency, or a public health agency. As such, section 1861(p) of the Act defines outpatient therapy services very broadly to include those furnished by providers and other institutional settings, as well as those furnished in office settings. Under section 1861(u) of the Act, a CAH is a "provider of services." As such; unless the outpatient therapy services furnished by a CAH fit within the outpatient hospital services exemption under section 1833(a)(8)(B) of the Act, the therapy caps would be applicable to PT, SLP, QT services furnished by a CAH. As noted above, section 1833(a)(8)(B) of the Act describes only outpatient therapy services for which payment is made under section 1834(k) of the Act. Payment for CAH services is made under section 1834(g) of the Act. Thus, the outpatient hospital services exemption to the therapy caps under section 1833(a)(8)(B) of the Act does not apply, and the therapy caps are applicable, to outpatient therapy services furnished by a CAH.

However, we recognize that our current regulation specifically excludes PT and SLP services furnished by CAHs from the therapy caps, and our consistent practice since 1999 has been to exclude PT, SLP and OT services furnished by CAHs from the therapy caps. As such, in order to apply the therapy caps and related policies to services furnished by CAHs for CY 2014

and subsequent years, we believe we would need to revise our regulations.

We proposed to apply the therapy cap limitations and related policies to outpatient therapy services furnished by a CAH beginning on January 1, 2014. In the proposed rule, we noted that not only do we believe this is the proper statutory interpretation, but we also believe it is the appropriate policy. Under the existing regulations, with the suspension of the outpatient hospital services exemption through 2013, the therapy caps apply to outpatient therapy services paid under Medicare Part B and furnished in all applicable settings except CAHs. We believe that outpatient therapy services furnished by a CAH should be treated consistently with outpatient therapy services furnished in all other settings. Therefore, we proposed to revise the therapy cap regulation at § 410.60(e)(3) to remove the exemption for services furnished by a CAH and make conforming amendments.

CAH outpatient therapy services are distinct from other outpatient therapy services in that outpatient therapy services furnished in office-based or other institutional settings are paid at the rates contained in the PFS, whereas CAHs are paid for outpatient therapy services under the methodology described under section 1834(g) of the Act. Because the CAH reasonable cost-based payment amounts are reconciled at cost reporting year-end, and are different from the fee schedule-based payments for other outpatient therapy services, it might have been difficult to identify the amounts that we should have accrued towards the therapy caps for services furnished by CAHs. Therefore, prior to 2013, not only did CMS not apply any caps to services provided by a CAH, but also did not count CAH services towards the caps. However, the ATRA amended the statute to require for outpatient therapy services furnished by CAHs during 2013 that we count towards the caps and the manual medical review thresholds the amount that would be payable for the services under Medicare Part B as if the services were paid as outpatient therapy services under section 1834(k)(1)(B) of the Act instead of as CAH services under section 1834(g) of the Act. We proposed to continue this methodology of counting the amount payable under section 1834(k)(1)(B) of the Act towards the therapy cap and threshold for services furnished by CAHs in CY 2014 and subsequent years.

We recognize that the outpatient hospital services exemption is suspended under current law only through December 31, 2013. If this provision is not extended, with our proposal to apply the therapy caps to services furnished by CAHs, effective January 1, 2014, therapy services furnished by CAHs would be treated differently than services furnished in other outpatient hospital settings. We recognize that the exceptions and manual medical review processes expire on December 31, 2013, and we would apply those polices to therapy services furnished by a CAH only if they are extended by statute. The exceptions process described above, including use of the KX modifier to attest to the medical necessity of therapy services above the caps and other requirements, if extended by legislation, would apply for services furnished by a CAH in the same way that it applies to outpatient therapy services furnished by other facilities (except for any that are expressly exempted). Similarly, the manual medical review process for claims that exceed the $3,700 thresholds, if extended by legislation, would apply to therapy services furnished by a CAH in the same way that they apply for outpatient therapy services furnished by certain other facilities.

We proposed to amend the regulations establishing the conditions for PT, OT, and SLP services by removing the exemption of CAH services from the therapy caps and specifying that the therapy caps apply to such services. Specifically, we proposed to amend the regulations, which pertain to the OT therapy cap and the combined PT and SLP therapy cap, respectively, by including paragraph (e)(1)(iv) under § 410.59 and (e)(1)(iv) under § 410.60 to specify that (occupational/physical) therapy services furnished by a CAH directly or under arrangements shall be counted towards the annual limitation on incurred expenses as if such services were paid under section 1834(k)(1)(B) of the Act. We also proposed to add new paragraph (e)(2)(v) to § 410.59 and (e)(2)(vi) to § 410.60. These new paragraphs would expressly include outpatient (occupational/physical) therapy services furnished by a CAH directly or under arrangements under the description of services to which the annual limitation applies. Further, we proposed to amend the regulation at § 410.60(e)(3), which currently excludes services furnished by a CAH from the therapy cap for PT and SLP services, to remove the phrase "or CAH."

The following is a summary of the comments we received regarding the proposal to apply the therapy cap limitations and related policies to outpatient therapy services furnished by a CAH beginning on January 1, 2014. We received many comments from professional therapy associations, hospital associations, health systems, nonprofit health care organizations, and specialty provider groups regarding our proposal, all of which opposed the application of the therapy caps to CAH services. A summary of the reasons stated for opposition follow.

Comment: Most of the comments we received argued that due to the critical role that CAHs play in furnishing healthcare services in underserved or rural areas, imposing the financial and administrative burden of the therapy caps on CAHs would result in Medicare beneficiaries having fewer, if any, options for accessing needed therapy services in CAH service areas. A few commenters noted that Congress established the CAH designation in order to make health care services accessible to Medicare beneficiaries in rural areas who would otherwise be unable to access hospital services and argued that our proposed policy would be contrary to Congress's goal. Commenters noted that those most affected by this policy are beneficiaries living in rural areas who are on average older, sicker, poorer, and more geographically isolated compared to individuals in urban areas. Commenters pointed out that in rural or underserved areas therapy services enable beneficiaries to recover and reconstruct their lives after experiencing medical emergencies such as a stroke. Commenters also noted that if a therapy cap exceptions process is not in place, our proposed policy would result in Medicare beneficiaries either being financially liable for additional services or foregoing medically necessary services. Several commenters stated that this proposal would place an unnecessary burden on CAHs since it was unlikely that applying the therapy caps to CAHs would result in significant cost savings or reduce unnecessary care; and some even said that our proposed policy would actually increase costs for the Medicare program.

Response: After reassessing our interpretation of section 1833(g) of the Act under our proposed policy, we continue to conclude that the proper statutory interpretation would be to apply the therapy caps and related provisions to outpatient therapy services furnished by CAHs. We agree with commenters that CAHs provide important access to medically necessary therapy services for Medicare beneficiaries; however, we do not believe that application of the therapy caps and related policies to services furnished by CAHs will lead to significant new impediments for

Medicare beneficiaries. Under our proposed policy, CAHs would be subject to the therapy caps, as well as any potential extension of the therapy caps exceptions and manual medical review processes, in the same manner as other providers of therapy services except for those that are specifically exempted by statute from application of the caps and related provisions. As such, the therapy caps and related provisions would affect therapy services furnished by a CAH and other providers of such services in a comparable degree. We also do not believe that applying the therapy caps to services furnished by CAHs would negatively affect the ability of CAHs to furnish therapy services to Medicare beneficiaries. We believe that any increase in the administrative burden presented by the therapy caps and, if extended by legislation, the exceptions and manual medical review processes, will be only minor. As we explained in the proposed rule and noted above, we believe the proper interpretation of the statute requires us to apply the therapy caps to services furnished by CAHs.

Comment: We received a few comments stating that the drawbacks of the therapy caps would be exacerbated by applying this policy to additional provider settings. Most of these commenters argued that the therapy cap has been problematic since its inception. One commenter suggested that, instead of applying the therapy caps to CAHs, we should develop an alternative policy to replace the cap.

Response: The therapy caps are mandated by statute and we do not have authority to repeal the caps. As such, we will continue to apply the statutorily mandated therapy caps as specified under the statute which, as we have discussed above, includes applying the therapy caps policy to CAHs.

Comment: We received several comments stating that our current policies, in addition to our proposed regulations, overly control the utilization of therapy services. Most of these commenters noted that under § 409.17 of the regulations, therapy services are required to be ordered by a physician prior to a qualified professional initiating a plan of care, and these commenters argued that the requirement for an order can control utilization of therapy services in CAHs. One commenter noted that the direct supervision policy expressed in the CY 2014 OPPS proposed rule coupled with our proposal would cause services in CAHs to be overregulated.

Response: We disagree with commenters that CAHs are overregulated with respect to outpatient therapy services. We do not believe our proposed policy overregulates CAH services as compared to other providers of therapy services. We also do not believe that § 409.17 requires an order for outpatient therapy services in a CAH as suggested by the commenters. This regulation requires that a qualified professional pursuant to a plan of care furnish PT, OT, or SLP services, which is not the same as an order. Section 409.17 does not provide for any utilization control or limits on the quantity of outpatient therapy services furnished by CAHs, but rather assures that therapy is furnished under a plan of care by a qualified professional. Further, as explained above, we believe that proper interpretation of the statute requires us to apply the therapy caps and related provisions to therapy services furnished by CAHs. As such, the therapy caps and related provisions would have a comparable effect on therapy services furnished by a CAH and those furnished by other therapy services providers (unless they are exempted by statute from the application of the caps).

Comment: We received numerous comments stating that our proposal resulted from a misinterpretation of the ATRA, and that it is preferable policy to treat CAHs and hospitals similarly for the purpose of the therapy caps. Several commenters believed that we have misinterpreted the language of the ATRA to conclude that the therapy caps should be applied to services furnished by CAHs. Commenters noted that the ATRA specifies a proxy value to accrue therapy services furnished by CAHs toward the caps, but does not indicate that we should count this value beyond December 31, 2013, or that we should generally subject services furnished by CAHs to the therapy caps. Most of these commenters argued that if Congress had intended to apply the therapy cap to CAHs, it would have explicitly indicated in the ATRA that CAHs should be subject to the therapy caps. One commenter raised concern that "the proposed change is unlawful" since the ATRA neither requires, nor allows the Secretary to revise the federal regulations to permanently subject to the caps outpatient therapy services furnished by CAHs.

Most commenters said that we should treat CAHs and outpatient hospital departments similarly with regard to the therapy caps by continuing to exclude services furnished by CAHs (presumably to the extent such exclusion is required by statute). Commenters argued that a CAH is intended to be "provider of services" by furnishing inpatient and outpatient hospital services in areas where care is severely limited and thereby acts as a "hospital" in the areas that it serves. One commenter believed that our interpretation of the exemption from the therapy caps of outpatient therapy services described under section 1833(a)(8)(B) of the Act and paid under section 1834(k)(1)(B) of the Act is misguided since the exemption only describes the provider type rather than the provider type and payment methodology for those services. As evidence for this reasoning, the commenter noted that skilled nursing facilities (SNFs), comprehensive outpatient rehabilitation facilities (CORFs), rehabilitation agencies, and home health agencies, described under section 1833(a)(8)(A) of the Act and paid under section 1834(k)(1)(B) of the Act, are not exempt from the therapy caps. The commenter suggested that we make a determination that, based on the statutory definition in section 1861(e) of the Act, a CAH is a hospital in the context of applying the therapy caps, and interpret the hospital services exemption from the therapy caps to include CAHs.

Response: We agree with commenters that the ATRA does not direct or require us to apply the therapy caps to services furnished by CAHs. As noted above, we agree that the ATRA only directed us to count therapy services furnished by CAHs towards the caps. However, the ATRA is not the basis of the proposed change to our regulations. Rather, we based our proposed change on our reassessment of language of section 1833(g) of the Act as added by the BBA.

After considering the comments concerning our interpretation of section 1833(g) of the Act, we again reassessed the statute and reviewed the rationale for our proposal. We continue to conclude that our proposal to revise our regulations to apply the therapy caps to services furnished by CAHs reflects the proper interpretation of section 1833(g) of the statute. We continue to believe that therapy services furnished by a CAH and paid under section 1834(g) of the Act are not described under section 1833(a)(8)(B) of the Act and thus do not meet the requirements of the outpatient hospital exemption. Rather, as we explained in the proposed rule, the outpatient hospital services exemption relates to the specific services described under section 1833(a)(8)(B) of the Act, which delineates both the entities that furnish the services and the manner in which those services are paid. We acknowledge the commenter's recognition that therapy services furnished by rehabilitation agencies, CORFs, SNFs, and home health agencies

(some of which are also considered "providers of services" along with CAHs under section 1861(u) of the statute) are subject to the therapy caps even though they are paid under 1834(k)(1)(B) of the Act, as are hospitals. However, the providers mentioned by the commenters are described under section 1833(a)(8)(A) of the Act rather than section 1833(a)(8)(B) of the Act. The outpatient hospital services exemption only applies to services described under section 1833(a)(8)(B) of the Act. We believe that the statute explicitly exempts only services described under section 1833(a)(8)(B) of the Act, which does not include any services for which payment is not made under section 1834(k)(1)(B) of the Act. We continue to believe that neither services furnished by CAHs, nor those furnished by SNFs, CORFs, rehabilitation agencies, and home health agencies, fall under that exemption. Regardless of whether we consider a CAH as a "hospital" for purposes of the therapy caps, therapy services furnished by CAHs are not described under section 1833(a)(8)(B) of the Act and, as such, do not fall within the scope of the outpatient hospital services exemption from the therapy caps. Therefore, we continue to believe that the outpatient hospital services exemption to the therapy caps under section 1833(g)(1) and (3) of the Act does not apply to outpatient therapy services furnished by a CAH.

Comment: Commenters expressed concern that therapy services furnished by CAHs after January 1, 2014 would be treated differently than therapy services furnished by outpatient hospital departments although both entities are subject to the same regulations regarding outpatient therapy services.

Response: Although we believe it would be preferable policy to treat all outpatient therapy services furnished in all settings consistently, we continue to believe the proper interpretation of the statute requires application of the therapy caps and related policies to services furnished by CAHs. As a result, if the outpatient hospital services exemption is no longer suspended by legislation, there may be differences in the application of the statutory therapy caps and related provisions between outpatient hospitals and CAHs.

After consideration of all comments, we are finalizing our proposal. As proposed, we are including paragraph (e)(1)(iv) under both § 410.59 and § 410.60 to specify that outpatient occupational therapy, physical therapy and speech-language pathology services furnished by a CAH directly or under arrangements shall be counted towards the annual limitation on incurred expenses as if such services were paid under section 1834(k)(1)(B) of the Act. In order to improve clarity that PT and SLP services are combined for the purposes of applying the cap, but not to change the substance of the current regulations or the proposed changes to the regulations, we are making a modification to the proposal. Specifically, we are adding the phrase "and speech-language pathology" to the text in § 410.60(e)(1)(iv). Also as proposed, we are adding new paragraph (e)(2)(v) to § 410.59 and (e)(2)(vi) to § 410.60. These new paragraphs will expressly include outpatient occupational therapy, physical therapy and speech-language pathology services furnished by a CAH directly or under arrangements in the description of services to which the annual limitation applies. Lastly, as proposed, we are amending the regulation at § 410.60(e)(3), which currently excludes services furnished by a CAH from the therapy cap for PT and SLP services, to remove the phrase "or CAH."

We received a number of comments that were not related to our proposal to amend our regulations to specify that the therapy caps and related provisions are applicable to therapy services furnished by a CAH. These comments pertained to repeal of the therapy caps, the therapy caps exceptions process, the manual medical review process, the therapy MPPR, and Functional Reporting. Because we made no proposals regarding these subjects, these comments are outside of the scope of the proposed rule and, therefore, are not addressed in this final rule with comment period.

J. Requirements for Billing "Incident To" Services

1. Background

Section 1861(s)(2)(A) of the Act establishes the benefit category for services and supplies furnished as incident to the professional services of a physician. The statute specifies that "incident to" services and supplies are "of kinds which are commonly furnished in physicians' offices and are commonly either rendered without charge or included in physicians' bills."

In addition to the requirements of the statute, our regulation at § 410.26 sets forth specific requirements that must be met in order for physicians and other practitioners to bill Medicare for incident to physicians' services. Section 410.26(a)(7) limits "incident to" services to those included under section 1861(s)(2)(A) of the Act and that are not covered under another benefit category. Section 410.26(b) specifies (in part) that in order for services and supplies to be paid as "incident to" services under Medicare Part B, the services or supplies must be:

- Furnished in a noninstitutional setting to noninstitutional patients.
- An integral, though incidental, part of the service of a physician (or other practitioner) in the course of diagnosis or treatment of an injury or illness.
- Furnished under direct supervision (as specified under § 410.26(a)(2)) of a physician or other practitioner eligible to bill and directly receive Medicare payment.
- Furnished by a physician, a practitioner with an "incident to" benefit, or auxiliary personnel.

In addition to § 410.26, there are regulations specific to each type of practitioner who is allowed to bill for "incident to" services. These are found at § 410.71(a)(2) (clinical psychologist services), § 410.74(b) (physician assistants' services), § 410.75(d) (nurse practitioners' services), § 410.76(d) (clinical nurse specialists' services), and § 410.77(c) (certified nurse-midwives' services). When referring to practitioners who can bill for services furnished incident to their professional services, we are referring to physicians and these practitioners.

"Incident to" services are treated as if they were furnished by the billing practitioner for purposes of Medicare billing and payment. Consistent with this terminology, in this discussion when referring to the practitioner furnishing the service, we are referring to the practitioner who is billing for the "incident to" service. When we refer to the "auxiliary personnel" or the person who "provides" the service, we are referring to an individual who is personally performing the service or some aspect of it as distinguished from the practitioner who bills for the "incident to" service.

Since we treat "incident to" services as services furnished by the billing practitioner for purposes of Medicare billing and payment, payment is made to the billing practitioner under the PFS, and all relevant Medicare rules apply including, but not limited to, requirements regarding medical necessity, documentation, and billing. Those practitioners who can bill Medicare for "incident to" services are paid at their applicable Medicare payment rate as if they furnished the service. For example, when "incident to" services are billed by a physician, they are paid at 100 percent of the fee schedule amount, and when the services are billed by a nurse practitioner or clinical nurse specialist, they are paid at

85 percent of the fee schedule amount. Payments are subject to the usual deductible and coinsurance amounts.

As the services commonly furnished in physicians' offices and other nonfacility settings have expanded to include more complicated services, the types of services that can be furnished "incident to" physicians' services have also expanded. States have increasingly adopted standards regarding the delivery of health care services in all settings, including physicians' offices, in order to protect the health and safety of their citizens. These state standards often include qualifications for the individuals who are permitted to furnish specific services or requirements about the circumstances under which services may actually be furnished. For example, since 2009, New York has required that offices in which surgery is furnished must be accredited by a state-approved accredited agency or organization. Similarly, Florida requires certain standards be met when surgery is furnished in offices, including that the surgeon must "examine the patient immediately before the surgery to evaluate the risk of anesthesia and of the surgical procedure to be performed" and "qualified anesthesia personnel shall be present in the room throughout the conduct of all general anesthetics, regional anesthetics and monitored anesthesia care."

Over the past years, several situations have come to our attention where Medicare was billed for "incident to" services that were provided by auxiliary personnel who did not meet the state standards for those services in the state in which the services were furnished. The physician or practitioner billing for the services would have been permitted under state law to personally furnish the services, but the services were provided by auxiliary personnel who were not in compliance with state law in providing the particular service (or aspect of the service).

Practitioners authorized to bill Medicare for services that they furnish to Medicare beneficiaries are required to comply with state law when furnishing services for which Medicare will be billed. For example, section 1861(r) of the Act specifies that an individual can be considered a physician in the performance of any function or action only when legally authorized to practice in the particular field by the state in which he performs such function or action. Section 410.20(b) of our regulations provides that payment is made for services only if furnished by a doctor who is ". . . legally authorized to practice by the State in which he or she performs the functions or actions, and who is acting within the scope of his or her license." Similar statutory and regulatory requirements exist for nonphysician practitioners. For example, section 1861(s)(2)(K)(i) of the Act, which provides a benefit category for services of a physician assistant (PA), includes only services that the PA is ". . . legally authorized to perform by the State in which the services are performed . . .", and § 410.74(a)(2)(ii) of our regulations provides that the services of a PA are covered only if the PA is ". . . legally authorized to perform the services in the State in which they are performed. . ." There are similar statutory and regulatory provisions for nurse practitioner services (1861(s)(2)(K)(ii), § 410.75(b)), certified nurse specialist services (1861(s)(2)(K)(ii), § 410.76(b)), qualified psychologist services (1861(s)(2)(M), § 410.71(a)), and certified nurse-midwife services (1861(s)(2)(L), § 410.77(a)(1)).

However, the Medicare requirements for services and supplies incident to a physician's professional services (§ 410.26 discussed above), do not specifically make compliance with state law a condition of payment for services (or aspects of services) and supplies furnished and billed as "incident to" services. Nor do any of the regulations regarding services furnished incident to the services of other practitioners contain this requirement. Thus, Medicare has had limited recourse when services furnished incident to a physician's or practitioner's services are not furnished in compliance with state law.

In 2009, the Office of Inspector General issued a report entitled "Prevalence and Qualifications of Nonphysicians Who Performed Medicare Physician Services" (OEI–09–06–00430) that considered in part the qualifications of auxiliary personnel who provided incident to physician services. This report found that services being billed to Medicare were provided by auxiliary personnel. After finding that services were being provided by auxiliary personnel ". . . who did not possess the required licenses or certifications according to State laws, regulations, and/or Medicare rule" and billed to Medicare the OIG recommended that we revise the "incident to" rules to, among other things, ". . . require that physicians who do not personally perform the services they bill to Medicare ensure that no persons except . . . nonphysicians who have the necessary training, certification, and/or licensure, pursuant to State laws, State regulations, and Medicare regulations personally perform the services under the direct supervision of a licensed physician."

2. Compliance With State Law

To ensure that auxiliary personnel providing services to Medicare beneficiaries incident to the services of other practitioners do so in accordance with the requirements of the state in which the services are furnished and to ensure that Medicare payments can be denied or recovered when such services are not furnished in compliance with the state law, we proposed to add a requirement to the "incident to" regulations at § 410.26, Services and supplies incident to a physician's professional services: Conditions. Specifically, we proposed to amend § 410.26(b) by redesignating paragraphs (b)(7) and (b)(8) as paragraphs (b)(8) and (b)(9), respectively, and by adding a new paragraph (b)(7) to state that "Services and supplies must be furnished in accordance with applicable State law." We also proposed to amend the definition of auxiliary personnel at § 410.26(a)(1) to require that the individual providing "incident to" services "meets any applicable requirements to provide the services, including licensure, imposed by the State in which the services are being furnished."

3. Elimination of Redundant Language

In addition, we proposed to eliminate redundant and potentially incongruent regulatory language by replacing the specific "incident to" requirements currently contained in the regulations relating to each of the various types of practitioners with a reference to the requirements of § 410.26. Specifically, we proposed to:

- Revise § 410.71(a)(2) regarding clinical psychologists' services to read "Medicare Part B covers services and supplies incident to the services of a clinical psychologist if the requirements of § 410.26 are met."
- Revise § 410.74(b) regarding physician assistants' services to read "Medicare Part B covers services and supplies incident to the services of a physician assistant if the requirements of § 410.26 are met."
- Revise § 410.75(d) regarding nurse practitioners' services to read "Medicare Part B covers services and supplies incident to the services of a nurse practitioner if the requirements of § 410.26 are met."
- Revise § 410.76(d) regarding certified nurse specialists' services to read "Medicare Part B covers services and supplies incident to the services of a clinical nurse specialist if the requirements of § 410.26 are met."

• Revise the language in § 410.77(c) regarding certified nurse-midwives' services to read "Medicare Part B covers services and supplies incident to the services of a certified nurse-midwife if the requirements of § 410.26 are met."

We noted in the proposed rule that these practitioners are, and would continue to be under this proposal, required to comply with the regulation at § 410.26 for services furnished incident to their professional services. We believe it is redundant and potentially confusing to have separate regulations that generally restate the requirements for "incident to" services of § 410.26 using slightly different terminology. We stated that our goal in proposing the revisions to refer to § 410.26 in the regulation for each practitioner's "incident to" services was to reduce the regulatory burden and make it less difficult for practitioners to determine what is required. Reconciling these regulatory requirements for physicians and all other practitioners who have the authority to bill Medicare for "incident to" services is also consistent with our general policy to treat nonphysician practitioners similarly to physicians unless there is a compelling reason for disparate treatment. We noted that we believed that this proposal made the requirements clearer for practitioners furnishing "incident to" services without eliminating existing regulatory requirements or imposing new ones and welcomed comments on any requirements that we may have inadvertently overlooked in our proposed revisions, or any benefit that accrues from continuing to carry these separate regulatory requirements.

4. Rural Health Clinics and Federal Qualified Health Centers

The regulations applicable to Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) have similar "incident to" rules, and we proposed to make conforming changes to these regulations. Specifically, we proposed to revise § 405.2413(a), which addresses services and supplies incident to physicians' services for RHCs and FQHCs, by redesignating paragraphs (a)(4) and (a)(5) as paragraphs (a)(5) and (a)(6), respectively and by adding a new paragraph (a)(4) that states services and supplies must be furnished in accordance with applicable state law. Additionally, we proposed to amend § 405.2415(a), which addresses services incident to nurse practitioner and physician assistant services by redesignating paragraphs (a)(4) and (a)(5) as paragraphs (a)(5) and (a)(6), respectively and by adding a new paragraph (a)(4), which specifies services and supplies must be furnished in accordance with applicable state law. We proposed to amend § 405.2452(a), which addresses services and supplies incident to clinical psychologist and clinical social worker services by redesignating paragraphs (a)(4) and (a)(5) as paragraphs (a)(5) and (a)(6), respectively and by adding a new paragraph (a)(4), which states services and supplies must be furnished in accordance applicable state law. Finally, we also proposed the removal of the word "personal" in § 405.2413, § 405.2415, and § 405.2452 to be consistent with the "incident to" provisions in § 410.26.

The following is a summary of the comments we received regarding the proposal to amend our regulations to include the requirement that "incident to" services must be furnished in accordance with applicable state law.

Comment: The vast majority of commenters supported requiring compliance with applicable state law as a condition of payment for "incident to" services. Many of these commenters noted that adoption of this regulation would increase quality of care and safety for Medicare beneficiaries and ensure that funds dedicated to services and supplies are appropriately utilized. We received only two comments opposing the adoption of a condition of payment requiring compliance with state laws. One of these stated that since at least 1997, Medicare has had a "demonstration project" that has tested the effects of lifting state scope of practice restrictions, and that with this proposed regulation we are abruptly ending this demonstration without an assessment of the effects of such action. The other stated that this regulation was unnecessary because section 1156 of the Act requires health care practitioners to ensure that ". . . the services it furnishes are of a quality that meets professional standards of care. . . ." Some who supported the concept of our proposal suggested that the condition of payment only require compliance with state laws relating to training, certification, and/or licensure. In support of this suggestion, a commenter noted that the broader requirement of compliance with any applicable state laws would allow CMS to deny Medicare payment for technical violations of state laws that are not targeted at patient health or safety, even when care was appropriately delivered and the quality of care not affected. One commenter pointed out that our regulations if revised as proposed would put providers at risk of having to defend False Claims Act actions brought on the theory that the provider improperly billed for services based on a minor defect with the physician or other practitioner's license or certification; and, in turn that this minor defect is unrelated to the quality of care furnished and outside the scope of practice and should therefore not result in the risk of possible False Claims Act allegations.

Response: After consideration of the comments, we are finalizing our proposal to adopt a new condition of payment imposing a requirement to comply with state laws for services furnished incident to a physician's or other practitioner's professional services. We believe this requirement will protect the health and safety of Medicare beneficiaries and enhance our ability to recover federal dollars when care is not delivered in accordance with state laws. In response to concerns that the proposal should be limited to state laws relating to who could perform the services, such as scope of practice or licensure laws, we believe that there are many and varied state laws that would protect the safety and health of Medicare beneficiaries. As such, we do not believe it would be prudent to limit the applicability as suggested. In response to the commenter's concern regarding technical and unintended violations of state laws, it is important that CMS only pays for services furnished in accordance with state law. In an effort to ensure that services are furnished in accordance with state law, it is expected that practitioners are cognizant of the qualifications of any individuals who provide services incident to the physician (or other practitioner). With regard to the comment stating that this regulation is unnecessary based on section 1156 of the Act, we note that compliance with section 1156 is a condition of eligibility and not an explicit basis for CMS to deny or recover payments for services furnished incident to services of a physician (or other practitioner) where services are not furnished in accordance with state law. After reviewing the comments we conclude that it is beneficial to make explicit as a condition of payment for "incident to" services the requirement to comply with state law. The fact that another provision of the law might also be relevant to the situation does not mean that both are not appropriate or beneficial to the program. With regard to the comment that we are ending a demonstration project that has existed since at least 1997 without an assessment, we disagree. We are unaware of any such demonstration

project either currently underway, or undertaken in the past. Moreover, as we noted in the proposed rule, practitioners furnishing services to Medicare beneficiaries are not exempt from complying with state law.

Comment: Several commenters, including some who supported our proposal, expressed concern about enforcement and expanding the administrative burden on Medicare practitioners. Suggestions were made that we be transparent in implementing the provision and provide ample education on the policy and how it will be enforced. One commenter asked that we ". . . take into account the already significant administrative burden that physicians face under Medicare, and avoid adding to that burden." Another commenter urged us to work with medical societies, particularly those representing practitioners in rural communities, to ensure the policy is well understood and does not impede beneficiary access to care. It was further suggested that we should know who is actually providing services or at least when services are provided "incident to" the billing professional's services, and that we consider implementing the OIG's recommendation to require the use of modifiers on the claim when reporting "incident to" services.

Response: We do not believe that this condition of payment would increase the administrative burden on practitioners as practitioners are already expected to comply with state law. As we have discussed above, we believe that this provision enhances our ability to deny or recover payments when the condition is not met. With regard to the suggestion that we impose a requirement for practitioners to bill "incident to" services using a modifier, we do not believe that a modifier requirement would assist in implementing or enforcing this condition of payment. Since a modifier requirement would not assist us in implementing this provision, we are not adopting one at this time. We would also note that there are impediments to imposing a modifier requirement at this time, including that a modifier and required definitions for use of a modifier do not exist. With regard to informing those affected by this change in regulations, we will use our usual methods to alert stakeholders of this new condition of payment and feel confident that the information will be efficiently and effectively disseminated to those who need it.

Comment: One commenter pointed out that states can and do punish individuals for furnishing services inappropriately, and that CMS should therefore leave it to the states to determine whether or when services are provided by an unlicensed professional.

Response: We agree with this commenter that it is primarily the responsibility of states to develop and enforce compliance with licensure laws for health care professionals, and note that nothing in this proposal would impede the states' ability to do so. Nor would anything in this proposal duplicate the states' activities in this arena. Rather, this proposal would reinforce the states' laws by providing explicit authority to limit Medicare payment for "incident to" services to those furnished in accordance with state laws. As noted above, in the absence of our proposed regulation, situations could arise where Medicare would otherwise make payment for services not furnished in accordance with state law. Such situations are not consistent with our recognition of states as principle regulators of health care practices for the protection and benefit of their citizens. The adoption of compliance with state law as a condition of Medicare payment allows us to deny, or if already paid, recover payment when services are not furnished in compliance with state law and thus supports state activities.

Comment: A commenter suggested that we eliminate the new proposed § 410.26(b)(7), which requires that "incident to" services be provided in compliance with applicable state law, because it was redundant with § 410.26(a)(1).

Response: Section 410.26(a)(1) defines "Auxiliary personnel" whereas § 410.26(b)(7) provides the conditions that must be met for Medicare Part B to pay for services and supplies. It is therefore not redundant, but instead necessary, to both define auxiliary personnel and to include the specific requirements that must be met.

In addition to the comments discussed above, we received several comments regarding the "incident to" benefit that were not within the scope of our proposal. Specifically, we received requests to expand the types of practitioners who are allowed to bill Medicare for "incident to" services and to limit auxiliary personnel under our "incident to" regulations to those who cannot bill Medicare directly for their services. Not only are these comments outside the scope of this regulation, but in most respects they are addressed by the Medicare statute and outside our discretion to change.

After consideration of public comments regarding our proposed rule, we are finalizing the changes to our regulations as proposed. The specific regulatory changes being made are described below.

Specifically, we are amending § 410.26(a)(7), which defines "auxiliary personnel" to add "and meets any applicable requirements to provide the services, including licensure, imposed by the State in which the services are being furnished." In § 410.26(b) we are redesignating paragraphs (b)(7) and (b)(8) as paragraphs (b)(8) and (b)(9), respectively, and adding a new paragraph (b)(7) to state that "Services and supplies must be furnished in accordance with applicable State laws;".

In addition, we are finalizing our proposal to eliminate redundant and potentially incongruent regulatory language by replacing the specific "incident to" requirements currently contained in the regulations relating to each of the various types of practitioners with a reference to the requirements of § 410.26. Specifically, we are:

- Revising § 410.71(a)(2) regarding clinical psychologist services to read "Medicare Part B covers services and supplies incident to the services of a clinical psychologist if the requirements of § 410.26 are met."
- Revising § 410.74(b) regarding physician assistants' services to read "Medicare Part B covers services and supplies incident to the services of a physician assistant if the requirements of § 410.26 are met."
- Revising § 410.75(d) regarding nurse practitioners' services to read "Medicare Part B covers services and supplies incident to the services of a nurse practitioner if the requirements of § 410.26 are met."
- Revising § 410.76(d) regarding clinical nurse specialists' services to read "Medicare Part B covers services and supplies incident to the services of a clinical nurse specialist if the requirements of § 410.26 are met."
- Revising the language in § 410.77(c) regarding certified nurse-midwives' services to read "Medicare Part B covers services and supplies incident to the services of a certified nurse-midwife if the requirements of § 410.26 are met."

We are also revising the regulations applicable to RHCs and FQHCs to make similar changes. Specifically, we are revising § 405.2413(a), which addresses services and supplies incident to physicians' services for RHCs and FQHCs, by redesignating paragraphs (a)(4) and (a)(5) as paragraphs (a)(5) and (a)(6), respectively and by adding a new paragraph (a)(4) that states "Services and supplies must be furnished in accordance with applicable State laws;". Additionally, we are amending § 405.2415(a), which addresses services incident to nurse practitioner and

physician assistant services by redesignating paragraphs (a)(4) and (a)(5) as paragraphs (a)(5) and (a)(6), respectively and by adding a new paragraph (a)(4) that "Services and supplies must be furnished in accordance with applicable State laws;". We are amending § 405.2452(a), which addresses services and supplies incident to clinical psychologist and clinical social worker services by redesignating paragraphs (a)(4) and (a)(5) as paragraphs (a)(5) and (a)(6), respectively and by adding a new paragraph (a)(4) that states "Services and supplies must be furnished in accordance with applicable State laws."

Finally, we are removing the word "personal" in § 405.2413, § 405.2415, and § 405.2452 to be consistent with the "incident to" provisions in § 410.26 Services and supplies incident to a physician's professional services: Conditions.

The changes being adopted in this final rule with comment period are consistent with the traditional approach of relying primarily on the states to regulate the health and safety of their residents in the delivery of health care services. Throughout the Medicare program, and as evidenced by several examples above, the qualifications required for the delivery of health care services are generally determined with reference to state law. As discussed above, our current regulations governing practitioners billing Medicare for services personally furnished include a basic requirement to comply with state law when furnishing Medicare covered services. However, the Medicare regulations for "incident to" services and supplies did not specifically make compliance with state law a condition of payment for services and supplies furnished and billed as incident to a practitioner's services. In addition to health and safety benefits that we believe will accrue to Medicare beneficiaries, these changes will help to assure that federal dollars are not expended for services that do not meet the standards of the states in which they are being furnished while providing the ability for the federal government to recover funds paid where services and supplies are not furnished in accordance with these requirements.

K. Chronic Care Management (CCM) Services

As we discussed in the CY 2013 PFS final rule with comment period, we are committed to supporting primary care and we have increasingly recognized care management as one of the critical components of primary care that contributes to better health for individuals and reduced expenditure growth (77 FR 68978). Accordingly, we have prioritized the development and implementation of a series of initiatives designed to improve payment for, and encourage long-term investment in, care management services. These initiatives include the following programs and demonstrations:

- The Medicare Shared Savings Program (described in "Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations; Final Rule" which appeared in the November 2, 2011 **Federal Register** (76 FR 67802)).
- The testing of the Pioneer ACO model, designed for experienced health care organizations (described on the Center for Medicare and Medicaid Innovation's (Innovation Center's) Web site at *innovations.cms.gov/initiatives/ACO/Pioneer/index.html*).
- The testing of the Advance Payment ACO model, designed to support organizations participating in the Medicare Shared Savings Program (described on the Innovation Center's Web site at *innovations.cms.gov/initiatives/ACO/Advance-Payment/index.html*).
- The Primary Care Incentive Payment (PCIP) Program (described on the CMS Web site at *www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/PCIP-2011-Payments.pdf*).
- The patient-centered medical home model in the Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration designed to test whether the quality and coordination of health care services are improved by making advanced primary care practices more broadly available (described on the CMS Web site at *www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/downloads/mapcpdemo_Factsheet.pdf*).
- The Federally Qualified Health Center (FQHC) Advanced Primary Care Practice demonstration (described on the CMS Web site at *www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/downloads/mapcpdemo_Factsheet.pdf* and the Innovation Center's Web site at *innovations.cms.gov/initiatives/FQHCs/index.html*).
- The Comprehensive Primary Care (CPC) initiative (described on the Innovation Center's Web site at *innovations.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/index.html*). The CPC initiative is a multi-payer initiative fostering collaboration between public and private health care payers to strengthen primary care in certain markets across the country.

In addition, HHS leads a broad initiative focused on optimizing health and quality of life for individuals with multiple chronic conditions. HHS' Strategic Framework on Multiple Chronic Conditions outlines specific objectives and strategies for HHS and private sector partners centered on strengthening the health care and public health systems; empowering the individual to use self-care management; equipping care providers with tools, information, and other interventions; and supporting targeted research about individuals with multiple chronic conditions and effective interventions. Further information on this initiative can be found on the HHS Web site at *http://www.hhs.gov/ash/initiatives/mcc/index.html*.

In coordination with all of these initiatives, we also have continued to explore potential refinements to the PFS that would appropriately value care management within Medicare's statutory structure for fee-for-service physician payment and quality reporting. For example, in the CY 2013 PFS final rule with comment period, we adopted a policy to pay separately for care management involving the transition of a beneficiary from care furnished by a treating physician during a hospital stay to care furnished by the beneficiary's primary physician in the community (77 FR 68978 through 68993). We view potential refinements to the PFS such as these as part of a broader strategy that relies on input and information gathered from the initiatives described above, research and demonstrations from other public and private stakeholders, the work of all parties involved in the potentially misvalued code initiative, and from the public at large.

1. Patient Eligibility for Separately Payable Non-Face-to-Face Chronic Care Management Services

Under current PFS policy, the payment for non-face-to-face care management services is bundled into the payment for face-to-face E/M visits because care management is a component of those E/M services. The pre- and post-encounter non-face-to-face care management work is included in calculating the total work for the typical E/M services, and the total work for the typical service is used to develop RVUs for the E/M services. In the CY 2012 PFS proposed rule, we highlighted some of the E/M services that include substantial care management work. Specifically, we noted that the vignettes that describe a typical service for mid-

level office/outpatient services (CPT codes 99203 and 99213) include furnishing care management, communication, and other necessary care management related to the office visit in the post-service work (76 FR 42917).

However, the physician community continues to tell us that the care management included in many of the E/M services, such as office visits, does not adequately describe the typical non-face-to-face care management work involved for certain categories of beneficiaries. In addition, there has been substantial growth in medical practices that are organized as medical homes and devote significant resources to care management as one of the keys to improve the quality and coordination of health care services. Practitioners in these medical homes have also indicated that the care management included in many of the E/M services does not adequately describe the typical non-face-to-face care management work that they furnish to patients.

Because the current E/M office/outpatient visit CPT codes were designed to support all office visits and reflect an overall orientation toward episodic treatment, we agree that these E/M codes may not reflect all the services and resources required to furnish comprehensive, coordinated care management for certain categories of beneficiaries. For example, we currently pay physicians separately for the non face-to-face care plan oversight services furnished to beneficiaries under the care of home health agencies or hospices and we currently pay separately for care management services furnished to beneficiaries transitioning from care furnished by a treating physician during a hospital stay to care furnished by the beneficiary's primary physician in the community.

Similar to these situations, we believe that the resources required to furnish chronic care management services to beneficiaries with multiple (that is, two or more) chronic conditions are not adequately reflected in the existing E/M codes. Therefore, for CY 2015, we proposed to establish a separate payment under the PFS for chronic care management services furnished to patients with multiple chronic conditions that are expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.

We also stated our intent to develop standards for furnishing chronic care management services to ensure that the physicians and practitioners who bill for these services have the capability to provide them.

Comment: The vast majority of commenters overwhelmingly supported the broad policy of paying separately for non-face-to-face chronic care management services, but submitted comments on many specific aspects of our proposal.

Response: We appreciate the widespread support expressed by commenters for our proposed policy. We address the more specific comments below in this section.

Comment: Some commenters supported our proposed patient eligibility for chronic care management services, at least for the initial implementation of separate payment for the services. Typical of these comments was this statement by one commenter:

"CMS should initially offer these services to patients with multiple chronic conditions that are expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline."

We also received comments indicating that the patient eligibility should be broadened, for example, to allow eligibility for patients with one condition or for all patients in a practice that meets the practice standards we establish.

On the other hand, some commenters believed that the eligible patient population should be narrowed. Many of these commenters indicated that the benefits of chronic care management are likely to increase with thethe patient's acuity and risk. Many commenters indicated that the criteria described in the prefatory language for the complex chronic care coordination CPT codes 99487–99489 describes a narrower and more appropriate patient population. The CPT criteria for CY 2014 currently state:

"Patients who require complex chronic care coordination services may be identified by practice-specific or other published algorithms that recognize multiple illnesses, multiple medication use, inability to perform activities of daily living, requirement for a caregiver, and/or repeat admissions or emergency department visits. Typical adult patients take or receive three or more prescription medications and may also be receiving other types of therapeutic interventions (eg, physical therapy, occupational therapy) and have two or more chronic continuous or episodic health conditions expected to last at least 12 months, or until the death of the patient, that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. Typical pediatric patients receive three or more therapeutic interventions (eg, medications, nutritional support, respiratory therapy) and have two or more chronic continuous or episodic health conditions expected to last at least 12 months, or until the death of the patient, that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. Because of the complex nature of their diseases and morbidities, these patients commonly require the coordination of a number of specialties and services. In some cases, due to inability to perform IADL/ADL and/or cognitive impairment the patient is unable to adhere to the treatment plan without substantial assistance from a caregiver. For example, patients may have medical and psychiatric behavioral co-morbidities (eg, dementia and chronic obstructive pulmonary disease or substance abuse and diabetes) that complicate their care. Social support requirements or access to care difficulties may cause a need for these services. Medical, functional, and/or psychosocial problems that require medical decision making of moderate or high complexity and extensive clinical staff support are required."

MedPAC and other some commenters did not recommend specific alternative patient eligibility criteria, but stated that CMS should develop such criteria to better target the beneficiaries requiring significant management. One commenter recommended that the eligible patient population be narrowed to patients with four or more chronic conditions.

Response: As we stated in the proposed rule, we believe that the resources required tofurnish chronic care management services to beneficiaries with two or more chronic conditions are not adequately reflected in the existing E/M codes. Furnishing care management to beneficiaries with multiple chronic conditions requires multidisciplinary care modalities that involve: regular physician development and/or revision of care plans; subsequent reports of patient status; review of laboratory and other studies; communication with other health professionals not employed in the same practice who are involved in the patient's care; integration of new information into the care plan; and/or adjustment of medical therapy. Our proposal was also supported by an analysis of Medicare claims for patients with selected multiple chronic conditions (see *http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Downloads/2012Chartbook.pdf*). This analysis indicated that patients with these selected multiple chronic conditions are at increased risk for hospitalizations, use of post-acute care services, and emergency department visits. We continue to believe these findings would hold in general for patients with

multiple chronic conditions that are expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline. (We note that we did not propose to limit the eligible chronic conditions to those contained in our Medicare data analysis.) We continue to believe that successful efforts to improve chronic care management for these patients could improve the quality of care while simultaneously decreasing costs (for example, through reductions in hospitalizations, use of post-acute care services, and emergency department visits.) Therefore, we agree with the commenters who supported our proposed patient eligibility criteria.

While we also agree with the commenters who stated that the benefits from chronic care management are likely to increase the greater the acuity and risk to the patient, we disagree that the benefits and higher resource requirements for furnishing the service are limited to those even higher risk patients within the population of patients with two or more chronic conditions. Therefore, we disagree that the eligible patient population should be narrowed.

We also disagree with commenters who indicated that we should immediately expand the eligible patient population, for example, to include some patients with a single chronic condition or all the patients in a practice that meets future standards. It is not clear at this time that the resources required to provide typical chronic care management to these patients are not reflected adequately in the existing E/M codes. However, as we indicated in the proposed rule, we have over time recognized certain categories of beneficiaries for whom we allow separate payment for care management. We have not indicated that we have exhaustively identified all such categories of beneficiaries. We will continue to carefully consider whether there are categories of patients for whom the resources required to provide chronic care management services are not adequately reflected in the existing E/M codes. We may consider changes to the patient eligibility in future rulemaking.

In summary, we are finalizing without modification our proposed patient eligibility for chronic care management services to be patients with multiple chronic conditions that are expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.

We note that although we are finalizing our proposed eligibility criteria, since we agree with commenters that the benefits from chronic care management are likely to increase with the greater the acuity and risk to the patient, we expect that physicians and other practitioners will particularly focus on higher acuity and higher risk patients (for example, patients with four or more chronic conditions as suggested by one commenter) when furnishing chronic care management services to eligible patients.

Comment: Many commenters found our use of the term "complex" to describe these services to be confusing in light of the number of Medicare beneficiaries within a practice potentially meeting our proposed eligibility criteria, and suggested that the word could be interpreted to significantly narrow the appropriate patient population eligible for chronic care management services.

Response: We regret any confusion generated by our proposed use of the term "complex" to describe the chronic care management services that are not adequately reflected in the existing E/M codes. Although the provision of these services is complex relative to the care management reflected in the existing E/M codes, we understand the confusion on the part of commenters regarding the number of patients within a practice that are potentially eligible for the service versus those that would be considered "complex." Therefore, to reduce potential confusion, we will revise the code description for these services to describe "chronic care management" services rather than complex chronic care management services. We note that we have revised references throughout this preamble to remove the word "complex" from the description of these services.

2. Scope of Chronic Care Management Services

We proposed that the scope of chronic care management services includes:

- The provision of 24-hour- a-day, 7-day- a-week access to address a patient's acute chronic care needs. To accomplish these tasks, we would expect that the patient would be provided with a means to make timely contact with health care providers in the practice to address urgent chronic care needs regardless of the time of day or day of the week. Members of the chronic care team who are involved in the after-hours care of a patient must have access to the patient's full electronic medical record even when the office is closed so they can continue to participate in care decisions with the patient.
- Continuity of care with a designated practitioner or member of the care team with whom the patient is able to get successive routine appointments.
- Care management for chronic conditions including systematic assessment of patient's medical, functional, and psychosocial needs; system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions; and oversight of patient self-management of medications. In consultation with the patient and other key practitioners treating the patient, the practitioner furnishing chronic care management services should create a patient-centered plan of care document to assure that care is provided in a way that is congruent with patient choices and values. A plan of care is based on a physical, mental, cognitive, psychosocial, functional and environmental (re)assessment and an inventory of resources and supports. It is a comprehensive plan of care for all health issues. It typically includes, but is not limited to, the following elements: problem list, expected outcome and prognosis, measurable treatment goals, symptom management, planned interventions, medication management, community/social services ordered, how the services of agencies and specialists unconnected to the practice will be directed/coordinated, identify the individuals responsible for each intervention, requirements for periodic review and, when applicable, revision, of the care plan. The provider should seek to reflect a full list of problems, medications and medication allergies in the electronic health record to inform the care plan, care coordination and ongoing clinical care.
- Management of care transitions within health care including referrals to other clinicians, visits following a patient visit to an emergency department, and visits following discharges from hospitals and skilled nursing facilities. The practice must be able to facilitate communication of relevant patient information through electronic exchange of a summary care record with other health care providers regarding these transitions. The practice must also have qualified personnel who are available to deliver transitional care services to a patient in a timely way so as to reduce the need for repeat visits to emergency departments and re-admissions to hospitals and skilled nursing facilities.

• Coordination with home and community based clinical service providers required to support a patient's psychosocial needs and functional deficits. Communication to and from home and community based providers regarding these clinical patient needs must be documented in practice's medical record system.

• Enhanced opportunities for a patient to communicate with the provider regarding their care through not only the telephone but also through the use of secure messaging, internet or other asynchronous non face-to-face consultation methods.

Comment: Some commenters supported our proposed scope of services, indicating that the requirements are consistent with what is expected in a primary care medical home. Other commenters, while generally supportive of the proposed scope of services, provided comments on specific aspects of the proposed scope.

Response: We agree with the commenters who supported our proposed scope of services and agree that the requirements are consistent with what is expected in a primary care medical home. We summarize and respond to comments on specific aspects of the proposed scope below.

Comment: Some commenters indicated that while they agreed with the goal of having members of the chronic care team who are involved in the after-hours care of a patient having access to the patient's full EHR, that this was not currently possible for too many physicians who would otherwise be able to provide this service. Some commenters indicated that many practices will be using EHR systems that qualify for Meaningful Use Stage 2, but that do not support 24/7 remote access. Some commenters suggested that the 24/7 EHR access requirement be changed to require that members of the chronic care team have access to timely EHR information (that is, through the EHR or other formats.)

Response: Given that the comments on our proposed policy to require 24/7 access to the EHR were generally part of broader comments on the role of EHRs in the standards that must be met in order to furnish chronic care management services, we intend to address this issue in future rulemaking to establish the standards. Summaries of these broader comments can be found below in the standards section.

Comment: Some commenters stated that it was not feasible in many practices for a patient's personal practitioner or another clinical team member to be available on a 24/7 basis for every patient. Other commenters recommended gradually phasing in this requirement over time.

Response: The evolving medical literature on chronic care management and patient centered medical homes emphasizes the central importance of members of the care team being available 24/7 to address a patient's acute chronic care needs. Moreover, we believe the 24/7 availability of the care team is an important factor contributing to higher resource costs for these services that are not currently reflected in E/M services. Therefore, we disagree with commenters who requested that we relax or phase in the 24/7 requirement.

Comment: Some commenters requested that we clarify the scope of services with respect to caregivers for patients with chronic care needs. Some of these commenters recommended that we require providers to address the needs of caregivers, especially caregivers who are Medicare beneficiaries, since caregivers are at elevated risk of health issues from emotional and physical stresses.

Response: As with transitional care management (77 FR 68989), communication that is within the scope of services for chronic care management includes communication with the patient and caregiver. We also agree with commenters that caregivers who are Medicare beneficiaries, as with any Medicare beneficiary, should be provided with needed high quality, efficient care congruent with the patient's choices and values. We note, however, that we do not have the statutory authority to extend Medicare benefits to individuals who are not eligible for those benefits.

Comment: While the majority of commenters expressed support for our proposal to require a patient-centered plan of care, some commenters believed that this requirement was not necessary in all cases. These commenters suggested that the requirement be changed to require a plan of care document as needed.

Response: We disagree with these comments. As we indicated in the propose rule, we believe that patients with multiple chronic conditions are at increased risk for hospitalizations, use of post-acute care services, and emergency department visits. Given this increased risk, we believe that a patient-centered plan of care document is a critical tool to help ensure appropriate care management for these patients. In the absence of such of document, we believe there would be significantly greater potential for gaps in care coordination. In addition, we received many comments supporting active involvement of the patient and caregiver in chronic care management. We believe our requirement that a written or electronic copy of the patient-centered plan of care document be provided to the patient facilitates this involvement.

Comment: Some commenters expressed concern regarding our proposal to include enhanced opportunities for a patient to communicate with the provider regarding their care through not only the telephone but also through the use of secure messaging, internet or other asynchronous non face-to-face consultation methods. They indicated that many patients and/or caregivers may not be capable of using this type of communication, even if the practice is equipped to provide it.

Response: We disagree with these comments. Recognizing the growing use of, and patient and caregiver interest in, asynchronous communication through secure email, text and other modalities to support access to health care, we believe that it is reasonable for beneficiaries and their caregivers who would receive non-face-to-face chronic care management services to be able to communicate with the practice not only by telephone but through asynchronous communication modalities. We note that although the expectation is for the practice to provide these communication options, there is no requirement that the practice ensure that every patient and caregiver makes use of these options.

Comment: Some commenters requested that we explicitly require the chronic care management practitioner to consider various specific services or disease specific services when furnishing the scope of chronic care management services.

Response: In our proposed scope of services, we stated that, "A plan of care is based on a physical, mental, cognitive, psychosocial, functional and environmental (re)assessment and an inventory of resources and supports. It is a comprehensive plan of care for *all health issues* (emphasis added)." Since the plan of care, as we described it, is to be comprehensive, we do not believe it is necessary for the scope of services to exhaustively list specific possible services that the chronic care management practitioner should consider when furnishing the scope of chronic care management services.

In summary, we are finalizing the following as the scope of chronic care management services.

• The provision of 24-hour- a-day, 7-day- a-week access to address a patient's acute chronic care needs. To accomplish these tasks, we would expect that the

patient and caregiver would be provided with a means to make timely contact with health care providers in the practice to address the patient's urgent chronic care needs regardless of the time of day or day of the week.

• Continuity of care with a designated practitioner or member of the care team with whom the patient is able to get successive routine appointments.

• Care management for chronic conditions including systematic assessment of patient's medical, functional, and psychosocial needs; system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions; and oversight of patient self-management of medications. In consultation with the patient, caregiver, and other key practitioners treating the patient, the practitioner furnishing chronic care management services should create a patient-centered plan of care document to assure that care is provided in a way that is congruent with patient choices and values. A plan of care is based on a physical, mental, cognitive, psychosocial, functional and environmental (re)assessment and an inventory of resources and supports. It is a comprehensive plan of care for all health issues. It typically includes, but is not limited to, the following elements: problem list, expected outcome and prognosis, measurable treatment goals, symptom management, planned interventions, medication management, community/social services ordered, how the services of agencies and specialists unconnected to the practice will be directed/coordinated, identify the individuals responsible for each intervention, requirements for periodic review and, when applicable, revision, of the care plan. The provider should seek to reflect a full list of problems, medications and medication allergies in the electronic health record to inform the care plan, care coordination and ongoing clinical care.

• Management of care transitions within health care including referrals to other clinicians, visits following a patient visit to an emergency department, and visits following discharges from hospitals and skilled nursing facilities. The practice must be able to facilitate communication of relevant patient information through electronic exchange of a summary care record with other health care providers regarding these transitions. The practice must also have qualified personnel who are available to deliver transitional care services to a patient in a timely way so as to reduce the need for repeat visits to emergency departments and re-admissions to hospitals and skilled nursing facilities.

• Coordination with home and community based clinical service providers required to support a patient's psychosocial needs and functional deficits. Communication to and from home and community based providers regarding these clinical patient needs must be documented in practice's medical record system.

• Enhanced opportunities for a patient and caregiver to communicate with the provider regarding the patient's care through not only the telephone but also through the use of secure messaging, internet or other asynchronous non face-to-face consultation methods.

We also note that we continue to assess the potential impact of the scope of our chronic care management policy on our current programs and demonstrations designed to improve payment for, and encourage long-term investment in, care management services. Likewise, to assure that there are not duplicate payments for delivery of care management services, we continue to consider whether such payments are appropriate for providers participating in other programs and demonstrations.

3. Standards for Furnishing Chronic Care Management Services

Not all physicians and nonphysician practitioners who wish to furnish chronic care management services currently have the capability to fully furnish the scope of these services without making additional investments in technology, staff training, and the development and maintenance of systems and processes to furnish the services. We stated in the proposed rule that we intended to establish standards that would be necessary to furnish high quality, comprehensive and safe chronic care management services. We also stated that one of the primary reasons for our 2015 implementation date was to provide sufficient time to develop and obtain public input on the standards. Since we continue to believe that practice standards are one of the most critical components of our chronic care management policy. We are developing the standards in 2014 and will implement them in 2015. They will be established through notice and comment rulemaking for CY 2015 PFS.

In the proposed rule (78 FR 43338–43339), we solicited public comments for suggestions regarding standards for furnishing chronic care management. Although we solicited comments, we did not propose to adopt any specific standards and are, therefore, not finalizing a policy relating to this issue in this final rule with comment period.

Below are our responses to public comments received. As stated above, the public comments received for these potential standards for chronic care management are beyond the scope of the proposed rule, and therefore, the adoption of any such standards would be addressed through separate notice-and-comment rulemaking.

Comment: Some commenters were in favor of establishing standards for furnishing chronic care management services, generally supporting CMS's acknowledgement of the critical importance of managing care for these Medicare beneficiaries with chronic conditions. Commenters also believe that care coordination is an integral part of improving patient care.

Many commenters expressed concerns and did not support establishing standards for furnishing chronic care management services as we discussed in the proposed rule (78 FR 43338–43339). Some commenters stated the standards we suggested were too aggressive, needed clarification and/or refinement, and were overly burdensome citing that adoption should be delayed, perhaps for years or indefinitely. Commenters suggested that practice capabilities as outlined could exclude many physicians from furnishing these services, despite the physicians being specially trained in chronic care management and having demonstrated the ability to furnish significant quality of care. Many commenters suggested that CMS partner (through an advisory group, workgroups, etc.) with interested stakeholders, obtain public input, and work with the CMS Innovation Center to continue developing and refining more reasonable potential future standards for furnishing chronic care management in order to ensure that the physicians who bill for these services have the capabilities to furnish them. Some commenters suggested integration of chronic care management standards with the State laws governing the practice of medicine. Commenters also urged CMS not to impose requirements that would preclude specialists from furnishing these critical services.

Response: We appreciate commenters' suggestions and will consider these comments for any future rulemaking on this topic.

As discussed in the proposed rule, potential standards (78 FR 43338–43339) could include the following:

• The practice must be using a certified Electronic Health Record (EHR) for beneficiary care that meets the most

recent HHS regulatory standard for meaningful use. The EHR must be integrated into the practice to support access to care, care coordination, care management, and communication.

Comment: Commenters generally supported the value of EHRs in regard to the capabilities to enhance the quality of care for chronic care management. Commenters requested that CMS clarify the following issues if CMS were to move forward with meaningful use as a standard for chronic care management: how a provider new to Medicare or new to a practice would be treated, and how a provider would be treated who formerly met meaningful use but failed to do so in a subsequent year (specifically, whether the practice would be required to repay the chronic care management payment, and whether the practice would have to stop providing these services to beneficiaries in the future). Other commenters noted that while EHRs may facilitate documentation, they are being replaced by "cloud-based" data repositories for beneficiary medical records and social media is being used for communication solutions.

Many commenters did not support requiring the practice to use a certified EHR, some questioning whether an EHR is really essential to providing these services. These commenters discouraged CMS from including meaningful use as a standard for chronic care management, noting that it is premature to link these services to meaningful use, and that requiring meaningful use as a standard should be delayed until the meaningful use policy has been stabilized and more practices have achieved it. Commenters generally expressed concern regarding linking the provision of chronic care management to meaningful use as practices would have to delay furnishing care management for a full year until they have met meaningful use, denying their patients the benefit of those services. Commenters urged CMS not to require a specific stage of meaningful use certification. Commenters urged elimination of this requirement noting it interfered with the physician's prerogatives and practice; and suggesting that it has nothing to do with how effectively a physician manages patients with chronic conditions. Some commenters suggested that the notion that there should be immediate online access to every patient's complete EHR is unrealistic for many practices (that is, internet access issues, 24/7 availability of the full EHR, on-call health professional being from a different practice and not having access, etc.), particularly those who would most benefit from the potential chronic care management reimbursement. Commenters also noted EHR interoperability is not yet attainable by the vast majority of physicians across the country. Many commenters suggested CMS consider flexibility (that is, a phased-in approach) in requiring EHRs to avoid excluding otherwise qualified practices in areas of need. Some commenters noted that phasing in EHR requirements would aid those smaller practices, or rural areas, that do not currently utilize EHRs and thus would not be able to be reimbursed for furnishing beneficiaries with chronic care management services. Other commenters expressed concern that this requirement could pose a problem for small practices (that is, economically depressed, medically underserved, etc.) for which the expense of obtaining and implementing EHR systems could be prohibitive despite the fact they could meet the remainder of the requirements for chronic care management. Commenters raised concerns that language in the preamble suggests that all practitioners participating in the care of a beneficiary receiving chronic care management services would need to be able to share information related to the care plan electronically, and that it would be very difficult to meet this requirement as not all practices have access to electronic means of communication.

Response: We appreciate commenters' suggestions and will consider these comments for any future rulemaking on this topic.

- The practice must employ one or more advanced practice registered nurses or physicians assistants whose written job descriptions indicate that their job roles include and are appropriately scaled to meet the needs for beneficiaries receiving services in the practice who require chronic care management services furnished by the practice.

Comment: Some commenters supported the requirement to employ non-physician professionals, and encouraged CMS to expand this list to include registered nurses, pharmacists (particularly hematology/oncology clinical specialist pharmacists), social workers, Emergency Department physicians, "caregivers" (that is, those that help with Alzheimer's disease and dementia patients), "direct-care worker," and other specialists such as hematologists, cardiologists, and nephrologists. Some commenters sought clarification regarding whether advanced practice nurse practitioners and physician assistants would have to be available 24/7, and what type of chronic care management services they must furnish.

Many commenters, however, were not in support of the requirement that advanced practice nurses or physician assistants must be employed by the medical practice. Commenters urged elimination of this requirement noting that it interfered with the physician's prerogatives; indicating that this staffing requirement would have little, if anything, to do with how effectively a physician manages patients with chronic conditions, and suggesting that it could be considered cost prohibitive. Some commenters urged CMS to relax this requirement and recognize that these services could be effectively performed by appropriately trained, licensed, and, when applicable, credentialed clinical staff. Commenters recommended that CMS not prescribe the hiring decisions for practices to be eligible to furnish chronic care management services. Commenters suggested that the agency instead should provide greater flexibility for practices to demonstrate that they have the structural capabilities, personnel, and systems to coordinate care effectively, through their own engagement with patients, as well as by having other qualified health care professionals available, either within the practice itself or through external arrangements to furnish chronic care management services.

Some commenters suggested that, under certain circumstances independently contracted (but not necessarily employed) personnel could participate in furnishing these services under the general supervision of a physician or non-physician practitioner, and sought clarification on whether "employ" could include "contract" personnel. Other commenters requested that the standards recognize that nurses can perform this work under the direction and supervision of physicians, especially since many practices employ registered nurses who are well qualified to provide care coordination. Some commenters believed that this requirement was particularly ill-advised and inappropriate, and strongly disagreed that employment of this level of staff should be a consideration in furnishing these services. Other commenters noted that this requirement would deter small and rural practices from offering chronic care management services. Commenters supported care teams/team-based care, but indicated that a practice should have the discretion to hire and develop those care teams, and not be required specifically to hire advanced practice nurse practitioners or physician

assistants. Some commenters suggested that a "care manager" concept could be used, which could be a registered nurse, social worker, advanced practice nurse or physician assistant who has received training to perform the service. Commenters also suggested that CMS revise the requirement regarding who must employ the care manager to also allow the practice, or physician organization on the practice's behalf, to be the employer.

Response: We appreciate commenters' suggestions and will consider these comments for any future rulemaking on this topic.

- The practice must be able to demonstrate the use of written protocols by staff participating in the furnishing of services that describe: (1) The methods and expected "norms" for furnishing each component of chronic care management services furnished by the practice; (2) the strategies for systematically furnishing health risk assessments to identify all beneficiaries eligible and who may be willing to participate in the chronic care management services; (3) the procedures for informing eligible beneficiaries about chronic care management services and obtaining their consent; (4) the steps for monitoring the medical, functional and social needs of all beneficiaries receiving chronic care management services; (5) system based approaches to ensure timely furnishing of all recommended preventive care services to beneficiaries; (6) guidelines for communicating common and anticipated clinical and non-clinical issues to beneficiaries; (7) care plans for beneficiaries post-discharge from an emergency department or other institutional health care setting, to assist beneficiaries with follow up visits with clinical and other suppliers or providers, and in managing any changes in their medications; (8) a systematic approach to communicate and electronically exchange clinical information with and coordinate care among all service providers involved in the ongoing care of a beneficiary receiving chronic care management services; (9) a systematic approach for linking the practice and a beneficiary receiving chronic care management services with long-term services and supports including home and community-based services; (10) a systematic approach to the care management of vulnerable beneficiary populations such as racial and ethnic minorities and people with disabilities; and (11) patient education to assist the beneficiary to self-manage a chronic condition that is considered at least one of his/her chronic conditions. These protocols must be reviewed and updated as is appropriate based on the best available clinical information at least annually.

Comment: Some commenters expressed support for the outlined written protocols. A few commenters suggested that CMS develop educational materials to be made available to patients so they better understand these services. Commenters suggested the 11th written protocol be revised (to be more interactive) to read "provide written protocols that describe collaborative problem solving/decision making that supports the patient in self-managing their chronic health conditions." Other commenters believe that physicians and other providers who care for chronically ill patients can be better supported with evidence-based guidelines, specialty expertise, and information systems; such as, providers encouraging patients (through partnerships with community organizations, etc.) to participate in medical systems like peer support groups, exercise programs, nurse educators, or dieticians.

Commenters urged CMS to revise this requirement to provide more flexibility for practices to demonstrate they have their own protocols to ensure that patients with chronic diseases have timely access to physicians and other team members within a realistic timeframe (that is, practices could be required to demonstrate that their patients have access the same or next day by phone, email, telemedicine, or in person). Other commenters suggested CMS give more consideration to therapy services, medication management, discharge planning, care coordination, and caregiver education. Commenters also asked CMS to clarify that the practice reporting these chronic care management services does not have to perform all care management itself, and that other practices or healthcare professionals can perform some services in coordination with the reporting practice. Commenters conveyed individuals with Alzheimer's and dementias may not be able to participate in the development of a care plan in the same capacity as individuals who are not cognitively impaired. Some commenters requested CMS go a step further in noting the importance of coordination with direct-care workers and family caregivers, and requiring that this communication be documented as well.

Response: We appreciate commenters' suggestions and will consider these comments for any future rulemaking on this topic.

- All practitioners, including advanced practice registered nurses or physicians assistants, involved in the furnishing of chronic care management services must have access at the time of service to the beneficiary's EHR that includes all of the elements necessary to meet the most recent HHS regulatory standard for meaningful use. This includes any and all clinical staff furnishing after hours care to ensure that the chronic care management services are available with this level of EHR support in the practice or remotely through a Virtual Private Network (VPN), a secure Web site, or a health information exchange (HIE) 24 hours per day and 7 days a week.

Comment: Commenters were generally in support of the concept that 24/7 access to the beneficiary's EHR would be a tremendous enhancement to furnishing chronic care management. Some commenters noted that many physicians practice in more than one setting, which can make it more challenging for them to furnish all beneficiaries with 24/7 EHR support to providers and care staff. Commenters noted that many of their members do not have the resources to evaluate patients 24/7; therefore, commenters urged CMS to clarify the 24/7 support can be furnished by members of the chronic care team by phone, or allow more flexibility in this requirement until the agency can assess the impact it may have on beneficiary access to chronic care management services. Some commenters noted that many physicians can access their own organization's EHR both in and outside typical business hours, but do not currently have "real-time" access to all of the EHR data for beneficiaries under their care, especially if they are moving provider settings.

Response: We appreciate commenters' suggestions and will consider these suggestions for any future rulemaking.

Some have suggested that, to furnish these services, practices could be recognized as a medical home by one of the national organizations (including the National Committee for Quality Assurance (NCQA), the Accreditation Association for Ambulatory Health Care, The Joint Commission, URAC, etc.), which are formally recognizing primary care practices as a patient-centered medical home. We understand there are differences among the approaches taken by national organizations that formally recognize medical homes and therefore, we solicited comment on these and other potential care coordination standards, and the potential for CMS recognizing a formal patient-centered medical home designation as one means

for a practice to demonstrate it has met any final care coordination standards for furnishing chronic care management services.

Comment: Some commenters supported recognizing a patient centered medical home model to meet the care coordination standards. Commenters recommended that CMS allow for multiple pathways for accreditation recognition, and/or certification of patient centered medical homes and patient centered medical home neighborhood practices, noting other entities offer these programs, such as URAC and The Joint Commission. Some commenters supported the specialty practice recognition program, under NCQA, to be included to enable specialists to be able to participate. Commenters also suggested that CMS include other approaches to recognize medical homes as developed by private health plans and within CMS via its Innovation Center Comprehensive Primary Care Initiative, some of which may not have been formally certified by an accreditation entity. Commenters noted medical homes would be good candidates to provide chronic care management, but Patient Centered Medical Homes represent a relatively small percentage of medical groups across the country.

Other commenters noted they do not support a requirement that physician practices be certified as a primary care medical home to receive payment for chronic care management. Other commenters urged elimination of this requirement, noting it is too burdensome and would disqualify many practices furnishing these care coordination services. Commenters believe that in general, medical societies have been reluctant to accept proposals that would require medical homes or patient-centered practices to obtain accreditation/recognition by external entities; and therefore, urged CMS to work with the medical community to develop an alternative to accreditation as a path for furnishing chronic care management services. Other commenters noted this approach ignores the fact that many patients—especially the poor—do not have a primary care provider and by default, may receive substantial services from the Emergency Department, especially when other sources of primary care are unavailable or inaccessible. Some commenters conveyed that many standards for accreditation as a patient centered medical home do not consider the needs of those with dementia; adding, accreditation bodies should include quality measures on dementia care as a standard for accreditation. Some commenters encouraged CMS to consider using QIOs to help determine if a provider is meeting the requirements for chronic care management, instead of relying on a formal recognition program.

Some commenters noted that, instead of requiring any particular certification or designation, any physician practice should be able to qualify for payment of chronic care management services as long as the individual practice meets the practice requirements established to report these individual codes. Other commenters recommended that CMS instead require practices to have certain capabilities (that is, 24/7 access to care, 24/7 access to the individual's medical record, those involved with the care of a patient are identified and accessible, the health risk assessment data be addressed in the care of the patient, etc.); moreover, commenters suggested that CMS should clearly articulate that the ultimate goal is for primary care practices to achieve patient-centered medical home certification by a certain date (for instance 2019) as this would satisfy the agency's intention without being overly restrictive. Commenters also recommended that if CMS decides to recognize certified medical homes—through accreditation organizations or otherwise—the certification standards should fully reflect the Joint Principles for the Patient-Centered Medical Home (*http://tinyurl.com/ccbhvzz*). Some commenters noted that requiring practice certification, such as that offered by NCQA for Patient-Centered Medical Homes, will undoubtedly limit access to chronic care management services for many beneficiaries, especially those in smaller practices and rural areas; and recommended CMS not make additional voluntary certifications mandatory, but rather look to those voluntary standards as it collaborates with the medical professional community to develop robust standards for chronic care management. Other commenters urged CMS to consider allowing practices to self-attest that they meet the protocol. Some commenters believe there needs to be an accountability mechanism for chronic care management which goes beyond "standards," such as quality measures that demonstrate improved outcomes and benefits for relevant patients.

Response: We appreciate commenters' suggestions and will consider these comments for any future rulemaking on this topic.

4. Billing for Separately Payable Chronic Care Management Services

To recognize the additional resources required to provide chronic care management services to patients with multiple chronic conditions, we proposed to create two new separately payable alphanumeric G-codes.

Complex chronic care management services furnished to patients with multiple (two or more) complex chronic conditions expected to last at least 12 months, or until the death of the patient, that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline;

GXXX1, initial services; one or more hours; initial 90 days

GXXX2, subsequent services; one or more hours; subsequent 90 days

Typically, we would expect the one or more hours of services to be provided by clinical staff directed by a physician or other qualified health care professional.

We also proposed that billing for subsequent chronic care management services (GXXX2) would be limited to those 90-day periods in which the medical needs of the patient require substantial revision of the care plan.

We proposed that the resources required to furnish care management services for patients that do not have multiple chronic conditions would continue to be reflected in the payment for face-to-face E/M services. We also proposed that the resources required to furnish care management services consisting of less than one or more hours of clinical staff time over a 90-day period, and for patients residing in facility settings, would continue to be reflected in the payment for face-to-face E/M visits.

We proposed that chronic care management services would include transitional care management services (CPT 99495, 99496), home health care supervision (HCPCS G0181), and hospice care supervision (HCPCS G0182). If furnished, to avoid duplicate payment, we proposed that these services may not be billed separately during the 90 days for which either GXXX1 or GXXX2 are billed. For similar reasons, we proposed that GXXX1 or GXXX2 cannot be billed separately if ESRD services (CPT 90951–90970) are billed during the same 90 days.

We proposed to pay only one claim for chronic care management services billed per beneficiary at the conclusion of each 90-day period.

We proposed that all of our proposed chronic care management services that are relevant to the patient must be furnished to bill for a 90-day period.

If a face-to-face visit is provided during the 90-day period by the practitioner who is furnishing chronic care management services, we proposed that the practitioner should report the appropriate evaluation and management

code in addition to billing for chronic care management.

We note that to bill for these services, we proposed that at least 60 minutes of chronic care management services must be provided during a 90-day period. Time of less than 60 minutes over the 90 day period could not be rounded up to 60 minutes to bill for these services. We also proposed that for purposes of meeting the 60-minute requirement, the practitioner could count the time of only one clinical staff member for a particular segment of time, and could not count overlapping intervals such as when two or more clinical staff members are meeting about the patient.

Comment: Many commenters requested that we either adopt the current CPT codes (CPT 99487–99489) for complex chronic care coordination services or work with the AMA to revise the current CPT codes rather than establish G-codes. Commenters also requested that we shorten the billing period from 90 days to 30 days, monthly, or weekly out of concern that it would be administratively burdensome for some practices to keep track of the amount of time they had furnished the service over a 90-day period. Many commenters also encouraged us to reconsider the need for separate G-codes for the initial delivery of chronic care management services versus subsequent delivery of these services since these commenters indicated that the resource use is similar. Some commenters supported our proposal that if a face-to-face visit is provided during the period by the practitioner who is furnishing chronic care management services, the practitioner should report the appropriate E/M code in addition to billing for chronic care management. Some commenters requested that we consider creating codes for chronic care management services to reflect different patient severity levels or create an add-on code, similar to the current CPT add-on code for 30 minutes of additional time (CPT 99489), that recognizes additional time for more complex patients within the eligible patient population. Some commenters agreed with our proposal that time less than the time specified in the code (60 minutes in our proposal) could not be rounded up to bill for these services. Some commenters also requested that we provide more detailed billing information for the services.

Response: Regarding the suggestion to work with CPT to avoid the need to establish G-codes, since we expect to implement payment for chronic care management services in 2015, there is time for CPT to establish a billing code that sufficiently reflects our policy. We would consider using such a new or revised code. The current CPT codes do not meet our policy requirements (for example, the eligible patient population, the time required for the code); therefore, we are not adopting these codes in this final rule.

We agree with commenters who suggested that we shorten the billing period for chronic care management services from 90 days to 30 days to reduce the administrative timekeeping burden on practices. We believe that a weekly billing interval would increase the administrative billing burden and note that very few commenters supported this option relative to 30 day or monthly billing.

We also agree with commenters that the resources required to furnish the initial and subsequent services are not sufficiently different to require the establishment of separate codes to distinguish initial and subsequent services.

In response to commenters' concerns, we are adopting a 30-day billing interval for chronic care management services. Given the shorter 30-day period, we are establishing a billing code that corresponds to 20 minutes of service during the 30-day period. Similar to our proposal, at least 20 minutes of chronic care management services must be provided during the 30-day billing interval. Time of less than 20 minutes over the 30-day period could not be rounded up to 20 minutes to bill for these services. For purposes of meeting the 20-minute requirement, the practitioner could count the time of only one clinical staff member for a particular segment of time, and could not count overlapping intervals such as when two or more clinical staff members are meeting about the patient.

With respect to comments requesting that we consider creating billing codes for chronic care management services to reflect different patient severity levels or create an add-on code that recognizes additional time for more severe patients within the eligible patient population, we are not adopting such a coding structure at this time. As recognized by the vast majority of commenters, paying separately for non-face-to-face chronic care management services is a significant policy change. As we gain more experience with separate payment for this service, we may consider additional changes in the coding structure in future rulemaking.

In response to comments asking that we provide more detailed billing information for these services, we intend to provide guidance to our contractors and make any necessary revisions to the relevant manual provisions to implement the chronic care management policy.

In summary, to recognize the additional resources required to provide chronic care management services to patients with multiple chronic conditions, we will be creating one new separately payable alphanumeric G-code for CY 2015.

GXXX1 Chronic care management services furnished to patients with multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; 20 minutes or more; per 30 days

Typically, we would expect that the 20 minutes or more of chronic care management services to be provided by clinical staff directed by a physician or other qualified health care professional.

At least 20 minutes of chronic care management services must be provided during the 30-day period. Time of less than 20 minutes over the 30-day period may not be rounded up to 20 minutes in order to bill for these services. For purposes of meeting the 20-minute requirement, the practitioner could count the time of only one clinical staff member for a particular segment of time, and could not count overlapping intervals such as when two or more clinical staff members are meeting about the patient.

We would consider using a revised CPT code that meets our policy requirements instead of creating a new G-code.

Comment: Some commenters stated that limiting the use of the billing code for subsequent delivery of chronic care management services to those circumstances in which the beneficiary requires "substantial revision of the care plan" undervalues the work the practitioner and practice care team does in furnishing ongoing assistance to beneficiaries in monitoring and implementing their care plans. Some commenters indicated that this restriction would reduce the potential benefits of chronic care management to the patient since in the absence of separate payment the services might be provided too intermittently. Other commenters, however, supported the restriction to time periods when the care plan has undergone significant revision since they believed that separately billable chronic care management should be for intense services delivered over a short period of time. Generally, these commenters were also ones who also favored narrowing the eligible patient population.

Response: As we stated in the discussion of the eligible patient population, we believe the resources required to furnish chronic care management services to beneficiaries with two or more chronic conditions are not adequately reflected in the existing E/M codes. We agree with commenters who argued that these resources could potentially be required during periods of time when the care plan is not undergoing substantial revision.

Therefore, after considering all the comments received, we are revising our proposed policy to specify that the chronic care management service may be billed for periods in which the medical needs of the patient require establishing, implementing, revising, or monitoring the care plan, assuming all other billing requirements are met.

Comment: Some commenters objected to our proposal that chronic care management services include transitional care management services (CPT 99495, 99496), home health care supervision (HCPCS G0181), and hospice care supervision (HCPCS G0182) and that these services cannot be billed separately during the time period when the chronic care management services are billed. Some commenters also objected to our proposal that chronic care management services cannot be billed separately if certain ESRD services (CPT 90951–90970) are billed during the same time period. Some commenters believed that there was insufficient overlap between the resources required to perform these services and chronic care management to justify restricting the billing in the manner we proposed. Other commenters indicated that more than one practitioner should be allowed to bill for chronic care management services for the same time period.

Response: Given that, in response to comments, we have modified our new separately payable alphanumeric G-code for chronic care management services to describe services furnished for 20 minutes or more over a 30-day period, it may not always be the case that the additional resources required to provide chronic care management services to beneficiaries with multiple chronic conditions are the same as the additional resources required provide transitional care management services (CPT 99495, 99496), home health care supervision (HCPCS G0181), hospice care supervision (HCPCS G0182), or certain ESRD services (CPT 90951–90970). Nevertheless, given that care management is an integral part of all of these services, we believe there is significant overlap, and that paying separately both for chronic care management and the care management included in these services would result in duplicate payment for the overlapping care management. Similarly, allowing multiple practitioners to bill for GXXX1 during a particular billing interval would result in duplicate payment for overlapping care management. Therefore, we are finalizing our policy that GXXX1 and any of CPT 99495–99496, HCPCS G0181–G0182, or CPT 90951–90970 cannot be billed during the same 30-day period; nor can GXXX1 be billed by multiple practitioners for the same time period.

Comment: Some commenters objected to our proposal that the resources required to provide care management services to patients residing in facility settings continues to be reflected in the payment for face-to-face E/M visits. Commenters believed there was insufficient overlap between the scope of these care management services and the care management services provided by facilities to justify restricting the billing in the manner we proposed.

Response: We disagree with these comments. The resources required to provide care management services to patients residing in facility settings significantly overlaps with care management activities by facility staff that is included in the associated facility payment. We are finalizing this part of our proposal without modification.

Comment: MedPAC recommended that practitioners employed or furnishing services under arrangement with hospice or home health agencies should not be eligible to bill for these chronic care management services, citing the Medicare claims processing manual requirements for care plan oversight services.

Response: There is a requirement in the Medicare Claims Processing Manual (see *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf*) for hospice care plan oversight (CPO) that states:

"The attending physician or nurse practitioner (who has been designated as the attending physician) may bill for hospice CPO when they are acting as an 'attending physician.' An 'attending physician' is one who has been identified by the individual, at the time he/she elects hospice coverage, as having the most significant role in the determination and delivery of their medical care. They are not employed nor paid by the hospice."

We will consider MedPAC's comment further, but are not adopting this suggestion at the current time. We note that, as stated earlier in this section, home health care supervision (HCPCS G0181) and hospice care supervision (HCPCS G0182) cannot be billed separately during the time period when the chronic care management services are billed.

Comment: Many commenters requested that we clarify that billing for chronic care management is not restricted to primary care physicians and that specialist physicians can bill for these services if they meet the requirements. Some non-physician practitioners similarly requested confirmation that they can bill for these services if they meet the requirements.

Response: We appreciate these comments and take this opportunity to confirm that, while we expect the chronic care management code to be billed most frequently by primary care physicians, specialists who meet the requirements may also bill for these services. As for nonphysician qualified health care professionals, we believe only NPs, PAs, CNSs, and certified nurse midwives (CNMs) can furnish the full range of these services under their Medicare benefit, and only to the extent permitted by applicable limits on their state scope of practice. We believe other nonphysician practitioners (such as registered dieticians, nutrition professionals or clinical social workers) or limited-license practitioners, (such as optometrists, podiatrists, doctors of dental surgery or dental medicine), would be limited by the scope of their state licensing or their statutory Medicare benefit to furnish the complete scope of these services such that they would not be able to furnish chronic care management services; and there is no Medicare benefit category that allows payment under the PFS to some of the other health professionals (such as pharmacists and care coordinators) mentioned by commenters.

We also note that given our longstanding restriction on the use of E/M codes by clinical psychologists and the fact that payment for these chronic care management services is currently included in the payment for E/M services, clinical psychologists are also not permitted to bill for these services. However, similar to transitional care management, we expect practitioners furnishing chronic care management services to refer patients to psychologists and other mental health professionals as part of chronic care management when doing so is warranted by an evaluation of the patient's psychosocial needs.

5. Obtaining Agreement From the Beneficiary

We stated in the proposed rule that not all patients who are eligible for separately payable chronic care management services may necessarily want these services to be provided. Therefore, before the practitioner can furnish or bill for these services, we proposed that the eligible beneficiary must be informed about the availability of the services from the practitioner and provide his or her consent, or synonymously in this context "agreement," to have the services provided, including the electronic communication of the patient's information with other treating providers as part of care coordination. This would include a discussion with the patient about what chronic care management services are, how these services are accessed, how their information will be shared among other providers in the care team, and that cost-sharing applies to these services even when they are not delivered face-to-face in the practice. To bill for the services, the practitioner would be required to document in the patient's medical record that all of the chronic care management services were explained and offered to the patient, noting the patient's decision to accept these services. Also, a written or electronic copy of the care plan would be provided to the beneficiary and this would also be recorded in the beneficiary's electronic medical record.

We proposed that a practitioner would need to reaffirm with the beneficiary at least every 12 months whether he or she wishes to continue to receive chronic care management services during the following 12-month period.

We proposed that the agreement for chronic care management services could be revoked by the beneficiary at any time. However, if the revocation occurs during a current chronic care management period, the revocation would not be effective until the end of that period. The beneficiary could notify the practitioner either verbally or in writing. At the time the agreement is obtained, the practitioner would be required to inform the beneficiary of the right to stop the chronic care management services at any time and the effect of a revocation of the agreement on chronic care management services. Revocation by the beneficiary of the agreement must also be noted by recording the date of the revocation in the beneficiary's medical record and by providing the beneficiary with written confirmation that the practitioner would not be providing chronic care management services beyond the current period.

We proposed that a beneficiary who has revoked the agreement for chronic care management services from one practitioner may choose instead to receive these services from a different practitioner, which can begin at the conclusion of the current period. The new practitioner would need to fulfill all the requirements for billing these services.

We proposed that prior to submitting a claim for chronic care management services, the practitioner must notify the beneficiary that a claim for these services will be submitted to Medicare. The notification must indicate: that the beneficiary has been receiving these services over the previous period (noting the beginning and end dates for the period); the reason(s) why the services were provided; and a description of the services provided. The notice may be delivered by a means of communication mutually agreed to by the practitioner and beneficiary such as mail, email, or facsimile, or in person (for example, at the time of an office visit). The notice must be received by the beneficiary before the practitioner submits the claim for the services. A separate notice must be received by the beneficiary for each period for which the services will be billed. A copy of the notice should be included in the medical record.

Comment: While most commenters endorsed the general concept that that there should be a process whereby a practitioner would obtain agreement from an eligible beneficiary for the delivery of the service, we received comments on specific aspects of our proposal.

Some commenters supported our beneficiary agreement policies as proposed. Other commenters believed that notifying the beneficiary would be sufficient and that a formal agreement should not be required. Some commenters raised concern about the burden of having to obtain an annual agreement rather than obtaining just one agreement at the outset of furnishing the services. Many commenters recommended that CMS remove the requirement that practitioners notify beneficiaries in writing prior to each billing for chronic care management services, while other commenters supported this requirement. The commenters opposed to the pre-billing notification requirement viewed this as administratively burdensome and unnecessary given the informed agreement process for this service. Some commenters indicated that beneficiary agreement would be much easier to obtain if the service were not subject to coinsurance. Many commenters requested that we provide beneficiary education on this issue.

Response: We appreciate commenters recognizing the value of our requiring practitioners to inform beneficiaries about their eligibility to receive chronic care management services. We note that we do not have the statutory authority to waive the cost-sharing for these services. Since beneficiaries who receive these services will be billed for cost-sharing, we believe it is prudent to require their written agreement prior to initiating the service. We agree that to reduce administrative burden, the informed agreement process need only occur once at the outset of furnishing the service, rather than annually as we had proposed, and that it only needs to be repeated if the beneficiary opts to change the practitioner who is delivering the services. We also agree with commenters who suggested that we relax the requirement that a practice inform a beneficiary prior to each time a bill is submitted. While we believe that this approach could reduce any potential confusion around cost-sharing charges, we agree that practitioners can address this in the informed agreement process.

In response to comments recommending that we educate beneficiaries about chronic care management services, we note that we provide extensive beneficiary education regarding Medicare benefits, including Medicare and You and other publications, Medicare.gov, and 1–800–MEDICARE. We will include information concerning chronic care management in our outreach efforts.

The final beneficiary agreement requirements for CY 2015 are as follows. Before the practitioner can furnish or bill for these services, the eligible beneficiary must be informed about the availability of the services from the practitioner and provide his or her written agreement to have the services provided, including agreeing to the electronic communication of the patient's information with other treating providers as part of care coordination. This would include a discussion with the patient, and caregiver when applicable, about what chronic care management services are, how these services are accessed, how the patient's information will be shared among other providers in the care team, and that cost-sharing applies to these services even when they are not delivered face-to-face in the practice. To bill for the services, the practitioner would be required to document in the patient's

medical record that all of the chronic care management services were explained and offered to the patient, noting the patient's decision to accept these services. Also, a written or electronic copy of the care plan is required to be provided to the beneficiary, and the provision of the plan to the patient must also be recorded in the beneficiary's electronic medical record.

The agreement for chronic care management services could be revoked by the beneficiary at any time. However, if the revocation occurs during a current chronic care management 30-day period, the revocation is not effective until the end of that period. The beneficiary could notify the practitioner of revocation either verbally or in writing. At the time the agreement is obtained, the practitioner is required to inform the beneficiary of the right to stop the chronic care management services at any time (effective at the end of a 30-day period) and the effect of a revocation of the agreement on chronic care management services. The practitioner is also required to inform the beneficiary that only one practitioner is able to be separately paid for these services during the 30-day period. Revocation by the beneficiary of the agreement must also be noted by recording the date of the revocation in the beneficiary's medical record and by providing the beneficiary with written confirmation that the practitioner would not be providing chronic care management services beyond the current 30-day period.

A beneficiary who has revoked the agreement for chronic care management services from one practitioner may choose instead to receive these services from a different practitioner, which can begin at the conclusion of the current 30-day period. If a beneficiary chooses to receive these services from a different practitioner, the beneficiary should revoke the agreement with the current practitioner. The new practitioner would need to fulfill all the requirements for billing these services.

5. Chronic Care Management Services and the Annual Wellness Visit (AWV) (HCPCS Codes G0438, G0439)

We proposed that a beneficiary must have received an AWV in the past 12 months for a practitioner to be able to bill separately for chronic care management services. We believe that the linking of these services to the AWV makes sense for several reasons. First, the AWV is designed to enable a practitioner to systematically capture information that is essential for the development of a care plan. This includes the establishment of a list of current practitioners and suppliers that are regularly involved in providing medical care to the beneficiary, the assessment of the beneficiary's functional status related to chronic health conditions, the assessment of whether the beneficiary suffers from any cognitive limitations or mental health conditions that could impair self-management of chronic health conditions, and an assessment of the beneficiary's preventive health care needs including those that contribute to or result from a beneficiary's chronic conditions. Second, the beneficiary's selection of a practitioner to furnish the AWV is a useful additional indicator to assist us in knowing which single practitioner a beneficiary has chosen to furnish chronic care management services. Although a beneficiary would retain the right to choose and change the practitioner to furnish chronic care management services, we do not believe that it is in the interest of a beneficiary to have more than one practitioner at a time coordinating the beneficiary's care and we do not intend to pay multiple practitioners for furnishing these services over the same time period. Third, the AWV is updated annually which is consistent with the minimal interval for reviewing and modifying the care plan required for the chronic care management services.

We would expect that the practitioner the beneficiary chooses for the AWV would be the practitioner furnishing the chronic care management services. For the less frequent situations when a beneficiary chooses a different practitioner to furnish the chronic care management services from the practitioner who in the previous year furnished the AWV, the practitioner furnishing the chronic are management services would need to obtain a copy of the assessment and care plan developed between the beneficiary and the practitioner who furnished the AWV prior to billing for chronic care management services.

Because a beneficiary is precluded from receiving an AWV within 12 months after the effective date of his or her first Medicare Part B coverage period, for that time period we proposed the Initial Preventive Physical Examination (G0402) can substitute for the AWV to allow a beneficiary to receive chronic care management services.

Comment: Although some commenters supported our proposal, there were numerous comments recommending that we remove the requirement for an Annual Wellness Visit prior to a practitioner being able to furnish chronic care management services. While some commenters acknowledged that the Annual Wellness visit could provide valuable information for establishing a care plan and for ensuring that only one practitioner billed for the chronic care management services, many expressed concern that this could present a significant barrier to otherwise eligible beneficiaries receiving the services.

Response: We believe that both the practitioner and the beneficiary would benefit if an AWV or an Initial Preventive Physical Examination (IPPE) occurs at the outset of chronic care management services. It would allow the practitioner to systematically gather information that can inform the care plan and it would allow the beneficiary the opportunity to address questions and concerns about wellness issues that may be important for those with multiple chronic conditions. With their required services, the IPPE or AWV assures that at least once a year there is a focus on the broad wellness aspects of care, which can easily be dominated by the more chronic conditions when they exist. In addition to the clinical benefits of the AWV or IPPE, these services provide administrative benefits as well. They allows us to know the one practitioner the beneficiary has chosen to furnish chronic care management services and assure that multiple practitioners cannot provide the service to the same patient. However, in light of the widespread concerns raised by commenters about this requirement, we have changed the requirement to a recommendation for a practitioner to furnish an AWV or IPPE to a beneficiary prior to billing for chronic care management services furnished to that same beneficiary. As an alternative, a practitioner who meets the practice standards that will be established to bill for chronic care management services may initiate services with an eligible beneficiary as a part of an AWV, an IPPE, or a comprehensive E/M visit.

6. Chronic Care Management Services Furnished Incident to a Physician's Service Under General Physician Supervision

In the proposed rule, we discussed the requirements for billing for services furnished in the office, but not personally and directly performed by the physician or qualified nonphysician practitioner (referred to as a "practitioner" in the following discussion), under our "incident to" requirements at 410.26 and in section 60, Chapter 15, of Medicare Benefit Policy Manual (100–02). One key requirement of "incident to" services is

that a physician directly supervise the provision of services by auxiliary personnel by being in the office suite and be immediately available to furnish assistance and direction throughout the provision of the service. Section 60.4 of the Manual specifically discusses the one exception, which allows for general supervision of "incident to" services furnished to homebound patients in medically underserved areas. Under that exception, we identify more specific requirements for the personnel who can provide "incident to" services under general supervision. For example, we require that the personnel must be employed by the physician billing the "incident to" services.

One of the required capabilities for a physician to furnish chronic care management services is 24-hour-a-day, 7-day-a-week beneficiary access to the practice to address the patient's chronic care needs. We would expect that the patient would be provided with a means to make timely contact with health care providers in the practice when necessary to address chronic care needs regardless of the time of day or day of the week. If the patient has a chronic care need outside of the practice's normal business hours, the patient's initial contact with the practice to address that need could be with clinical staff employed by the practice, (for example, a nurse) and not necessarily with a physician. Those services could be furnished incident to the services of the billing physician.

We also proposed to require a minimum amount of time of chronic care services be furnished to a patient during a period for the physician to be able to bill separately for the chronic care services. The time, if not personally furnished by the physician, must be directed by the physician. We proposed that the time spent by a clinical staff person providing aspects of chronic care services outside of the practice's normal business hours during which there is no direct supervision would count towards the time requirement even though the services do not meet the direct supervision requirement for "incident to" services.

We stated our belief that the additional requirements we impose for auxiliary personnel under the exception for general supervision for homebound patients in medically underserved areas should apply in these circumstances where we are allowing a physician to bill Medicare for chronic care management services furnished under their general supervision and incident to their professional services. In both of these unusual cases, these requirements help to ensure that appropriate services are being furnished by appropriate personnel in the absence of the direct supervision. Specifically, we proposed that if a practice meets all the conditions required to bill separately for chronic care management services, the time spent by a clinical staff employee providing aspects of these services to address a patient's chronic care need outside of the practice's normal business hours can be counted towards the time requirement when at a minimum the following conditions are met:

- The clinical staff person is directly employed by the physician.
- The services of the clinical staff person are an integral part of the physician's chronic care management services to the patient (the patient must be one the physician is treating and for which an informed agreement is in effect), and are performed under the general supervision of the physician. General supervision means that the physician need not be physically present when the services are performed; however, the services must be performed under the physician's overall supervision and control. Contact is maintained between the clinical staff person and the physician (for example, the employed clinical staff person contacts the physician directly if warranted and the physician retains professional responsibility for the service.)
- The services of the employed clinical staff person meet all other "incident to" requirements, compliance with applicable state law, with the exception of direct supervision.

Comment: The vast majority of commenters supported the idea of general rather than direct supervision, although we did receive comments on specific aspects of our proposal. A few commenters said they recognized the difficulties in making exceptions to the "incident to" policies. Some commenters supported the proposal as stated in the proposed rule. Many commenters objected to the proposed requirement that the clinical staff person be directly employed by the physician, indicating that this would be a barrier to widespread adoption of the policy. Some commenters requested that we remove the employment requirement entirely, especially given that eligible practices will need to meet certain standards to be able to separately bill for chronic care management services. Other commenters indicated that if CMS were to keep the employment requirement it should be modified to allow the clinical staff person to be an employee of the physician or an employee of the practice. Some commenters recommended that the policy be modified to allow the clinical staff person be either an employee or an independent contractor. These commenters stated a distinction between the clinical staff person as an independent contractor and having the services provided under arrangement since typically the practice would directly supervise the contracted individual. A few commenters stated that a requirement to have all possible chronic care management services provided by employees would undermine access to these services. Some commenters indicated that CMS should allow general rather than direct supervision for more situations, not just time spent by clinical staff outside of the practices normal business hours. For example, one commenter indicated that time spent by clinical staff providing chronic care management services to homebound patients in the patient's homes should count towards the time requirement if provided under general supervision. Some commenters expressed concern that our use of the word "physician" in this discussion could potentially create confusion that we are not also referring to qualified non-physician practitioners.

Response: We appreciate the general support for our proposal as well as the recognition by some commenters of the challenges presented by the issue of an exception to "incident to related requirements," even for this unusual case. We agree with the commenters who supported our policy as stated in the proposed rule since we continue to believe that within eligible practices the employment requirement helps ensure that appropriate services are being furnished by appropriate personnel under the lesser requirement of general supervision. We are clarifying that the clinical staff person furnishing the chronic care management services could be employed either by the physician or the practice.

Given the potential risk to the patient that exceptions to the direct physician supervision requirement could create, we believe it is appropriate to proceed deliberately in this area. We believe that this exception in this unusual case should be designed as narrowly as possible while still facilitating the chronic care management policy. Therefore, we disagree at the current time with commenters who requested broader exceptions to the direct physician supervision requirement to remove the employment requirement entirely, to include independent contractors, or to include other situations for CY 2015.

In response to commenters who stated that a requirement to have all possible chronic care management services provided by employees would undermine access to these services, we note that we did not propose such a requirement. Our proposed employment requirement was limited to allowing the time spent by a clinical staff employee in providing aspects of chronic care management services to address a patient's chronic care need outside of the practice's normal business hours to count towards the time requirement for these services to be separately billed. To bill for "incident to" services, practitioners should follow all the usual "incident to" requirements except when furnishing services outside of normal business hours under conditions that meet the requirements for the general supervision exception as described above.

We also note that our "incident to" policies apply to all pracitioners who can bill Medicare directly for services, and thus apply to physicians and other nonphysician practitioners. As discussed in section II.J, we are aligning the requirements for "incident to" services to make clear that all practitioners who can bill Medicare for "incident to" services are subject to the same regulations at 410.26. We intend that the exception to the direct supervision requirement for after-hours chronic care management services furnished on an "incident to" basis will apply to all practitioners who can bill Medicare for services incident to their services and who can provide chronic care management services.

In summary, we are finalizing our proposal for CY 2015 without modification except for our clarification that the clinical staff person furnishing the chronic care management services could be employed either by the physician or the practice.

In light of the concerns by some commenters that our use of the word "physician" in this discussion could potentially create confusion that we are not also referring to qualified non-physician practitioners, we reiterate that, as we stated in the proposed rule, "physician" in this discussion also refers to qualified non-physician practitioners.

7. Chronic Care Management Services and the Primary Care Incentive Payment Program (PCIP)

Under section 1833(x) of the Act, the PCIP provides a 10 percent incentive payment for primary care services within a specific range of E/M services when furnished by a primary care physician. Specific physician specialties and qualified nonphysician practitioners can qualify as primary care practitioners if 60 percent of their PFS allowed charges are primary care services. As we explained in the CY 2011 PFS final rule (75 FR 73435 through 73436), we do not believe the statute authorizes us to add codes (additional services) to the definition of primary care services. However, to avoid inadvertently disqualifying community primary care physicians who follow their patients into the hospital setting, we finalized a policy to remove allowed charges for certain E/M services furnished to hospital inpatients and outpatients from the total allowed charges in the PCIP primary care percentage calculation. In the CY 2013 final rule (77 FR 68993), we adopted a policy that the TCM code should be treated in the same manner as those services for the purposes of PCIP because post-discharge TCM services are a complement in the community setting to the hospital-based discharge day management services already excluded from the PCIP denominator. Similar to the codes already excluded from the PCIP denominator, we expressed concern that inclusion of the TCM code in the denominator of the primary care percentage calculation could produce unwarranted bias against "true primary care practitioners" who are involved in furnishing post-discharge care to their patients.

Chronic care management services are also similar to the services that we have already excluded from the from the PCIP denominator. For example, chronic care management includes management of care transitions within health care settings including referrals to other clinicians, visits following a patient visit to an emergency department, and visits following discharges from hospitals and skilled nursing facilities. Therefore, while physicians and qualified nonphysician practitioners who furnish chronic care management services would not receive an additional incentive payment under the PCIP for the service itself (because it is not considered a "primary care service" for purposes of the PCIP), we proposed that the allowed charges for chronic care management services would not be included in the denominator when calculating a physician's or practitioner's percent of allowed charges that were primary care services for purposes of the PCIP.

Comment: Many commenters supported, and no commenters opposed, our proposed treatment of chronic care management services in the PCIP calculation given that these services are not eligible for the incentive payment under the PCIP.

Response: We agree with the commenters and are finalizing our proposal for CY 2015 without modification.

L. Collecting Data on Services Furnished in Off-Campus Provider-Based Departments

As we discussed in the CY 2014 PFS proposed rule (78 FR 43301) and CY 2014 OPPS/ASC proposed rule (78 FR 43626), in recent years, the research literature and popular press have documented the increased trend toward hospital acquisition of physician practices, integration of those practices as a department of the hospital, and the resultant increase in the delivery of physicians' services in a hospital setting (for example, we refer readers to Ostrom, Carol M., "Why you might pay twice for one visit to a doctor," *Seattle Times,* November 3, 2012, and O'Malley, Ann, Amelia M. Bond, and Robert Berenson, *Rising hospital employment of physicians: better quality, higher costs?* Issue Brief No. 136, Center for Studying Health System Change, August 2011).

When a Medicare beneficiary receives outpatient services in a hospital, the total payment amount for outpatient services made by Medicare is generally higher than the total payment amount made by Medicare when a physician furnishes those same services in a freestanding clinic or in a physician's office. As more physician practices become hospital-based, news articles have highlighted beneficiary liability that is incurred when services are furnished in a hospital-based physician practice. MedPAC has questioned the appropriateness of increased Medicare payment and beneficiary cost-sharing when physicians' offices become hospital outpatient departments and has recommended that Medicare pay selected hospital outpatient services at the MPFS rates (MedPAC March 2012 Report to Congress; "Addressing Medicare Payment Differences across Settings," presentation to the Commission on March 7, 2013).

The total payment generally is higher when outpatient services are furnished in the hospital outpatient setting rather than a freestanding clinic or a physician office. When a service is furnished in a freestanding clinic or physician office, only one payment is made under the MPFS; however when a service is furnished in a hospital-based office, Medicare pays the hospital a "facility fee" and a payment for the physician portion of the service, which is a lower payment than if the service would have

been furnished in a physician's office. Although the physician payment is lower when the services are furnished in a hospital, the total payment (facility fee and physician fee) is generally more than the Medicare payment if the same service was furnished in a freestanding clinic or physician office. The beneficiary pays coinsurance for both the physician payment and the hospital outpatient payment (facility fee). Upon acquisition of a physician practice, hospitals frequently treat the practice locations as off-campus provider-based departments of the hospital and bill Medicare for services furnished at those locations under the OPPS. (For further information on the provider-based regulations at § 413.65, we refer readers to *http://www.gpo.gov/fdsys/pkg/CFR-2010-title42-vol2/pdf/CFR-2010-title42-vol2-sec413-65.pdf*). Since October 1, 2002, we have not required hospitals to seek from CMS a determination of provider-based status for a facility that is located off campus. We also do not have a formal process for gathering information on the frequency, type, and payment of services furnished in off-campus provider-based departments of the hospital.

We stated in the CY 2014 proposed rules that in order to better understand the growing trend toward hospital acquisition of physician offices and subsequent treatment of those locations as off-campus provider-based outpatient departments, we were considering collecting information that would allow us to analyze the frequency, type, and payment of services furnished in off-campus provider-based hospital departments. We stated that we have considered several potential methods. Claims-based approaches could include (1) creating a new place of service code for off campus departments of a provider under § 413.65(g)(2) as part of item 24B of the CMS–1500 claim form, comparable to current place of service codes such as "22 Outpatient" and "23 Emergency Room-Hospital" when physician services are furnished in an off-campus provider-based department, or (2) creating a HCPCS modifier that could be reported with every code for services furnished in an off-campus provider-based department of a hospital on the CMS–1500 claim form for physician services and the UB–04 (CMS form 1450) for hospital outpatient claims. In addition, we have considered asking hospitals to break out the costs and charges for their provider-based departments as outpatient service cost centers on the Medicare hospital cost report, form 2552–10. We noted that some hospitals already break out these costs voluntarily or because of cost reporting requirements for the 340B Drug Discount Program, but this practice is not consistent or standardized. In the proposed rules, we invited public comments on the best means for collecting information on the frequency, type, and payment of services furnished in off-campus provider-based departments of hospitals.

Comment: Although most commenters agreed on the need to collect information on the frequency, type, and payment for services furnished in off-campus provided-based departments of hospitals, opinions differed on how to best collect this additional data. Some commenters preferred identifying services furnished in provider-based departments on the cost report, while others preferred one of the claims-based approaches. Some commenters supported either approach, noting the trade-offs in terms of the type of data that could be collected accurately and the administrative burden involved. Some suggested we convene a group of stakeholders to develop consensus on the best approach. Commenters generally recommended that CMS choose the least administratively burdensome approach that would ensure accurate data, but did not necessarily agree on what approach would optimally achieve that result. For example, limiting the data collection to cost report approaches results in little administrative burden for physicians since they do not file cost reports, but could result in varying degrees of administrative effort for hospitals depending on the specific cost reporting requirements.

Several commenters noted that some hospitals already voluntarily identify costs specific to provider-based departments on their cost reports. Since cost and charge information is already reported separately, these commenters asserted there would be no additional burden, although additional variables or changes to the structure of the cost report may be required. In addition, the commenters noted that cost report information would be transparent and audited for accuracy. One commenter recommended aggregate reporting of all off-campus provider-based departments as one or several cost centers, and another indicated that CMS should consider assigning separate sub-provider numbers for off-campus departments similar to those used for rehabilitation and psychiatric units.

However, other commenters believed that a HCPCS modifier would more clearly identify specific services provided and would provide better information about the type and level of care furnished. Some commenters believed a HCPCS modifier would be the least administratively burdensome as hospitals and physicians already report a number of claims-based modifiers. However, other commenters used this same fact about the number of existing claims-based modifiers to argue that additional modifiers would increase administrative burden since it would increase the number of modifiers that needed to be considered when billing. These commenters and others recommended that CMS should consider the establishment of a new Place of Service (POS) code since they believed it would be less administratively burdensome than attaching a modifier to each service on the claim that was furnished in an off-campus provider-based department. Some commenters stated that establishing a new POS code would work better under the PFS than the OPPS since under the OPPS a single claim was more likely to contain lines for services furnished in both on-campus and off-campus parts of the hospital on the same day for the same beneficiary.

MedPAC believes there may be some limited value in collecting data on services furnished in off-campus provider-based departments to validate the accuracy of site-of-service reporting when the physician office is off-campus but billing as an outpatient department, but did not recommend a particular data collection approach. MedPAC emphasized that any data collection effort should not prevent the development of policies to align payment rates across settings.

Response: We appreciate the public feedback in response to our comment solicitation in the proposed rules. We will take the comments received into consideration as we continue to consider approaches to collecting data on services furnished in off-campus provider-based departments.

M. Chiropractors Billing for Evaluation & Management Services

Section 1861(r)(5) of the Act includes chiropractors in its definition of "physician" with language limiting chiropractors to "treatment by means of manual manipulation of the spine (to correct a subluxation)." In accordance with the statute as we noted on page 43342 of the CY2014 proposed rule, chiropractic coverage, therefore, is limited to treatment of subluxation of the spine and payment can only be made for that purpose. Specifically, we make payment for only the following

three codes listed in the chiropractic section of the CPT Manual:

98940—Chiropractic manipulation treatment (CMT), spinal, 1–2 regions
98941—CMT spinal, 3–4 regions
98942—CMT spinal, 5 regions

We solicited comments in the CY2014 proposed rule regarding the appropriateness of the billing of E/M services by chiropractors although we did not propose to pay chiropractors for E/M services in 2014. We wanted to determine whether there are situations in which E/M services not included in Chiropractic Manipulative Treatment (CMT) codes 98940–98942 would meet the statutory requirements for chiropractic services and therefore, could be appropriately billed.

To achieve that goal, we asked that information be submitted regarding the following: the services that would be provided; the benefits that would accrue including whether access to chiropractic services for Medicare beneficiaries would be expanded; the justification for E/M services beyond those included in the CMT codes; the appropriateness of allowing billing for all office E/M codes for new or existing patients; the specific creation of one or a set of codes for chiropractic E/M services; the frequency that chiropractors should be allowed to bill E/M services; and the volume that could be expected.

Although very few commenters submitted comments that addressed all of the information we requested in the proposed rule, we do thank all the commenters for their input. Any possible changes to our current policy on allowing chiropractors to bill E/M services will be addressed in future notice and comment rulemaking.

III. Other Provisions of the Proposed Regulations

A. Medicare Coverage of Items and Services in FDA-Approved Investigational Device Exemption Clinical Studies—Revisions of Medicare Coverage Requirements

1. Background and Statutory Authority

a. General

Section 1862(m) of the Act (established by section 731(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108–173, enacted on December 8, 2003)) allows for payment of the routine costs of care furnished to Medicare beneficiaries in a Category A investigational device exemption (IDE) trial and authorizes the Secretary to establish criteria to ensure that Category A IDE trials conform to appropriate scientific and ethical standards. By providing Medicare coverage of routine costs in Category A trials, the Congress removed a financial barrier that may have discouraged beneficiaries from participating in these trials. It also gives Medicare beneficiaries the opportunity to have earlier access to new medical devices. However, the statute does not require Medicare to cover the Category A device itself. We note that throughout this section of the preamble, the words study and trial are used interchangeably.

(1) Category A IDE Devices

For Category A IDE devices, existing § 405.201(b) defines an "experimental/investigational (Category A) device" as an innovative device believed to be in Class III for which "absolute risk" of the device type has not been established (that is, initial questions of safety and effectiveness have not been resolved and the FDA is unsure whether the device type can be safe and effective). Existing § 405.207(b)(2) states that payment may be made for the routine care services related to Category A IDE devices if, among other things, the services are furnished in conjunction with an FDA-approved clinical trial, and that the trial is required to meet criteria established through the Medicare national coverage determination process.

(2) Category B IDE Devices

Existing § 405.201(b) defines a "non-experimental/investigational (Category B) device" as a device believed to be in Class I or Class II, or a device believed to be in Class III for which the incremental risk is the primary risk in question (that is, underlying questions of safety and effectiveness of that device type have been resolved), or it is known that the device type can be safe and effective because, for example, other manufacturers have obtained FDA approval for that device type. Existing § 405.211 allows Medicare contractors to make coverage decisions for non-experimental/investigational (Category B) devices if certain requirements are met. If a Medicare contractor determines that a Category B device is covered, Medicare also covers routine care services related to a non-experimental/investigational (Category B) device furnished in conjunction with an FDA-approved clinical trial, per § 405.207(b)(3). Based on our rulemaking authority in section 1871 of the Act, we proposed to apply the same Medicare coverage requirements and scientific and ethical standards to Medicare coverage related to Category B IDE studies/trials that would be applicable to Category A IDE studies/trials.

b. Background

We sought and received input from stakeholders (for example: manufacturers, study sponsors, and hospitals) regarding the Medicare coverage approval process for Category B IDE devices. The majority of stakeholders told us that obtaining Medicare coverage of the Category B IDE device and the costs of routine items and services is inefficient since local Medicare contractors have differing processes for reviewing IDE studies for purposes of Medicare coverage, which result in inconsistent Medicare coverage of Category B IDE devices and associated routine care services across the Medicare contractor jurisdictions. Stakeholders also suggested that these factors contribute to their reluctance to enroll Medicare beneficiaries in IDE trials and studies, and that Medicare coverage variability between Medicare contractors made it difficult to conduct national IDE trials.

We also requested input from local Medicare contractors regarding their existing processes for determining coverage of Category B IDE devices and associated routine care services. They reported that they review pertinent available evidence and the FDA-approved IDE trial protocol as factors in their decision-making process to ensure that the device is reasonable and necessary for Medicare beneficiaries and furnished in appropriate settings. Local Medicare contractors apply varying levels of scrutiny to these factors. While most Medicare contractors extensively review IDE study protocols, other contractors may review them less extensively. Although there is variability among contractors, in many cases the review processes are duplicative in that multiple Medicare contractors are reviewing the same materials in the same way.

2. Summary of Provisions of the Proposed Regulation

We proposed to modify our regulations related to Medicare coverage of routine care items and services in Category A IDE studies and trials, and Medicare coverage of Category B IDE devices and routine care items and services. We proposed to establish criteria for IDE studies so that Category A IDE trials conform to appropriate scientific and ethical standards for Medicare coverage consistent with our authority under section 1862(m)(2)(B) of the Act. We proposed to extend the same Medicare coverage requirements to Medicare coverage of Category B IDE

device trials, using our general rulemaking authority under section 1871 of the Act. We proposed that Medicare coverage decisions related to coverage of items and services in Category A and B IDE trials and studies be made by CMS centrally.

a. Proposed Definitions

We proposed to replace the definitions in § 405.201(b) with the following:

- *Category A (Experimental) device:* A device for which "absolute risk" of the device type has not been established (that is, initial questions of safety and effectiveness have not been resolved) and the FDA is unsure whether the device type can be safe and effective.
- *Category B (Nonexperimental/investigational) device:* A device for which the incremental risk is the primary risk in question (that is, initial questions of safety and effectiveness of that device type have been resolved) or it is known that the device type can be safe and effective because, for example, other manufacturers have obtained FDA approval for that device type.
- *ClinicalTrials.gov:* The National Institutes of Health's National Library of Medicine's online registry and results database of publicly and privately supported clinical studies of human participants conducted around the world.
- *Contractors:* Medicare Administrative Contractors and other entities that contract with CMS to review and adjudicate claims for Medicare items and services.
- *IDE stands for investigational device exemption:* An FDA-approved IDE application permits a device, which would otherwise be subject to marketing approval or clearance, to be shipped lawfully for the purpose of conducting a clinical study in accordance with 21 U.S.C. 360j(g) and 21 CFR parts 812.
- *Pivotal studies or trials:* Clinical investigations designed to collect definitive evidence of the safety and effectiveness of a device for a specified intended use, typically in a statistically justified number of subjects. It may or may not be preceded by an early and/or a traditional feasibility study.
- *Routine care items and services:* Items and services that are otherwise generally available to Medicare beneficiaries (that is, a benefit category exists, it is not statutorily excluded, and there is not a national noncoverage decision) that are furnished in either the experimental or the control arms of a clinical trial and that would be otherwise furnished even if the beneficiary were not enrolled in a clinical trial.
- *Superiority studies or trials:* Studies or trials that are intended to demonstrate at some prespecified level of confidence that the effect of an investigational treatment is superior to that of an active control by more than a prespecified margin.

b. Proposed Provisions for Medicare Coverage of Items and Services in FDA-Approved IDE Studies

To ensure that Medicare coverage of items and services in Category A and B IDE studies is more consistent across Medicare administrative regions, we proposed that IDE coverage decisions be made by CMS centrally. We proposed a centralized IDE coverage review process for Category A and Category B IDEs, by adding § 405.201(a)(3) stating that CMS identifies criteria for coverage of items and services furnished in IDE studies. We proposed to replace existing § 405.211 with the following Medicare coverage requirements for items and services in Category A and Category B FDA-approved IDE studies.

- CMS will review the following items and supporting materials as needed: (1) the FDA approval letter, (2) IDE study protocol, (3) IRB approval letter(s), (4) ClinicalTrials.gov identifier.
- Medicare may cover routine care items and services furnished in any FDA-approved Category A IDE study if the criteria in proposed new § 405.212(a) and (b) are met.
- Medicare covers a Category B IDE device and routine care items and services furnished in any FDA-approved Category B IDE study if the criteria in proposed new § 405.212(a) and (c) are met.
- If an IDE device is furnished in an FDA-approved IDE study that does not wholly fall under proposed new § 405.212(b) or (c), CMS considers whether the study's attainment of the criteria in proposed new § 405.212(a) are sufficient to mitigate the failure to meet the criteria in proposed new § 405.212(b) or (c).

We also proposed to notify the public of Medicare covered Category A and B IDE studies by posting the IDE study title and ClinicalTrials.gov identifier on the CMS coverage Web site and publishing a list of trials in the **Federal Register**. We stated that a centralized review process would be more efficient by reducing the burden for stakeholders interested in seeking Medicare coverage related to nationwide IDE studies or trials. Having a single entity making Medicare coverage decisions would enhance administrative efficiency by eliminating the need for duplicative submissions from stakeholders to different Medicare contractors and duplicative reviews by Medicare contractors. In the preamble to the proposed rule, we stated that we did not believe that the proposed coverage requirements would significantly change the number of items and services covered compared to coverage under existing requirements.

We stated in the preamble to the proposed rule that any interested party who seeks Medicare coverage related to a Category A or B IDE study may send us a request letter that describes the scope and nature of the Category A or B IDE study, discussing each of the criteria in the proposed policy. Requests would be submitted via email to *clinicalstudynotification@cms.hhs.gov* or via hard copy to the following address: Centers for Medicare & Medicaid Services; Center for Clinical Standards & Quality; Director, Coverage and Analysis Group; ATTN: Clinical Study Certification; Mailstop: S3–02–01; 7500 Security Blvd.; Baltimore, MD 21244.

c. Proposed Medicare Coverage IDE Study Criteria

We proposed to add a new § 405.212 that describes the Medicare coverage criteria that Category A and B IDE studies or trials must meet in order for Medicare to cover routine care items and services in Category A IDE studies or trials, and for Medicare to cover Category B IDE devices and routine care items and services (per proposed revised § 405.207 and § 405.211). We proposed the following Medicare coverage IDE study criteria.

(1) The principal purpose of the study is to test whether the item or service meaningfully improves health outcomes of patients who are represented by the Medicare-enrolled subjects.

(2) The rationale for the study is well supported by available scientific and medical information, or it is intended to clarify or establish the health outcomes of interventions already in common clinical use.

(3) The study results are not anticipated to unjustifiably duplicate existing knowledge.

(4) The study design is methodologically appropriate and the anticipated number of enrolled subjects is adequate to answer the research question(s) being asked in the study.

(5) The study is sponsored by an organization or individual capable of completing it successfully.

(6) The study is in compliance with all applicable Federal regulations concerning the protection of human subjects found at 45 CFR part 46.

(7) All aspects of the study are conducted according to appropriate

standards of scientific integrity set by the International Committee of Medical Journal Editors.

(8) The study has a written protocol that clearly demonstrates adherence to the standards listed here as Medicare requirements.

(9) Where appropriate, the clinical research study is not designed to exclusively test toxicity or disease pathophysiology in healthy individuals. Trials of all medical technologies measuring therapeutic outcomes as one of the objectives may be exempt from this standard only if the disease or condition being studied is life threatening as defined in 21 CFR 312.81(a) and the patient has no other viable treatment options.

(10) The study is registered on the ClinicalTrials.gov Web site and/or the Registry of Patient Registries (RoPR) by the principal sponsor/investigator prior to the enrollment of the first study subject.

(11) The study protocol specifies the method and timing of public release of results on all pre-specified outcomes, including release of negative outcomes. The release should be hastened if the study is terminated early. The results must be made public within 24 months of the end of data collection. If a report is planned to be published in a peer reviewed journal, then that initial release may be an abstract that meets the requirements of the International Committee of Medical Journal Editors. However, a full report of the outcomes must be made public no later than 3 years after the end of data collection.

(12) The study protocol explicitly discusses subpopulations affected by the item or service under investigation, particularly traditionally underrepresented groups in clinical studies, how the inclusion and exclusion criteria [a]ffect enrollment of these populations, and a plan for the retention and reporting of said populations in the study. If the inclusion and exclusion criteria are expected to have a negative effect on the recruitment or retention of underrepresented populations, the protocol must discuss why these criteria are necessary.

(13) The study protocol explicitly discusses how the results are or are not expected to be generalizable to subsections of the Medicare population to infer whether Medicare patients may benefit from the intervention. Separate discussions in the protocol may be necessary for populations eligible for Medicare due to age, disability, or Medicaid eligibility.

We stated in the preamble to the proposed rule that all IDE investigational device studies where Medicare coverage is sought should conform to rigorous scientific and ethical standards. We believe that these criteria are essential to protecting Medicare study participants in Category A and Category B trials. Studies that have high scientific and ethical standards lead to generalizable and reliable knowledge for the Medicare program including, providers, practitioners, and beneficiaries.

We believe that additional Medicare coverage criteria are needed for Category A and B IDE studies where Medicare coverage for items and services is sought, to ensure that the study design is appropriate to answer questions of importance to the Medicare program and its beneficiaries. Although an item or service may be considered appropriate when used by a clinician for the benefit of an individual patient, it may not be reasonable and necessary when used in the context of an IDE study or trial for purposes of Medicare coverage. The use of such a device in an IDE study or trial may expose study participants to increased risks that must be balanced by other factors, including the likelihood that the study would add important information to the body of medical knowledge relevant to the Medicare program.

While most studies are undertaken only after a detailed protocol has been developed, some are not. The protocol is the primary source of knowledge on the proposed design and management of the study. Without this document, reviewers and funding entities are unable to ascertain the quality and validity of the study, and whether the study is appropriate to answer questions of importance to the Medicare program. The exercise of committing to paper all the aspects of the study is crucial to ensuring that all potential concerns have been addressed.

We proposed these 13 Medicare coverage IDE study criteria because we believe they must be integral to any study that is approved for purposes of Medicare coverage. The proposed first four criteria and the seventh criterion were developed because they embody ethical values. The fifth and sixth proposed criteria were developed in response to reports of egregious misconduct in the past in endeavors to conduct clinical research by placing individuals at the risk of harm for the good of others.

In § 405.211, we proposed that if the following two characteristics are also met, in addition to the IDE study criteria listed in proposed new § 405.212(a)(1) through (a)(13), we would automatically cover the costs of routine items and services in the Category A study or trial, and the costs of the investigational device and the routine items and services in a Category B study or trial as follows:

- The study is a pivotal study.
- The study has a superiority study design.

Existing § 405.207(b)(2) requires that for Medicare coverage of related routine care services, all Category A IDE studies and trials must meet the criteria established through the NCD process. We proposed to modify § 405.207(b) to remove the NCD process requirement and state that payment may be made for routine care items and services related to experimental/investigational (Category A) devices as defined in § 405.201(b), and furnished in conjunction with an FDA-approved clinical trial that meets the Medicare coverage IDE study criteria in proposed new § 405.212. We proposed to modify § 411.15(o)(2) to specify that the exclusions from Medicare coverage include experimental or investigational devices, except for certain devices furnished in accordance with the Medicare coverage requirements proposed in revised § 405.211.

3. Summary of Public Comments

We received 48 comments from various entities including the medical device industry, academic medical centers, health care systems, consultants, and medical societies. Regarding centralization of the IDE review process, commenters' opinions were mixed with the majority requesting additional details about the centralized review process, clarification of the IDE study criteria, and delayed implementation of the rule. Commenters expressed concerns about the proposed IDE study criteria, believing that they were duplicative of FDA review activities and suggested that CMS allow for additional input from stakeholders before the rule is finalized. The following is a summary of the comments we received and our responses.

a. Definitions

Comment: Commenters were concerned that our proposed definition of routine care items and services would limit Medicare coverage of routine care items and services related to Category A or Category B IDE studies. The comments suggested that we align this definition with section 310.1 of the Medicare NCD Manual (Clinical Trials).

Response: We appreciate the commenters' feedback. While we believe that this definition of routine care items and services is aligned with section 310.1 of the Medicare National

Coverage Determinations Manual, for purposes of clarity, we are modifying this definition to refer to items and services that are otherwise generally available to Medicare beneficiaries (that is, a benefit category exists, it is not statutorily excluded, and there is no national noncoverage decision) that are furnished during a clinical study and that would be otherwise furnished even if the beneficiary were not enrolled in a clinical study.

b. Provisions for Medicare Coverage of Items and Services in FDA-approved Category A or B IDE Studies or Trials

Comment: Several commenters were generally supportive of the concept of a centralized Medicare review process for Category A and B IDE studies for purposes of Medicare coverage. However, the commenters requested additional information regarding submission format and review timeframes, with some commenters concerned about the availability of appropriate staff at CMS to complete reviews and issue approvals. Commenters also asked for clarification regarding appeals of Medicare coverage decisions related to Category A or B IDE studies and evaluation/oversight of the CMS Medicare coverage review process.

Response: Seeking Medicare coverage related to Category A or B IDE studies is voluntary. While we are finalizing this rule, we are delaying implementation of these changes until January 1, 2015. Upon implementation of these changes, interested parties, such as the study sponsor, that wish to seek Medicare coverage in Category A or B IDE studies must submit their requests via email to *clinicalstudynotification@cms.hhs.gov* or via hard copy to the following address: Centers for Medicare and Medicaid Services; Center for Clinical Standards and Quality; Director, Coverage and Analysis Group; ATTN: Clinical Study Certification; Mail Stop S3–02–01; 7500 Security Blvd.; Baltimore, MD 21244.

Requests must include the following information:

- A request letter that describes the scope and nature of the IDE study, discussing how the interested party believes that the IDE study meets each Medicare Coverage IDE Study Criteria.
- FDA approval letter of the IDE.
- IDE study protocol.
- IRB approval letter.
- National Clinical Trial (NCT) number.
- Supporting materials, as appropriate.

We understand and appreciate commenters' concerns regarding review time and the availability of appropriate staff to complete the reviews. Once a complete request is received by CMS (or its designated entity), we expect that the review timeframe will be approximately 30 days. While we believe that we have sufficient resources to process Medicare coverage reviews of the IDE studies, we are modifying the provisions of section 405.211 to allow for reviews by a CMS-designated entity if future needs arise.

We anticipate that claims for routine care items and services related to Category A or B IDE studies and claims for Category B IDE devices will continue to be submitted to local Medicare contractors who will identify routine costs for which Medicare payment is made for each related claim. We plan to issue appropriate manual instructions to Medicare contractors. Additional information regarding Medicare claim appeals is available on the CMS Web site at *http://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/index.html.*

Comment: A few commenters opposed a centralized Medicare coverage process for Category A or B IDE studies and believed that the current local Medicare contractor review process is sufficient, that centralization could increase approval time, and may not have the intended impact of eliminating inconsistencies in coverage. Several commenters suggested that CMS focus on streamlining claims processing for routine costs incurred by Medicare beneficiaries participating in clinical trials. One commenter was concerned that local Medicare contractors may impose additional coverage requirements.

Response: While some stakeholders may be satisfied with the current localized coverage review process, we believe that centralizing the submission, review and determination of Medicare coverage IDE study requests enhances administrative efficiency by eliminating the need for duplicative submission of requests by providers and duplicative reviews by local Medicare contractors. For example, under existing procedures, each provider that participates in an IDE trial and that anticipates filing Medicare claims must notify the Medicare contractor and furnish the contractor with certain information about the IDE trial. Once the contractor notifies the provider that all required information for the IDE study has been furnished, the provider may bill related Category A or B IDE claims.

Effective January 1, 2015, interested parties (such as study sponsors) that wish to seek Medicare coverage related to Category A or B IDE studies, will have a centralized point of contact for submission, review and determination of Medicare coverage IDE study requests. Providers will no longer need to notify individual contractors regarding IDE studies for which they plan to submit claims since CMS-approved Category A and B IDE studies will be listed on the CMS Web site and in the **Federal Register**. We encourage providers to check the CMS Web site to see if an IDE study has been approved for coverage before submitting IDE related claims.

Comment: Some commenters believed that the Medicare coverage requirements duplicate the responsibilities of the FDA (such as review of scientific and ethical standards) with commenters suggesting that CMS deem coverage for Category A or B IDE studies that have received FDA and IRB approval.

Response: CMS and FDA operate under different statutory authorities and have distinct authorities and responsibilities. FDA approves IDE studies or trials when, among other things, the risks to the subjects are outweighed by the anticipated benefits and the importance of the knowledge to be gained. For purposes of Medicare coverage, we seek evidence that an item or service is reasonable and necessary. The disease burden borne by elderly individuals and the important health care interventions unique to the Medicare population are important areas of focus for the Medicare program; we would not expect the FDA review to include substantive consideration of these Medicare priorities. Thus, we believe that Medicare coverage standards are needed for IDE studies for which Medicare coverage is sought. We wish to ensure that Medicare beneficiaries who volunteer to participate in studies are protected, that the study design is appropriate to answer questions of importance to the Medicare program, and to ensure that the information gained from important clinical trials could be used to inform Medicare coverage decisions.

There are numerous studies that may be considered scientifically valid but are of little benefit to Medicare beneficiaries or to the Medicare program. We believe that this policy establishes Medicare coverage requirements that need to be met to best support a body of clinical knowledge that is relevant to the Medicare program and its beneficiaries. It is essential that IDE studies where Medicare coverage is sought serve the best interests of the Medicare program and its beneficiaries; and that they be useful in improving healthcare delivery to Medicare beneficiaries, and informing Medicare coverage.

Comment: Commenters suggested that the proposed coverage requirements

would increase burden and create access barriers for Medicare coverage of Category A IDE routine care items and services and Category B IDE devices and routine care items and services, particularly in small or localized studies or trials. Commenters suggested that these changes may decelerate medical device innovation and that many sponsors may choose not to seek Medicare coverage for IDE trials due to possible delays during the transition to these new coverage requirements. Other commenters suggested that we pilot a voluntary centralized coverage review process for at least a year, or establish separate review processes for small and large studies since commenters believed that the existing review process by local Medicare contractors is appropriate for small, single-site studies, and that centralized review should only be applied to large, national studies. Some commenters requested clarification regarding whether Medicare would automatically cover items and services related to Category A or B IDE studies, if the studies met the criteria in proposed new § 405.212.

Response: Seeking Medicare coverage related to Category A or B IDE studies is voluntary under existing procedures and will continue to be voluntary under the provisions of this final rule. Study sponsors are not required to seek Medicare coverage in order to conduct their studies or trials. Establishing separate Medicare coverage for IDE study review processes for large and small studies would create unnecessary infrastructure. Similarly, piloting the centralized Medicare coverage IDE study review process would create more duplication and variation in reviews and coverage of items and services, in addition to the variation currently present under the existing local Medicare contractor review process.

In this final rule, we are revising § 405.211(a) to specify that Medicare covers routine care items and services that are furnished in FDA-approved Category A IDE studies if CMS (or its designated entity) determines that the IDE study criteria in § 405.212 are met. We are also revising § 405.211(b) to specify that Medicare may make payment for Category B IDE devices and routine care items and services furnished in FDA-approved Category B IDE studies if CMS (or its designated entity) determines that the IDE study criteria in § 405.212 are met.

Comment: One commenter expressed concern that beneficiaries could be at risk of losing Medicare coverage for medical emergencies and other health care items and services that would otherwise be available to Medicare beneficiaries outside of an IDE study or trial.

Response: We do not believe this policy will have an impact on coverage for treatment of an individual trial participant with a medical emergency because this policy does not address Medicare coverage provisions outside the context of a Category A or B IDE study or trial. We would not expect to make a separate review of the IDE study information submitted to CMS (or its designated entity) for each enrolled subject or each related claim submitted to Medicare contractors for adjudication. Additionally, we are unaware of any current paradigm by which an FDA approved IDE trial would be conceived, developed, reviewed and approved in such a short timeframe, that is, a few minutes or hours, to address a beneficiary's medical emergency.

Comment: Commenters requested information about what role, if any, the FDA would serve in the proposed centralized IDE review process for purposes of Medicare coverage of Category A IDE routine care items and services and Category B IDE devices and routine care items and services.

Response: We did not propose any changes to § 405.203, which addresses FDA categorization of IDE devices and subsequent FDA notification to CMS regarding such categorization.

c. Medicare Coverage IDE Study Criteria

Comment: Many commenters believed that proposed criterion 1 (the principal purpose of the study is to test whether the item or service meaningfully improves health outcomes in patients who are represented by the Medicare-enrolled subjects), was too specific to the Medicare population and should more closely align with FDA requirements since IDE studies are designed to answer FDA regulatory questions, not Medicare or other insurer coverage questions. Some commenters suggested that we modify the standard to indicate that measuring meaningful outcomes in Medicare beneficiaries need not be the principal purpose, but only one of the purposes.

Response: As discussed in the preamble to the proposed rule, we believe that this criterion is necessary because it embodies important scientific and ethical considerations needed to ensure that the study design is appropriate to answer questions of importance to Medicare and its beneficiaries. We expect that the results of all approved studies will specifically benefit the Medicare population and, as such, covered studies or trials must address how the study will affect Medicare beneficiaries if it desires to receive Medicare payment for services provided to Medicare beneficiaries within that study. However, based on the comments received, we are modifying this criterion to state that the principal purpose of the study is to test whether the device improves health outcomes of appropriately selected patients, since a discussion of the potential benefit of the device being studied to the applicable Medicare population is implicit in other criteria.

Comment: Commenters suggested that we remove or modify the second proposed criterion (the rationale for the study is well supported by available scientific and medical information, or it is intended to clarify or establish the health outcomes of interventions already in common clinical use). Commenters believed that there is already well established government oversight, and self-governance through IRBs and scientific review committees. The commenters requested additional guidance regarding how this criterion would align with FDA requirements and oversight through the IRBs and scientific committees.

Response: Study protocols typically have a section that describes the scientific rationale for the research. We believe that this criterion reflects a fundamental principle of research and does not require something that would otherwise be absent from a *bona fide* clinical study protocol. We seek assurance of compliance with this criterion because it is needed to ensure that the study or trial focuses on health outcomes important to the Medicare program and its beneficiaries. Therefore, we are not making changes to this criterion.

Comment: Some commenters were concerned about how proposed criterion 3 (the study results are not anticipated to unjustifiably duplicate existing knowledge) would affect IDE device studies that are versions of devices already on the market. A commenter believed that this criterion should not be used to restrict Medicare coverage of IDE studies that build on an existing body of evidence or that provide confirmatory data on new devices.

Response: We realize that FDA reviews many new devices being tested in IDE trials that may be similar to devices already on the market, and that this process is a necessary part of competition and innovation. However, because we are not assured that all devices of a similar class will necessarily have identical benefits and harms, we do not believe, as a general principle, that IDE studies or trials addressing new device versions always duplicate prior knowledge. We expect

that knowledge about new devices or significantly changed devices will add to, rather than duplicate, existing knowledge. We believe this criterion is necessary to ensure that the study focuses on health outcomes important to the Medicare program and its beneficiaries. Therefore, we are not making changes to this criterion.

Comment: Commenters stated that proposed criterion 4 (the study design is methodologically appropriate and the anticipated number of enrolled subjects is adequate to answer the research question(s) being asked in the study) is duplicative of the FDA's role. One commenter asked how we would determine if a study design is methodologically appropriate.

Response: Fundamentally, *bona fide* clinical research depends on the use of study designs that are appropriate to address the study questions. Otherwise there is no real production of generalizable knowledge, which is the hallmark of research, and enrolled subjects encounter risk without a realistic expectation that their participation will result in personal or societal benefit relevant to the Medicare program. The use of such a device in an IDE study may expose the study participants to increased risks that must be balanced by other factors including the likelihood that the study would add important information to the body of medical knowledge relevant to the Medicare program. There are numerous studies that may be considered scientifically valid but are of little benefit to the Medicare program. We are sensitive to the unique needs of Medicare beneficiaries, particularly the elderly. A trial design that may be adequate for a generally younger population may be comparatively insensitive to clinical factors commonly found in the elderly that may adversely impact the potential benefit or tolerability of a device, which is of particular importance to the Medicare program.

Comment: A few commenters requested information on how proposed criterion 5 (the study is sponsored by an organization or individual capable of completing it successfully) will be used to determine that the sponsoring organization or individual is capable of completing a study successfully.

Response: Institutional capabilities and scientific expertise are typically described in study protocols, which will be reviewed by CMS. Robust clinical studies depend on a supporting infrastructure to assure protocol adherence and that intended patient protections are actually in place. Clinical trials that are not completed successfully expose enrolled subjects to the risks of research participation without the benefit of producing generalizable knowledge applicable to the Medicare program. We believe that this criterion reflects a fundamental principle of research and does not require something that would otherwise be absent from a bona fide clinical study protocol. Therefore, we are finalizing this criterion as proposed.

Comment: One commenter suggested that for proposed criterion 6 (the study is in compliance with all applicable Federal regulations concerning the protection of human subjects found at 45 CFR part 46) that we also require compliance with FDA regulations at 21 CFR 50 (Informed Consent) and 21 CFR 56 (Institutional Review Board oversight) since 45 CFR 46 only refers to government funded research.

Response: We agree with the commenter's suggestions and are modifying this criterion in this final rule to require that the study is in compliance with all applicable Federal regulations concerning the protection of human subjects found at 21 CFR parts 50, 56, and 812, and 45 CFR part 46.

Comment: Commenters recommended that we delete the reference to the International Committee of Medical Journal Editors in proposed criterion 7 (all aspects of the study are conducted according to appropriate standards of scientific integrity set by the International Committee of Medical Journal Editors.

Response: In response to the comments received, we are removing proposed criterion 7. We believe that the intent of proposed criterion 7 can be largely accomplished by adherence to the remaining CMS IDE study criteria.

We are also removing proposed criterion 8 (the study has a written protocol that clearly demonstrates adherence to the standards listed here as Medicare requirements) because the intent of proposed criterion 8 is implicit in the CMS coverage criteria and requirements.

Comment: One commenter suggested that proposed criterion 9 (where appropriate, the clinical research study is not designed to exclusively test toxicity or disease pathophysiology in healthy individuals. Trials of all medical technologies measuring therapeutic outcomes as one of the objectives may be exempt from this standard only if the disease or condition being studied is life threatening and the patient has no other viable treatment options), since the commenter believed that Medicare would only be furnishing coverage for "conventional" care.

Response: As discussed in the preamble to the proposed rule, the intent of this criterion is to limit Medicare coverage to IDE studies that do not exclusively test toxicity or disease pathophysiology in healthy individuals, but also have a therapeutic outcome. However, a study that exclusively tests toxicity or disease pathophysiology may still be covered if the disease or condition being studied is life-threatening or a severely-debilitating illness, and the patient has no other viable treatment options. We recognize that many research projects could be considered to have varying degrees of contributions towards understanding interventions that improve health outcomes for the Medicare program. While we agree that in some cases, safety and toxicity studies may assess the benefits of the interventions they examine, and in limited circumstances may be considered appropriate to inform the clinical knowledge base applicable to the Medicare program, we are maintaining this criterion without change.

Comment: Commenters expressed interest in the possible impact of the rule on ClinicalTrials.gov reporting, and suggested that we require that proposed criterion 10 (the study is registered on the ClinicalTrials.gov Web site and/or the Registry of Patient Registries (RoPR) by the principal sponsor/investigator prior to the enrollment of the first study subject) comply with section 801 of the Food and Drug Administration Amendments Act of 2007 (FDAAA) (Pub. L. 110–85, enacted on September 27, 2007), which requires registration on ClinicalTrials.gov within 21 days of enrollment of the first subject.

Response: As discussed in the preamble to the proposed rule, we believe that all studies seeking Medicare coverage under this policy should be registered with ClinicalTrials.gov. Registrants at ClinicalTrials.gov must submit a standardized set of data elements to describe the study design, eligible populations, outcome measures, and other parameters and results. Registration, for some studies, serves as a vehicle for Medicare beneficiaries to learn about, and identify studies in which they may want to participate. When results reporting is required, it also offers an assurance of quality because, generally, public access to information enables a higher level of accountability in the accurate reporting of the clinical study protocol and results, and in the conduct of the trial itself. This accountability derives both from public access to information about studies and from the risk of penalty for

submitting false or misleading clinical trial information. We recognize that, for some studies of unapproved devices, FDAAA prohibits the public display of information on registration and results until after the device is approved or cleared for marketing. We have revised our regulation to avoid indicating that Medicare coverage of such IDE studies would require public display of all information in ClinicalTrials.gov for these unapproved devices. However, we believe that delayed display for this subset of studies, should the device be cleared or approved for marketing, will not significantly undermine our goals. For some studies, we expect public access to ClinicalTrials.gov data will not be delayed and therefore our requirement will immediately lead to greater public transparency for many of the studies supported by Medicare. For those studies about which information cannot be displayed publicly prior to marketing approval, we believe that the possibility of future public access and the risk of liability for the submission of false or misleading clinical trial information to ClinicalTrials.gov remain valuable. Registration with ClinicalTrials.gov also assures that Medicare beneficiaries and their treating healthcare professionals will, for those devices ultimately approved or cleared by FDA, eventually have pertinent information about these IDE studies. We note that clinical trials of devices that register for purposes of this regulation are subject to any applicable requirements under FDAAA. Finally, we have modified the criteria to simply require registration on ClinicalTrials.gov.

Comment: In summary, proposed criterion 11 stated that the study protocol must specify the method and timing of public release of results on all pre-specified outcomes, including release of negative outcomes. One commenter stated that time to publication may not be in the control of the sponsors and that some studies may not be published at all for various reasons. Commenters suggested that we modify this criterion to be consistent with section 801 of the FDAAA.

Response: Based on the comments received, we are modifying this criterion to state that the study protocol describes the method and timing of release of results on all pre-specified outcomes, including release of negative outcomes and that the release should be hastened if the study is terminated early.

Comment: In summary, proposed criteria 12 and 13 stated that the study protocol must explicitly discuss the subpopulations affected by the items or services under investigation and discuss how the study results would be expected to be generalizable to the Medicare population. Commenters believed that explicitly requiring this information in the study protocol was inappropriate, with other commenters indicating that this information could be provided in the request for coverage submission package versus explicitly requiring it in the study protocol. A commenter stated that generalizability to populations beyond those which are studied in the trial may be difficult to articulate, especially when the class of device is new. Commenters opined that if the device class is the subject of a Medicare national or local coverage decision, the criterion is redundant and may create undue burden on a trial being conducted in a least burdensome environment.

One commenter suggested that for devices that represent a device improvement, the existing body of knowledge and other supporting documents will likely address sub- and special populations. The commenter also stated that for truly new devices, safety and efficacy at a baseline level are not yet established and that a mandate to include special populations and under-represented groups is likely to be prohibitive to completion of the trial.

Response: We want to support and encourage the conduct of research studies that add to the knowledge base about efficient, appropriate, and effective use of products and technologies in the Medicare population, thus improving the quality of care that Medicare beneficiaries receive. We understand the commenters' concerns; however, we expect that the results of studies or trials approved for purposes of Medicare coverage will specifically benefit the Medicare population.

It is not our intention to require enrollment of all subpopulations. It is, however, our intention that study protocols for which Medicare coverage is sought address all populations affected by the technology under investigation, specifically those of interest to the Medicare program (populations due to age, disability, or other eligibility status). We expect that protocols describe the potential for subgroup differences and discuss how the study will evaluate any differences found.

In this final rule, we are combining and modifying proposed criteria 11 and 12 to state that for purposes of Medicare coverage, Category A or Category B IDE study protocols must discuss how Medicare beneficiaries may be affected by the device under investigation, how the study results are or are not expected to be generalizable to the Medicare population, and must include separate discussions for populations eligible for Medicare due to age, disability, or other eligibility status.

Comment: Commenters suggested that we remove the proposed Medicare coverage requirements that a Category A or B IDE study must be a pivotal study and have a superiority study design. Commenters expressed concern that noninferiority studies were not specifically discussed. One commenter recommended that IDE studies conducted as part of the FDA premarket approval (PMA) process be deemed as meeting the pivotal trial definition and be eligible for automatic coverage. Commenters stated that noninferiority studies and studies without an active comparator are designed to address important research questions and ultimately improve patient care, and cited the following concerns about including this requirement:

- Requiring that the study be either a superiority or pivotal study may undermine innovation.
- Not all clinical questions require superiority designs.
- Development of devices that are similar to devices already on the market may only require evidence of equivalence or noninferiority to a preexisting device while offering an expanded treatment option and lower healthcare costs through competition in the market.
- Medical device development may follow less well-defined paths of clinical study with individual studies not always easily characterized by a specific Phase, but still providing important evidence on a device's safety and effectiveness.
- In many cases, the protocol is not changed between the pilot and pivotal phases and including this requirement may make studies in the pilot phase ineligible for coverage.
- Investigator-initiated studies often evaluate novel approaches in small studies and are unlikely to be pivotal.

Response: We appreciate the commenters' concerns about the proposed pivotal study and superiority study design Medicare coverage criteria. We believe that noninferiority trial designs are recognized to have certain risks of bias that are mitigated in superiority trial designs. These criteria were intended as specific positive factors that could have streamlined the Medicare coverage review of IDE study protocols. We did not intend that these proposals would be absolute requirements or that IDE studies that are not pivotal or studies with noninferiority designs could not be

approved for Medicare coverage. Therefore, we are modifying the Medicare coverage IDE study criteria in new § 405.212 by removing the proposed pivotal study and superiority study design coverage requirements and removing the proposed definitions of pivotal studies or trials and superiority studies or trials in revised § 405.201(b).

d. Additional Issues

Comment: Commenters stated that submitting IRB letters for every site involved in a multi-site clinical trial would create significant burden for stakeholders and is duplicative of the FDA's review process.

Response: We believe that Medicare beneficiaries should be enrolled in studies that have been vetted by IRBs. However, we recognize commenters' concerns regarding the potential burden of submitting IRB letters for every site involved in a multi-site clinical trial. Therefore, we are clarifying in this final rule that interested parties, such as the study sponsor, that wish to seek Medicare coverage related to Category A or B IDE studies need only submit one IRB approval letter with their request.

Comment: Commenters requested assurance that information provided by the study sponsor will be kept confidential.

Response: Seeking Medicare coverage for Category A or B IDE trials is voluntary. Medicare coverage is not a requirement for study sponsors to conduct research. Effective January 1, 2015, interested parties (such as the study sponsor) that wish to seek Medicare coverage in Category A or B IDE studies must submit a request to CMS for review and approval of a Category A or B IDE study in order to meet the Medicare coverage requirements for Category A or B IDE routine care items and services, and Category B devices.

Upon CMS approval of a Category A or B IDE study, we will post on the CMS Web site and periodically in the **Federal Register** limited information supplied by the interested party as part of their Medicare coverage IDE study review request (study title, sponsor name, NCT number, and the IDE number), along with the CMS approval date. We note that the same type of information is currently posted on the CMS Web site for other clinical study approvals related to Medicare coverage under the coverage with evidence development (CED) paradigm. We note that we did not propose any changes to § 405.215, which addresses confidential commercial and trade secret information by specifying that, to the extent that we rely on confidential commercial or trade secret information in any judicial proceeding, we will maintain confidentiality of the of the information in accordance with Federal law.

Comment: Commenters requested information about appropriate procedures for notification of trial revisions, protocol changes, and review of consent forms. One commenter requested that we align with the ClinicalTrials.gov registry, so that sponsors and researchers can provide updates to both systems. Other commenters suggested that instead of notifying the public of CMS-approved IDE studies in the **Federal Register**, that we post this information to the CMS Web site.

Response: We do not believe that the creation of a shared registry with the National Library of Medicine's ClinicalTrials.gov registry to include information regarding CMS approval of Category A or B IDE studies could be accomplished before the effective date of this regulation. As previously discussed, limited information regarding CMS-approved Category A and B IDE studies will be posted on the CMS Web site and in the **Federal Register**.

Comment: A few commenters asked how the proposed changes to the coverage requirements would impact or interact with the NCD process, including CED.

Response: Medicare coverage of Category A IDE routine care items and services, and Medicare coverage of Category B IDE devices and routine care items and services do not predict nor directly lead to Medicare coverage outside of the context of an IDE study, nor does it necessarily lead to consideration under the Medicare national coverage determination (NCD) process. The NCD process is separate and distinct with its own statutory basis and requirements. Additional information regarding the Medicare national coverage determination process can be found on the CMS coverage Web site at *http://www.cms.gov/Center/Special-Topic/Medicare-Coverage-Center.html?redirect=/center/coverage.asp.*

Comment: Commenters requested clarification about Medicare coverage of Category A IDE related routine care items and services and Category B IDE devices and related routine care items and services, when the Medicare beneficiary is enrolled in a Medicare Advantage plan or Medicare health plan.

Response: Medicare Advantage plans must abide by the IDE study payment policy as instructed in the Medicare Managed Care Manual, Chapter 4, Section 10.7.2.

4. Summary of Changes to Proposed Provisions

As a result of the comments received, we are making the following changes in this final rule.

- For the purpose of clarity, we are modifying the following definitions to state:

++ *Category B (Nonexperimental/investigational) device* refers to a device for which the incremental risk is the primary risk in question (that is, initial questions of safety and effectiveness of that device type have been resolved), or it is known that the device type can be safe and effective because, for example, other manufacturers have obtaind FDA premarket approval or clearance for that device type.

++ *Routine care items and services* refers to items and services that are otherwise generally available to Medicare beneficiaries (that is, a beneficiary category exists, it is not statutorily excluded, and there is no national noncoverage decision) that are furnished during a clinical study and that would be otherwise furnished even if the beneficiary were not enrolled in a clinical study.

- We are revising § 405.207(b)(3) to state "Routine care items and services related to Category A (Experimental) devices as defined in § 405.211."

- We are revising § 405.207(b)(3) to state "Routine care items and services related to Category B (Nonexperimental/investigational) devices as defined in § 405.201(b), and furnished in conjunction with FDA-approved clinical studies that meet the coverage requirements in § 405.211."

- We are modifying § 405.211 so that—

++ Medicare covers routine care items and services furnished in an FDA-approved Category A IDE study if CMS (or its designated entity) determines that the Medicare coverage IDE study criteria in § 405.212 are met.

++ Medicare may make payment for a Category B (Nonexperimental/investigational) IDE device and routine care items and services furnished in an FDA-approved Category B (Nonexperimental/investigational) IDE study if CMS (or its designated entity) determines that the Medicare coverage IDE study criteria in § 405.212 are met.

++ CMS (or its designated entity) must review the following to determine if the Medicare coverage IDE study criteria in § 405.212 are met (that is, FDA approval letter of the IDE, IDE study protocol, IRB approval letter, NCT

number, and supporting materials, if needed).

++ A listing of all CMS-approved Category A IDE studies and Category B IDE studies shall be posted on the CMS Web site and published in the **Federal Register**.

• We modified new § 405.212 (IDE study criteria) to require that, for Medicare coverage of items and services described in § 405.211, a Category A (Experimental) or Category B (Nonexperimental/investigational) IDE study must meet all of the following criteria.

++ The principal purpose of the study is to test whether the device improves health outcomes of appropriately selected patients.

++ The rationale for the study is well supported by available scientific and medical information or it is intended to clarify or establish the health outcomes of interventions already in common clinical use.

++ The study results are not anticipated to unjustifiably duplicate existing knowledge.

++ The study design is methodologically appropriate and the anticipated number of enrolled subjects is adequate to confidently answer the research question(s) being asked in the study.

++ The study is sponsored by an organization or individual capable of successfully completing the study.

++ The study is in compliance with all applicable Federal regulations concerning the protection of human subjects found at 21 CFR parts 50, 56, and 812, and 45 CFR part 46.

++ Where appropriate, the study is not designed to exclusively test toxicity or disease pathophysiology in healthy individuals. Studies of all medical technologies measuring therapeutic outcomes as one of the objectives may be exempt from this criterion only if the disease or condition being studied is life threatening and the patient has no other viable treatment options.

++ The study is registered with the National Institutes of Health's National Library of Medicine's ClinicalTrials.gov.

++ The study protocol describes the method and timing of release of results on all pre-specified outcomes, including release of negative outcomes and that the release should be hastened if the study is terminated early.

++ The study protocol must describe how Medicare beneficiaries may be affected by the device under investigation, and how the study results are or are not expected to be generalizable to the Medicare beneficiary population. Generalizability to populations eligible for Medicare due to age, disability, or other eligibility status must be explicitly described.

We are also making the following conforming changes to 42 CFR 405 subpart B.

• To reflect changes in § 405.201(b), we are making conforming changes to the following sections: § 405.201(a)(2); § 405.203(a)(1) and (a)(2); § 405.203(b); § 405.205(a)(1); § 405.209; § 405.213(a)(1); and § 411.15(o)(1), by replacing the term experimental/investigational (Category A) device with Category A (Experimental) device, and the term Non-experimental/investigational (Category B) device with Category B (Nonexperimental/investigational) device, as applicable.

• In § 405.201(b), we are changing the term IDE to investigational device exemption (IDE) for clarity purposes.

• In § 405.207(b)(2), we are making conforming changes to reflect changes to the definitions in § 405.201(b) and revised § 405.211.

• In § 411.15(o)(2), we are making conforming changes to reflect revised § 405.211.

B. Ultrasound Screening for Abdominal Aortic Aneurysms

1. Background and Statutory Authority

Section 1861(s)(2)(AA) of the Act authorizes Medicare coverage under Part B of ultrasound screening for abdominal aortic aneurysms ("AAA screening"), as defined in section 1861(bbb) of the Act. Our implementing regulations for AAA screening are at § 410.19. AAA screening is covered for a beneficiary that meets certain criteria including that he or she must receive a referral during the initial preventive physical examination (IPPE) and has not previously had an AAA screening covered under the Medicare program. The IPPE, as described in section 1861(ww) of the Act (and regulations at § 410.16), includes a time restriction and must be furnished not more than 1 year after the effective date of the beneficiary's first Part B coverage period (see section 1862(a)(1)(K) of the Act). This time limitation for the IPPE effectively reduces a Medicare beneficiary's ability to obtain a referral for AAA screening.

Section 1834(n) of the Act, added by section 4105 of the Affordable Care Act, grants the Secretary the discretion and authority to modify coverage of certain preventive services identified in section 1861(ddd)(3) of the Act, which in turn cross-references section 1861(ww)(2) of the Act (including AAA screening at section 1861(ww)(2)(L)). The Secretary may modify coverage to the extent that such modification is consistent with the recommendations of the United States Preventive Services Task Force (USPSTF) per section 1834(n)(1)(A) of the Act. In 2005, the USPSTF recommended "one-time screening for [AAA] by ultrasonography in men aged 65 through 75 who have ever smoked. (Grade: B Recommendation)" (Screening for Abdominal Aortic Aneurysm: Recommendation Statement. *http://www.uspreventiveservicestaskforce.org/uspstf05/aaascr/aaars.htm*). The USPSTF recommendation does not include a time limit with respect to the referral for this test.

2. Provisions of the Regulations for Final Rule With Comment Period

We proposed to exercise our discretion and authority under section 1834(n) of the Act to modify coverage of AAA screening consistent with the recommendations of the USPSTF to eliminate the one-year time limit with respect to the referral for this service. This modification will allow coverage of AAA screening for eligible beneficiaries without requiring them to receive a referral as part of the IPPE. Specifically for purposes of coverage of AAA screening, we proposed to modify the definition of "eligible beneficiary" in § 410.19(a) by removing paragraph (1) of the definition of "eligible beneficiary" and redesignating paragraphs (2) and (3) of the definition of "eligible beneficiary" as paragraphs (1) and (2), respectively.

The IPPE is a one-time benefit available to beneficiaries under Part B that receive the IPPE not more than 1 year after the effective date of the beneficiary's first Medicare Part B coverage period. Many beneficiaries were either not eligible to receive an IPPE (which did not become effective until January 1, 2005) or may not have taken advantage of the IPPE when they were eligible, which limited beneficiary access to coverage of AAA screening. We believe that our modification is consistent with current USPSTF recommendations for one-time screening and allows for expanded access to this important preventive service.

We received 12 public comments from various entities including physician specialty societies, a manufacturer and a manufacturer advocacy group, a beneficiary advocacy organization, a medical group management association, and a health insurer. All of the comments supported our proposal to modify coverage of AAA screening to eliminate the one-year time limit with respect to the referral for this service. Below is a summary of comments received and our response.

Comment: Two commenters believed that the proposed modification to eliminate the one-year time limit with respect to the referral for AAA screening would only apply to men aged 65–75 who are smokers, and that individuals with a family history would continue to be required to receive a referral from the IPPE in order to be eligible for coverage of AAA screening.

Response: This modification eliminates the one-year time limit with respect to referral for this service and allows coverage of AAA screening for all beneficiaries that meet the eligibility requirements for this benefit without requiring them to receive a referral as part of the IPPE. An eligible beneficiary, for purposes of this covered service, is an individual that meets the following criteria:

- Has not been previously furnished AAA screening under the Medicare program; and
- Is included in at least one of the following risk categories: (1) has a family history of an abdominal aortic aneurysm; or (2) is a man aged 65 to 75 who has smoked at least 100 cigarettes in his lifetime.

After taking into consideration the public comments received, we are finalizing this policy as proposed.

C. Colorectal Cancer Screening: Modification to Coverage of Screening Fecal Occult Blood Tests

1. Background and Statutory Authority

Sections 1861(s)(2)(R) and 1861(pp)(1) of the Act authorize Medicare coverage of colorectal cancer screening. The statute authorizes coverage of screening fecal occult blood tests (FOBT), screening flexible sigmoidoscopies, screening colonoscopies, and other tests determined to be appropriate, subject to certain frequency and payment limits. Our implementing regulations are codified at § 410.37. Section 410.37(b) (condition for coverage of screening FOBT) specifies that Medicare Part B pays for screening FOBT if ordered in writing by the beneficiary's attending physician. For purposes of § 410.37, "attending physician" is defined as "a doctor of medicine or osteopathy (as defined in section 1861(r)(1) of the Act) who is fully knowledgeable about the beneficiary's medical condition, and who would be responsible using the results of any examination performed in the overall management of the beneficiary's specific medical problem."

The coverage provisions for FOBT screening were established in 1997 and effective on January 1, 1998 (62 FR 59048, October 31, 1997). In the preamble to that final rule, we stated that the requirement for a written order from the attending physician was intended to make certain that beneficiaries receive appropriate preventive counseling about the implications and possible results of having these examinations performed (62 FR 59081).

Since then, Medicare coverage of preventive services has expanded to include, among other things, coverage of an annual wellness visit (as defined in § 410.15). The annual wellness visit includes provisions for furnishing personalized health advice and appropriate referrals. In addition to physicians, the annual wellness visit can be furnished by certain nonphysician practitioners, including physician assistants, nurse practitioners, and clinical nurse specialists.

We also note that § 410.32, which provides coverage and payment rules for diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests, states in subsection (a)(2): "Nonphysician practitioners (that is, clinical nurse specialists, clinical psychologists, clinical social workers, nurse-midwives, nurse practitioners, and physician assistants) who furnish services that would be physician services if furnished by a physician, and who are operating within the scope of their authority under State law and within the scope of their Medicare statutory benefit, may be treated the same as physicians treating beneficiaries for the purpose of this paragraph."

2. Provisions of the Regulations for Final Rule With Comment Period

We proposed to revise § 410.37(b), "Condition for coverage of screening fecal-occult blood tests," to allow an attending physician, physician assistant, nurse practitioner, or clinical nurse specialist to furnish written orders for screening FOBT. These modifications will allow for expanded coverage and access to screening FOBT, particularly in rural areas.

We received 8 public comments from various entities including physician and practitioner specialty societies, a pharmaceutical manufacturer, a beneficiary advocacy organization, a medical center, and a health insurer. All of the commenters supported our proposal to expand the types of practitioners that are able to furnish written orders for screening FOBT, in addition to a beneficiary's attending physician. Additionally, we invited public comment regarding whether a practitioner permitted to order a screening FOBT must be the beneficiary's attending practitioner as described earlier. Below is a summary of the comments received and our response.

Comment: One commenter suggested that the practitioners ordering the test function under the direct and responsible supervision of a practicing, licensed physician. Another commenter thought that the qualified practitioner furnishing the order should be knowledgeable about the patient and their plan of care. One commenter opined that the limitation of orders from the attending practitioner should be removed to prevent unnecessary office visits with the patient, scheduled solely to demonstrate compliance with a requirement that the test results be used in the practitioner's management of the patient's condition. The same commenter suggested that decisions regarding the medical necessity of follow-up care be left to the clinical judgment of the practitioner.

Response: After considering the public comments, we are retaining the "attending" requirement that provides assurance that the non-physician practitioner will be knowledgeable about the patient and the patient's plan of care. We are not requiring that these practitioners act only under the direct supervision of a practicing licensed physician as we view this suggestion as contrary to our goal of increasing access to this screening test, particularly in rural areas. Our expansion of coverage of screening FOBT to include tests ordered by an attending physician assistant, nurse practitioner, or clinical nurse specialist are consistent with the requirements for tests ordered for diagnostic purposes where nonphysician practitioners may be treated the same as physicians treating beneficiaries. The attending practitioner (physician, physician assistant, nurse practitioner, or clinical nurse specialist) would be responsible for using the results of the screening test in the overall management of the beneficiary's medical care. We leave it to the discretion of the attending practitioner to determine what follow-up care may be necessary. After consideration of the public comments received, we are implementing this policy as proposed.

D. Ambulance Fee Schedule

1. Amendment to Section 1834(l)(13) of the Act

Section 146(a) of the Medicare Improvements for Patients and Providers Act of 2008 (Pub. L. 110–275, enacted on July 15, 2008) (MIPPA) amended section 1834(l)(13)(A) of the Act to specify that, effective for ground ambulance services furnished on or after July 1, 2008 and before January 1, 2010,

the ambulance fee schedule amounts for ground ambulance services shall be increased as follows:

- For covered ground ambulance transports that originate in a rural area or in a rural census tract of a metropolitan statistical area, the fee schedule amounts shall be increased by 3 percent.
- For covered ground ambulance transports that do not originate in a rural area or in a rural census tract of a metropolitan statistical area, the fee schedule amounts shall be increased by 2 percent.

Sections 3105(a) and 10311(a) of the Affordable Care Act further amended section 1834(l)(13)(A) of the Act to extend the payment add-ons described above for an additional year, such that these add-ons also applied to covered ground ambulance transports furnished on or after January 1, 2010, and before January 1, 2011. In the CY 2011 PFS final rule with comment period (75 FR 73385, 73386, 73625), we revised § 414.610(c)(1)(ii) to conform the regulations to this statutory requirement.

Section 106(a) of the Medicare and Medicaid Extenders Act of 2010 (Pub. L.111–309, enacted December 15, 2010) (MMEA) again amended section 1834(l)(13)(A) of the Act to extend the payment add-ons described above for an additional year, such that these add-ons also applied to covered ground ambulance transports furnished on or after January 1, 2011, and before January 1, 2012. In the CY 2012 End-Stage Renal Disease Prospective Payment System (ESRD PPS) final rule (76 FR 70228, 70284 through 70285, and 70315), we revised § 414.610(c)(1)(ii) to conform the regulations to this statutory requirement.

Section 306(a) of the Temporary Payroll Tax Cut Continuation Act of 2011 (TPTCA) (Pub. L. 112–78, enacted on December 23, 2011) amended section 1834(l)(13)(A) of the Act to extend the payment add-ons described above through February 29, 2012; and section 3007(a) of the Middle Class Tax Relief and Job Creation Act of 2012 (Pub. L. 112–96, enacted on February 22, 2012) (MCTRJCA) further amended section 1834(l)(13)(A) of the Act to extend these payment add-ons through December 31, 2012. Thus, these payment add-ons also applied to covered ground ambulance transports furnished on or after January 1, 2012 and before January 1, 2013. In the CY 2013 PFS final rule (77 FR 69139, 69368), we revised § 414.610(c)(1)(ii) to conform the regulations to this statutory requirement.

Subsequently, section 604(a) of the ATRA amended section 1834(l)(13)(A) of the Act to extend the payment add-ons described above through December 31, 2013. Thus, these payment add-ons also apply to covered ground ambulance transports furnished on or after January 1, 2013 and before January 1, 2014. In the proposed rule, we proposed to revise § 414.610(c)(1)(ii) to conform the regulations to this statutory requirement. We did not receive any comments on this proposal. Accordingly, we are finalizing our proposal to revise § 414.610(c)(1)(ii) to conform the regulations to the statutory requirement described above.

This statutory requirement is self-implementing. A plain reading of the statute requires only a ministerial application of the mandated rate increase, and does not require any substantive exercise of discretion on the part of the Secretary.

2. Amendment to Section 146(b)(1) of MIPPA

Section 146(b)(1) of MIPPA amended the designation of certain rural areas for payment of air ambulance services. This section originally specified that any area that was designated as a rural area for purposes of making payments under the ambulance fee schedule for air ambulance services furnished on December 31, 2006, must continue to be treated as a rural area for purposes of making payments under the ambulance fee schedule for air ambulance services furnished during the period July 1, 2008 through December 31, 2009.

Sections 3105(b) and 10311(b) of the Affordable Care Act amended section 146(b)(1) of MIPPA to extend this provision for an additional year, through December 31, 2010. In the CY 2011 PFS final rule (75 FR 73385, 73386, and 73625 through 73626), we revised § 414.610(h) to conform the regulations to this statutory requirement.

Section 106(b) of the MMEA amended section 146(b)(1) of MIPPA to extend this provision again through December 31, 2011. In the CY 2012 ESRD PPS final rule (76 FR 70284, 70285, and 70315), we revised § 414.610(h) to conform the regulations to this statutory requirement.

Subsequently, section 306(b) of the TPTCCA amended section 146(b)(1) of MIPPA to extend this provision through February 29, 2012; and section 3007(b) of the MCTRJCA further amended section 146(b)(1) of MIPPA to extend this provision through December 31, 2012. In the CY 2013 PFS final rule (77 FR 69139, 69140, and 69368), we revised § 414.610(h) to conform the regulations to this statutory requirement.

Subsequently, section 604(b) of the ATRA amended section 146(b)(1) of MIPPA to extend this provision through June 30, 2013. Thus, we proposed to revise § 414.610(h) to conform the regulations to this statutory requirement. We did not receive any comments on this proposal. Therefore, we are finalizing our proposal to revise § 414.610(h) to conform the regulations to the statutory requirement described above.

This statutory requirement is self-implementing. A plain reading of the statute requires only a ministerial application of a rural indicator, and does not require any substantive exercise of discretion on the part of the Secretary. Accordingly, for areas that were designated as rural on December 31, 2006, and were subsequently re-designated as urban, we re-established the "rural" indicator on the ZIP Code file for air ambulance services through June 30, 2013.

3. Amendment to Section 1834(l)(12) of the Act

Section 414 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub. L. 108–173, enacted on December 8, 2003) (MMA) added section 1834(l)(12) to the Act, which specified that in the case of ground ambulance services furnished on or after July 1, 2004, and before January 1, 2010, for which transportation originates in a qualified rural area (as described in the statute), the Secretary shall provide for a percent increase in the base rate of the fee schedule for such transports. The statute requires this percent increase to be based on the Secretary's estimate of the average cost per trip for such services (not taking into account mileage) in the lowest quartile of all rural county populations as compared to the average cost per trip for such services (not taking into account mileage) in the highest quartile of rural county populations. Using the methodology specified in the July 1, 2004 interim final rule (69 FR 40288), we determined that this percent increase was equal to 22.6 percent. As required by the MMA, this payment increase was applied to ground ambulance transports that originated in a "qualified rural area"; that is, to transports that originated in a rural area included in those areas comprising the lowest 25th percentile of all rural populations arrayed by population density. For this purpose, rural areas included Goldsmith areas (a type of rural census tract).

Sections 3105(c) and 10311(c) of the Affordable Care Act amended section 1834(l)(12)(A) of the Act to extend this rural bonus for an additional year through December 31, 2010. In the CY 2011 PFS final rule with comment period (75 FR 73385, 73386 and 73625), we revised § 414.610(c)(5)(ii) to conform the regulations to this statutory requirement.

Section 106(c) of the MMEA amended section 1834(l)(12)(A) of the Act to extend the rural bonus described above for an additional year, through December 31, 2011. Therefore, in the CY 2012 ESRD PPS final rule (76 FR 70284, 70285 and 70315), we revised § 414.610(c)(5)(ii) to conform the regulations to this statutory requirement.

Section 306(c) of the TPTCCA amended section 1834(l)(12)(A) of the Act to extend this rural bonus through February 29, 2012; and section 3007(c) of the MCTRJCA further amended section 1834(l)(12)(A) of the Act to extend this rural bonus through December 31, 2012. In the CY 2013 PFS final rule with comment period (77 FR 69140, 69368), we revised § 414.610(c)(5)(ii) to conform the regulations to these statutory requirements.

Subsequently, section 604(c) of the ATRA amended section 1834(l)(12)(A) of the Act to extend this rural bonus through December 31, 2013. Therefore, we are continuing to apply the 22.6 percent rural bonus described above (in the same manner as in previous years), to ground ambulance services with dates of service on or after January 1, 2013 and before January 1, 2014 where transportation originates in a qualified rural area.

This rural bonus is sometimes referred to as the "Super Rural Bonus" and the qualified rural areas (also known as "super rural" areas) are identified during the claims adjudicative process via the use of a data field included on the CMS-supplied ZIP Code File.

In the proposed rule, we proposed to revise § 414.610(c)(5)(ii) to conform the regulations to the statutory requirement set forth at section 604(c) of the ATRA. We did not receive any comments on this proposal. Accordingly, we are finalizing our proposal to revise § 414.610(c)(5)(ii) to conform the regulations to this statutory requirement.

This statutory requirement is self-implementing. This provision requires a one-year extension of the rural bonus (which was previously established by the Secretary) through December 31, 2013, and does not require any substantive exercise of discretion on the part of the Secretary.

4. Addition of Section 1834(l)(15) of the Act

Section 637 of the ATRA, which added section 1834(l)(15) of the Act, specifies that the fee schedule amount otherwise applicable under the preceding provisions of section 1834(l) of the Act shall be reduced by 10 percent for ambulance services furnished on or after October 1, 2013, consisting of non-emergency basic life support (BLS) services involving transport of an individual with end-stage renal disease for renal dialysis services (as described in section 1881(b)(14)(B) of the Act) furnished other than on an emergency basis by a provider of services or a renal dialysis facility. We proposed to revise § 414.610 by adding paragraph (c)(8) to conform the regulations to this statutory requirement. We did not receive any comments on this proposal. Accordingly, we are finalizing our proposal to revise § 414.610 by adding paragraph (c)(8) to conform the regulations to the statutory requirement described above.

This statutory requirement is self-implementing. A plain reading of the statute requires only a ministerial application of the mandated rate decrease, and does not require any substantive exercise of discretion on the part of the Secretary. Accordingly, for the ambulance services described in section 637 of the ATRA furnished on or after October 1, 2013, the fee schedule amount otherwise applicable (both base rate and mileage) is reduced by 10 percent. For further information regarding application of this mandated rate decrease, please see CR 8269.

5. Studies of Ambulance Costs

Section 604(d)(1) of the ATRA provides that the Secretary shall conduct the following studies:

(A) A study that analyzes data on existing cost reports for ambulance services furnished by hospitals and critical access hospitals, including variation by characteristics of such providers of services, with a Report to Congress on such study due by October 1, 2013; and

(B) A study of the feasibility of obtaining cost data on a periodic basis from all ambulance providers of services and suppliers for potential use in examining the appropriateness of the Medicare add-on payments for ground ambulance services furnished under the fee schedule under section 1834(l) of the Act and in preparing for future reform of such payment system, with a Report to Congress due on such study by July 1, 2014.

Further, in conducting the study under paragraph (B) above, section 604(d)(2) of the ATRA directs the Secretary to:

- Consult with industry on the design of such cost collection efforts;
- Explore the use of cost surveys and cost reports to collect appropriate cost data and the periodicity of such cost data collection;
- Examine the feasibility of developing a standard cost reporting tool for providers of services and suppliers of ground ambulance services; and
- Examine the ability to furnish such cost data by various types of ambulance providers of services and suppliers, especially by rural and super-rural providers of services and suppliers.

As noted above, in conducting the study under section 604(d)(1) of the ATRA described in paragraph (B) above, the Secretary is required to consult with industry on the design of such cost collection efforts (see section 604(d)(2)(A) of the ATRA). We used the proposed rule as the instrument to collect information, comments, and ideas from the industry on the design of such cost collection efforts as described above, and on the feasibility of obtaining cost data on a periodic basis from all ambulance providers of services and suppliers for potential use in examining the appropriateness of the Medicare add-on payments for ground ambulance services furnished under the fee schedule under section 1834(l) of the Act and in preparing for future reform of such payment system. We therefore invited public comment on these issues as part of the study we are conducting under section 604(d)(1)(B) of the ATRA.

Several organizations provided detailed comments on the issues described above. We appreciate the commenters' insights and suggestions. We will consider those comments as we perform the study required by section 604(d)(1)(B) of the ATRA and prepare the Report to Congress.

E. Policies Regarding the Clinical Laboratory Fee Schedule

1. Background on the Clinical Laboratory Fee Schedule

Under Medicare Part B, clinical diagnostic laboratory tests furnished on or after July 1, 1984, in a physician's office, by an independent laboratory, or by a hospital laboratory for its outpatients and nonpatients are paid on the basis of the Clinical Laboratory Fee Schedule (CLFS), with certain exceptions. For each Healthcare

Common Procedure Coding System (HCPCS) code, payment is the lesser of:

- The amount of charges billed for the test;
- The fee schedule amount for the state or a local geographic area; or
- A national limitation amount (NLA) (see section 1833(a)(1)(D)(i), (a)(2)(D)(i), (h)(1), and (h)(4)(B) of the Act). The NLA for a clinical diagnostic laboratory test performed after December 31, 1997 is equal to 74 percent of the median of all fee schedules established for that test for that laboratory setting or 100 percent of such median in the case of a clinical diagnostic laboratory test performed on or after January 1, 2001 that the Secretary determines is a new test for which no limitation amount has previously been established (see section 1833(h)(4)(B)(viii) of the Act).

Currently, we update the CLFS amounts annually to reflect changes in the Consumer Price Index for all Urban Consumers (CPI–U) and apply a multi-factor productivity adjustment (see section 1833(h)(2)(A) of the Act). In the past, we also implemented other adjustments or did not apply the change in the CPI–U to the CLFS for certain years in accordance with statutory mandates. We do not otherwise update or change the payment amounts for tests on the CLFS.

For any clinical diagnostic laboratory tests where a new or substantially revised HCPCS code is assigned on or after January 1, 2005, we determine the basis for, and amount of, payment for these clinical diagnostic laboratory tests (see section 1833(h)(8) of the Act and § 414.500 through § 414.509). Once established, however, in most cases, we only have the opportunity to reconsider the basis and/or amount of payment for new tests for one additional year after the basis or payment is initially set. Once the reconsideration process is complete, payment is not further adjusted (except by a change in the CPI–U, the productivity adjustment, and any other adjustments required by statute), regardless of any shift in the actual costs incurred to perform the test.

This lack of an established mechanism to adjust payment amounts is unique among the Medicare payment schedules and systems. Generally, other fee schedules and prospective payment systems are evaluated each year to reflect the changing mix of services provided under that system or schedule and then the system or schedule is adjusted to maintain budget neutrality. Since there is currently no process to make such adjustments for the CLFS, payment amounts are not changed despite changes in technology, which affect the cost of performing the tests. This potentially results in CMS not paying as accurately for these tests. As discussed in the CY 2014 PFS proposed rule (78 FR 43350 through 43352), we proposed to implement a process to adjust payment amounts based on changes in technology. Below, we discuss our proposals regarding this process and, at the end of section III.E.2. of this final rule with comment period, respond to comments about our proposals and finalize our policies.

2. Policies Regarding Technological Changes Under Section 1833(h)(2)(A)(i) of the Act

a. Background on Technological Changes

As discussed in the CY 2014 PFS proposed rule (78 FR 43350 through 43351), there has been a significant amount of technological change in the clinical laboratory area since the implementation of the CLFS. This technological change has led to the increased use of point-of-care testing, brand new tests being developed, and the proliferation of laboratory-developed tests. The Institute of Medicine (IOM) dedicated a chapter of its 2000 report "Medicare Laboratory Payment Policy: Now and in the Future" to discussing trends in laboratory technology. The report noted rapid and dramatic innovation in the laboratory sector since the 1980s and remarkable growth in the range and complexity of available tests. The IOM concluded that the introduction of new tests, advances in equipment and testing techniques, and the proliferation of advanced information technology have all made testing more efficient and automated.

Technology has enabled a significant site-of-service shift for many laboratory tests from the laboratory environment to the point of health care delivery. This point-of-care testing has increased since the 1980s, when this type of testing first became available, mainly due to changes in technology which resulted in smaller, cheaper, and more portable test kits that are simple to use. For example, drug abuse testing has become readily available at the point-of-care. Point-of-care testing can be performed in various institutional and community settings but the main objective of such testing is to produce a result quickly, at the place where the patient is receiving care, such as at a physician's office or at a hospital bedside, in order to facilitate decisions about appropriate treatment.

There also are brand new technologies that did not exist when the CLFS was established, most notably the methods that are the basis for many genetic and genomic tests. Many of these methods evolved from the work of the Human Genome Project and subsequent research and development by both the federal government and private firms. The cost of sequencing a genome has dropped dramatically since the early inception of this technology in 2001 from more than $95 million per genome to approximately $5,700 in early 2013 (*http://www.genome.gov/pages/der/sequencing_cost.xlsx*). Early tests in this area were less likely to be covered by Medicare because they were either screening tests or tests for conditions found largely in a pediatric population. As this area has expanded over the past several decades, Medicare has taken on a more prominent role in payment for these services. We expect the number of codes and tests in this area to continue to grow as the technology evolves and more tests become available in the areas of pharmacogenomics, personalized and predictive medicine, and companion diagnostics. Moreover, we expect the costs of these tests to change over time, and we believe that the CLFS ought to be able to better reflect these changes.

We also note the growth in laboratory-developed tests (LDTs) over the years. These proprietary tests are developed by laboratories, which then offer the service of providing the test. Some of the most advanced laboratory tests currently being performed are LDTs which use sophisticated proprietary technology. Many LDTs do not have their own HCPCS codes; instead, they are billed using unlisted codes for which Medicare Administrative Contractors (MACs) establish a payment amount for their local jurisdictions. Prior to 2012, other LDTs were billed to Medicare using "stacking codes," where a laboratory submits a code for each step of the testing process. These "stacking codes" were eliminated at the end of 2012 and replaced with new test-specific codes.

The use of unlisted CPT and "stacking" codes provided us with limited information about the technology used to perform these tests. However, we know that the number of LDTs has been growing over the years. We also know that multiple laboratories have developed different ways to perform the same test. Further, our recent experience with using a gapfilling methodology to price molecular pathology tests, which can be LDTs, has shown that the costs of performing these tests have decreased since contractors initially established payment amounts for the tests, or compared to the code stack previously billed. Our experience with gapfilling

molecular pathology tests also has shown that there is wide variation in the cost of performing the same test by different laboratories.

We believe that, given the technological changes that have occurred in the laboratory industry over the past several decades and the growth in the number of clinical laboratory tests (for example, we have added approximately 800 new test codes to the CLFS since its inception), it would be appropriate to establish a process to reexamine payment amounts on the CLFS to take into account increased efficiency, changes in laboratory personnel and supplies necessary to conduct a test, changes in sites of service, and other changes driven by technological advances.

Section 1833(h)(2)(A)(i) of the Act requires the Secretary to set the fee schedules for clinical laboratory tests "for the 12-month period beginning July 1, 1984, adjusted annually (to become effective on January 1 of each year) by, subject to [the multi-factor productivity adjustment], . . . a percentage increase or decrease equal to the percentage increase or decrease in the [CPI–U], . . . and *subject to such other adjustments as the Secretary determines are justified by technological changes*" (emphasis added). Under this authority, in the CY 2014 PFS proposed rule (78 FR 43350 through 43352), we proposed a process under which we would systematically reexamine the payment amounts established under the CLFS to determine if changes in technology for the delivery of that service warrant an adjustment to the payment amount.

b. Definition of Technological Changes

In the CY 2014 PFS proposed rule (78 FR 43351), we proposed to define technological changes as changes to the tools, machines, supplies, labor, instruments, skills, techniques, and devices by which laboratory tests are produced and used. We stated that changes in technology could result in changes to, among other things, the resources required to perform the test (such as the type, volume, or number of supplies or reagents required), the laboratory personnel required to perform the test, and/or the frequency of testing, volume of testing, or site of service (for example, a shift in service site from a specialty laboratory to a physician's office). We believe this broad definition would capture all of the technological changes that could impact the resource inputs for various tests on the CLFS. As we explained in the CY 2014 PFS proposed rule (78 FR 43351 and 43352) and as discussed below, the technological changes for a specific test would be discussed in the proposed rule in which we are proposing to adjust the payment amount for that test, and we would seek public comment on our determination of the technological changes and the proposed payment adjustment. We respond to any comments on the proposed definition at the end of section III.E.2. of this final rule with comment period.

c. The Process

In the CY 2014 PFS proposed rule (78 FR 43351), we proposed that, each year, we would review certain codes on the CLFS, as described in the next section, to determine whether we believe that payment for these codes should be adjusted due to technological changes. For those codes where we determine that payment adjustments should be made, beginning with the CY 2015 PFS proposed rule (which will be promulgated during 2014 and any finalized payment adjustments would affect payments beginning in CY 2015), we would identify the test code, discuss how it has been impacted by technological changes, and propose an associated adjustment to the payment amount for the test code as appropriate to reflect the impact of such technological changes.

We believe such adjustments could be made both to increase fee schedule amounts (for example, in situations where new high cost technologies are employed), and to provide for reductions in existing amounts (for example in situations where technology reduces costs through increased efficiencies). We stated that we expect that most payment amounts would decrease due to the changes in technology that have occurred over the years since the payment amounts were established and the general downward trend of costs once a new technology has had an opportunity to diffuse. A key goal in establishing this review process is to ensure payment accuracy after technological changes; thus, payment amounts could increase or decrease as a result of these reviews.

Under our proposed process, we would list codes that we reviewed for which there was insufficient information to support or establish an adjustment to the payment amount due to technological changes. We also would solicit comment on the technology used to perform any tests we reviewed for possible payment changes, and any relevant cost information. We stated that we expect that we would finalize any payment adjustments in the PFS final rule during 2014, which would affect payments beginning in CY 2015. We proposed that the CPI–U and multi-factor productivity adjustments would be applied after we established the new payment amount through our usual instruction process.

We believe that this proposed process would best allow for the greatest amount of transparency in review and the most structured and consistent opportunity for the public to provide input into the process. We solicited comment on these proposals. We respond to comments on this proposed process at the end of section III.E.2. of this final rule with comment period.

d. Identification and Prioritization of Codes To Be Reviewed

In the CY 2014 PFS proposed rule (78 FR 43351 through 43352), we proposed to review all codes currently on the CLFS. We proposed to start our review by examining the payment amounts for codes that have been on the CLFS the longest and then work our way forward, over multiple years, until we have reviewed all of the codes on the CLFS. We believe that the payment amounts for codes that have been on the CLFS the longest amount of time would be most affected by changes in technology because, in general, technology is most expensive earliest in its life cycle but decreases in cost as the technology matures and diffuses. If during the course of reviewing these individual codes we find that there are additional, newer codes that are clinically and/or technologically similar, we proposed to consider them for review at the same time as we review the older codes because we expect that we would have the same or similar justifications for making payment adjustments to those codes. We stated that we intend to review these codes as quickly as possible but we believe there would be a significant administrative burden associated with such a comprehensive review of the approximately 1,250 codes on the CLFS. We estimated that it would take at least 5 years to review all of the existing codes on the CLFS.

Once we completed our review of the codes currently on the CLFS and made any adjustments necessary due to technological changes, we proposed to review codes added to the CLFS after 2015 that have been on the CLFS for at least 5 years. We also would review codes again that have not been reviewed in the previous 5 years, as time and resources allow. We believe that tests that are less than 5 years old are likely still in their technological infancy and enough time would not have passed to adequately assess any change in technology for those services. Similarly, for previously reviewed codes, we believe that technology likely would not

have changed dramatically in less than 5 years. We solicited public comment on how to prioritize these codes, which we expect to address in future rulemaking on this issue.

After the initial review of the codes currently on the CLFS, we also proposed to allow the public to nominate additional codes for review, including those that had been previously reviewed for technological change. We proposed that the public may nominate only codes that have been on the CLFS for at least 5 years and that have not been reviewed in the previous 5 years. Further, we proposed that the nomination must include an explanation from the nominator of the technological change in the service and the way that change affects its delivery. We would then consider these nominations and, in the **Federal Register** the following year, either propose a payment change based on technological changes or explain why we think such a change is not warranted at that time.

We proposed to codify the proposed definition of technological changes and the process at § 414.511.

We solicited public comment on these proposals. We also solicited comment on alternative approaches to achieving our goal of paying appropriately for laboratory tests by accounting for changes in technology. Finally, we solicited comment on general trends in technology change in the laboratory industry and the health care sector in general. The following is a summary of the comments we received regarding our proposals for the CLFS in the CY 2014 PFS proposed rule:

Comment: Several commenters recommended that CMS reconsider its proposal to review and adjust CLFS payment amounts.

Response: The existing payment amounts on the CLFS have not been changed since they were first implemented (excluding changes for inflation and other statutory adjustments). In some cases, payment amounts have not changed for over 30 years (excluding changes for inflation and other statutory adjustments). Therefore, we believe it is necessary and important to review and adjust payment amounts based on technological changes for tests on the CLFS.

Comment: Several commenters were concerned about CMS developing a transparent process where the public, specifically laboratories, could participate in determining which test codes on the CLFS to revisit for payment purposes and provide input on technological changes with respect to a code being reviewed for adjustment. These commenters suggested that one solution might be some type of advisory committee made up of representatives from the laboratory industry and organized by CMS.

Response: We appreciate the comment and agree that the process to adjust payment amounts for tests on the CLFS based on technological changes should be a transparent one. However, developing a formal advisory committee would be a time-consuming and resource intensive process. We believe that we can accomplish the same purpose by utilizing the annual rulemaking cycle, which includes a comment period where the public can provide information on how the technology for providing clinical diagnostic laboratory tests has changed over time and suggestions for data to support revised payment amounts on particular test codes.

We agree that the public also should participate in determining which test codes should be reviewed. We proposed that, after the initial review of all of the test codes currently on the CLFS concludes, the public could nominate codes for review that have been on the CLFS for at least 5 years and that have not been reviewed in the previous 5 years. We also proposed that the nomination must include an explanation from the nominator of the technological change in the service and the way that change affects its delivery. However, based on these comments and upon further reflection, we are changing our proposal so that nominations are not limited to the time period after the initial review period or to certain types of test codes. Under our process, the public may nominate test codes that are on the CLFS for review during the public comment period to the proposed rule.

As we proposed for situations where the public nominates test codes, the nominator must include an explanation of the technological change in the service and the way the change affects its delivery because this information will assist us in determining whether the test code should move forward through the payment adjustment process. In addition, we are changing our proposal to require the nominator to provide any relevant cost information, as well because this information will assist us in determining an appropriate payment should the test code move forward through the payment adjustment process. CMS will retain the final authority in determining which test codes move forward through the payment revision process because, for example, some test codes may be suggested which do not have enough supporting information to justify payment rate revisions based on changes in technology or more test codes may be suggested for payment rate revisions than can possibly be addressed within one rulemaking cycle.

For those codes identified by the public for review where we determine that payment adjustments based on technological changes should be made, in the following year's proposed rule, we will identify the test code, discuss how it has been impacted by technological changes, and propose an associated adjustment to the payment amount for the test code as appropriate to reflect the impact of such technological changes. We also will list any test codes that the public suggested for review but for which we are not proposing to move forward through the payment revision process and explain why we are not proposing any changes at that time. Finalized payment revisions would take effect the following January 1. For example, test codes suggested during the comment period to the CY 2015 PFS proposed rule and agreed to by CMS for the payment revision process will be addressed through the CY 2016 PFS rulemaking process with finalized payment adjustments being effective January 1, 2016.

Comment: Several commenters, along with MedPAC, stated that, if CMS does implement changes in payment amounts for test codes on the CLFS, CMS should consider data from private insurers, federal insurers, and CMS contractors; however, some commenters suggested that contractor data not be used.

Response: It is our intention to consider data from all available sources in order to evaluate the impact of technological changes on payment amounts. We believe that this will promote fair and equitable fee schedules that reflect current and reasonable payments for laboratory tests. Therefore, we plan to review all data that can be obtained from any source.

Comment: Some commenters, along with MedPAC, suggested that CMS focus on high dollar payments first, while other commenters recommended a focus on codes with rapid spending growth. Some commenters recommended that a different timeframe be implemented instead of the proposed one which limits the ability to review a test code until it has been on the CLFS for at least 5 years. These commenters also believe that it will take longer than 5 years to review all the test codes currently on the CLFS.

Response: In the CY 2014 PFS proposed rule (78 FR 43351 through 43352), we proposed to review all codes

currently on the CLFS and we proposed to start our review by examining the payment amounts for codes that have been on the CLFS the longest and then work our way forward over multiple years until we reviewed all of the codes on the CLFS. We also proposed to review newer codes that were clinically and/or technologically similar to the codes being reviewed. Once we had completed this initial review, which we estimated would take at least 5 years, we proposed to review codes added to the CLFS after 2015 that had been on the CLFS for at least 5 years and would review codes again that had not been reviewed in the previous 5 years, as time and resources allowed. Further, as discussed above, we proposed that the public could nominate additional codes for review after this initial review period that had been on the CLFS for at least 5 years and had not been reviewed in the previous 5 years. We sought comment on these proposals as well as alternative approaches to achieving our goal of paying appropriately for laboratory tests by accounting for changes in technology. Upon further reflection and based on these comments, we are modifying our approach to the identification and prioritization of codes for review.

We agree with the commenters who suggest that our proposal limits the ability to review a test code until it has been on the CLFS for at least 5 years. While we believe that addressing test codes that have been on the CLFS at least 5 years provides ample time for the technology to mature and diffuse, we recognize that there are circumstances that would warrant examining test codes for the payment revision process prior to this time. For example, new technologies could be developed that make it more or less costly to perform a test within a timeframe that is less than 5 years. Consistent with commenters' suggestions, we also believe that we should expand the criteria for identifying and prioritizing test codes for review to include criteria, such as rapid spending growth, high dollar payment, and high volume, as well as the oldest test codes on the CLFS, among other considerations, rather than focusing on the oldest codes currently on the CLFS and codes that have been on the CLFS for at least 5 years. We believe that test codes that are most ripe for review will be test codes where the current payment amounts do not account for changes in technology that have occurred since the test code was added to the CLFS and where the adjustments to the payment amounts will have a significant impact on payments made under the CLFS. We believe that expanding and maintaining flexibility with respect to the criteria will assist us in identifying and prioritizing test codes which are most ripe for revision. We will determine which test codes are most ripe for review based on an analysis of the data for test codes on the CLFS.

Therefore, upon further reflection and based on these comments, we are finalizing a modified approach to identify and prioritize codes that will be reviewed every year. Each year, we will conduct a data analysis of codes on the CLFS to determine which codes should be proposed during the rulemaking cycle for a payment adjustment due to technological changes. This review will involve examining test codes in several different ways, such as examining those that have been on the CLFS the longest, those that are high volume test codes, those that have a high dollar payment, or those that have experienced rapid spending growth, among other considerations. As proposed, if we identify codes that are clinically and/or technologically similar to the ones identified through our data analysis process, we will consider them for review at the same time as we review the related codes. As discussed previously, we also will allow the public to nominate codes for review.

Comment: Some commenters, along with MedPAC, asked that CMS not lower all payments and suggested that CMS must take into consideration the technological changes that may have added costs over the years.

Response: We will not be automatically lowering all payment amounts on the CLFS. Rather, test codes and corresponding payment amounts will be reviewed on a case-by-case basis to determine how changes in technology have affected the cost of the test. As we stated in the CY 2014 PFS proposed rule (78 FR 43351) and above in this final rule with comment period, we believe adjustments could be made to increase fee schedule amounts for certain tests (for example, in situations where new high cost technologies are employed), and to provide for reductions in existing amounts for other tests (for example in situations where technology reduces costs through increased efficiencies). A key goal in establishing this review process is to increase payment accuracy after technological changes; thus, payment amounts could increase or decrease as a result of these reviews.

Comment: Some commenters recommended that CMS proceed through negotiated rulemaking, so that interested stakeholders will have a say in the process.

Response: Similar to what we stated above regarding a formal advisory committee, we believe that using a negotiated rulemaking vehicle would be a time-consuming and resource intensive process. We believe that we can accomplish the same purpose by utilizing the rulemaking process, under which we would propose payment revisions for identified test codes and provide a comment period during which the public could comment prior to the publication of the final rule (which would finalize any payment changes). During the comment period, the public can nominate codes for review, provide information on how the technology for providing clinical diagnostic laboratory tests has changed over time and suggest data to support revised payment amounts for particular test codes. Therefore, our annual rulemaking process will provide the public with ample opportunity to comment and interact with us as the process proceeds. CMS will retain the final authority in determining which test codes move forward through the payment revision process.

Comment: Several commenters suggested that the amount of a payment adjustment should be capped during the first year, and any remaining payment adjustment should be phased in over a number of years so that smaller laboratories or laboratories that offer only a small menu of tests would be minimally disrupted.

Response: While we recognize that laboratories of different sizes or specialties may respond differently to market forces, our goal is to adjust payment amounts for test codes up for consideration in a given year as soon as possible to more accurately reflect the costs of these tests based on changes in technology. Laboratories that may be affected by the examination of a payment amount for any specific test code will have the opportunity to comment through the rulemaking process.

Comment: Many commenters suggested that CMS recognize the difference between large and small laboratories so that small laboratories will not be phased out or forced out of business.

Response: It is not our intention to eliminate or phase out any organization or business. Our goal is to adjust the payment amounts for tests on the CLFS to more accurately reflect the costs of tests based on technological changes, which should result in payment amounts under the CLFS being more commensurate with the current costs of providing these tests.

Comment: Several commenters recommended that CMS send proposed adjustments out to interested parties prior to any final decisions for feedback.

Response: We agree that we need to provide notice and an opportunity to comment on proposed adjustments to the fee schedules due to technological changes to interested parties prior to finalizing these adjustments and we believe that our proposed process, which we are finalizing, does this. Specifically, the rulemaking process would propose payment revisions for the identified test codes and provide a comment period during which the public could comment prior to the publication of the final rule (which would finalize any payment adjustments). Therefore, as proposed, we will utilize the rulemaking process with a comment period so that the public can provide information on how the technology of providing clinical diagnostic laboratory tests has changed over time and suggestions for data to support revised payment amounts on particular test codes.

Comment: Some commenters suggested creating a pilot program, a demonstration project, or competitive bidding for changing the payment amounts for codes on the CLFS.

Response: We believe, similar to our response above concerning either a negotiated rulemaking process or an advisory board, that developing anything formal such as a pilot program, a demonstration project, or competitive bidding would be a time-consuming and resource intensive process. We believe that we can accomplish the same purpose by utilizing the rulemaking process with a comment period where the public can nominate test codes for review, provide information on how the technology for delivering clinical diagnostic laboratory services has changed over time and suggest data to support revised payment amounts on particular test codes.

After considering all of the comments received, we are finalizing our proposal without modification to define technological changes as changes to the tools, machines, supplies, labor, instruments, skills, techniques, and devices by which laboratory tests are produced and used. We are finalizing our proposed process, including the prioritization of codes for review, with modification as discussed above and noted below.

Each year, we will conduct a data analysis of codes on the CLFS to determine which codes should be proposed during the rulemaking cycle for a payment adjustment due to technological changes. This review will involve examining test codes in several different ways, such as examining those that have been on the CLFS the longest, those that are high volume test codes, those that have a high dollar payment, or those that have experienced rapid spending growth, among other considerations. If we identify codes that are clinically and/or technologically similar to the ones identified through our data analysis process, we will consider them for review at the same time as we review the related codes.

For those codes where we determine that payment adjustments should be made, beginning with the CY 2015 PFS proposed rule (which will be promulgated during 2014 and any finalized payment adjustments would affect payments beginning CY 2015), we will identify the test code, discuss how the test has been impacted by technological changes, and propose an associated adjustment to the payment amount for the test code as appropriate to reflect the impact of such technological changes. We will solicit comment on the technology used to perform any tests we reviewed for possible payment changes, and any relevant cost information.

Under our process, the public may nominate test codes that are on the CLFS for review during the public comment period to the proposed rule. Test codes nominated for review by the public must include an explanation from the nominator of the technological change in the service and the way that change affects its delivery as well as any relevant cost information. CMS will retain the final authority in determining which test codes move forward through the payment revision process. For those codes identified by the public for review where we determine that payment adjustments based on technological changes should be made, in the following year's proposed rule, we will identify the test code, discuss how it has been impacted by technological changes, and propose an associated adjustment to the payment amount for the test code as appropriate to reflect the impact of such technological changes. We also will list any test codes that the public suggested for review but for which we are not proposing to move forward through the payment revision process and explain why we are not proposing any changes at that time. Finalized payment revisions would take effect the following January 1. For example, test codes suggested during the comment period to the CY 2015 PFS proposed rule and agreed to by CMS for the payment revision process will be addressed through the CY 2016 PFS rulemaking process with finalized payment adjustments being effective January 1, 2016. The CPI–U and multi-factor productivity adjustments will be applied after we establish the new payment amount through our usual instruction process.

Finally, we are codifying our proposed definition of technological changes and the process at § 414.511 with one technical correction. In § 414.511(a), we are adding the words "fee schedules," which we inadvertently omitted in the proposed rule.

3. Changes in the CY 2014 OPPS/ASC Final Rule With Comment Period

In the CY 2014 PFS proposed rule (78 FR 43352), we notified readers that we were proposing to package payment for certain clinical diagnostic laboratory tests into the Ambulatory Payment Classification (APC) group payment for the significant procedures and services with which those laboratory tests are billed in the CY 2014 OPPS/ASC proposed rule. We discussed this proposal in the section on "Proposed Changes to Packaged Items and Services" in the CY 2014 OPPS/ASC proposed rule. For details on the final policy, please see the "Changes to Packaged Items and Services" section of the CY 2014 OPPS/ASC final rule with comment period.

F. Liability for Overpayments to or on Behalf of Individuals Including Payments to Providers or Other Persons

1. Background and Statutory Authority

CMS waives recovery of overpayments in certain situations for claims based fee-for-service provider, supplier or beneficiary overpayments in accordance with section 1870 of the Act. Section 1870(b) and (c) of the Act provide a waiver of recovery of provider, supplier or beneficiary overpayments under certain presumptions within a specified timeframe. Section 1870(b) and (c) of the Act allow the Secretary to reduce the specified time period to not less than 1 year if the Secretary finds that such a reduction is consistent with the objectives of the Medicare program. Section 638 of the American Taxpayer Relief Act of 2012 (ATRA) (Pub. L. 112–240, enacted January 2, 2013) changed the timeframes associated with section 1870(b) and (c) of the Act.

Section 1870(b) of the Act provides for the waiver of recovery of an overpayment to a provider of services (hereinafter, "provider") or other person whenever that provider or other person is "without fault" in incurring the overpayment. For purposes of section

1870 of the Act and this final rule with comment period, the term "other person" includes practitioners, physicians, and other suppliers.

Section 1870(b) of the Act also establishes circumstances under which a provider or other person is presumed for administrative purposes to be "without fault" for an overpayment. If an overpayment is determined after a specified period of time, a provider or other person is presumed to be "without fault." This presumption is negated, however, if there is evidence to show that the provider or other person was responsible for causing the overpayment.

Section 1870(c) of the Act provides for the waiver of recovery of an overpayment to an individual whenever the individual is "without fault" in incurring the overpayment, and recovery would either defeat the purpose of the Social Security or Medicare programs or would be "against equity and good conscience."

Section 1870(c) of the Act also establishes circumstances under which recovery of an overpayment for an individual is presumed to be "against equity and good conscience." After a specified period of time, recovery of certain overpayments from individuals who are "without fault" is presumed "against equity and good conscience." The overpayments addressed by this provision are payments for items or services for which payment may not be made because of the prohibitions found in section 1862(a)(1) or (a)(9) of the Act. Sections 1862(a)(1) and (a)(9) prohibit payment for, among other things, items and services that are not reasonable and necessary or that are for custodial care.

Section 638 of the ATRA amended the timeframe specified in section 1870(b) of the Act "without fault" presumption from 3 to 5 years so that the presumption of "without fault" only applies if the Medicare claims based fee-for-service overpayment determination for a provider or other person is made subsequent to the fifth year (instead of the third year) following the year in which the notice was sent to such individual that such amount had been paid. Likewise, section 638 of the ATRA amended the timeframe in section 1870(c) of the Act so that the presumption for "against equity and good conscience" for certain types of denials for an individual who is "without fault" only applies if the overpayment determination is made subsequent to the fifth year (instead of the third year) following the year in which notice of such payment was sent to such individual.

These ATRA changes do not affect or change CMS' claims reopening regulation at § 405.980. Specifically, we retain our authority to reopen claims for any reason within 1 year, for good cause within 4 years, and at any time for fraud or similar fault.

2. Provisions of the Proposed Regulations

We proposed to revise § 405.350(c) and § 405.355(b). These revisions would change the timing of the triggering event for the "without fault" and "against equity and good conscience" presumptions. These revisions reflect the revisions to section 1870 of the Act as specified in section 638 of ATRA.

Specifically, we proposed to change the timeframe at § 405.350(c) so that the rebuttable "without fault" presumption for the provider or other person would apply if the Medicare claims based fee-for-service overpayment determination is made subsequent to the fifth year (instead of the third year) following the year in which the notice was sent to such individual that such amount had been paid.

Likewise, we proposed to amend the timeframe at § 405.355(b) for the presumption "against equity and good conscience" for certain types of denials for an individual who is "without fault" so that the presumption would apply if the overpayment determination is made subsequent to the fifth year (instead of the third year) following the year in which the notice of payment was sent to the individual.

Additionally, in our review of the current regulation implementing section 1870(c) of the Act, we noted that § 405.355(b) does not clearly reflect the statutory language, which limits the "against equity and good conscience" presumption to overpayments associated with denials under section 1862(a)(1) or (a)(9) of the Act. Accordingly, we proposed to update and clarify § 405.355(b) so that it clearly reflects the statutory language by adding that the "against equity and good conscience" presumption would be applicable for an individual who is "without fault" only if the overpayment is related to items and services that are not payable under section 1862(a)(1) or (a)(9) of the Act. In addition, we proposed to delete the parenthetical at the end of § 405.355(b) because the regulations referenced no longer exist; those sections of the regulations were reassigned. (See the October 11, 1989 **Federal Register** (54 FR 41733).) The modifications we proposed to § 405.355(b) make the references in the parenthetical no longer necessary.

The following is a summary of the comments we received regarding our proposals.

Comment: Commenters were opposed to CMS changing the timeframe for the "without fault" presumptions in § 405.350(c) and § 405.355(b) from 3 years to 5 years. These commenters expressed concern that changing the timeframe would require physicians to be subject to audits, recovery initiatives, and other undue burdens, including onerous record-keeping requirements, for an additional 2 years despite inadvertently or unknowingly receiving the overpayments.

Response: We are finalizing the revisions to the regulations as proposed and changing the timeframe for the "without fault" presumptions from 3 years to 5 years as specified in section 638 of ATRA. Although the Secretary has the *authority* to reduce the 5-year timeframe to not less than 1 year consistent with the objectives of the program, we do not believe that the Secretary has any basis for such reduction at this time, particularly in light of the Congressional intent expressed by the ATRA provisions.

In addition, although section 638 of ATRA changed the timeframe for the "without fault" presumptions, ATRA did not change CMS' claims reopening timeframes. (In accordance with § 405.980, claims may be reopened within 1 year for any reason, up to 4 years for good cause, and at any time for fraud or similar fault.) We believe maintaining the existing claim reopening timeframes will alleviate the commenters concerns about an increased burden.

We did not receive any comments on our proposals to edit § 405.355(b). Specifically, we proposed to (1) update and clarify § 405.355(b) so that it clearly reflects the statutory language and (2) delete the parenthetical at the end of § 405.355(b) because the regulations referenced no longer exists. We are finalizing the updates to § 405.355(b) as proposed.

G. Physician Compare Web Site

1. Background and Statutory Authority

Section 10331(a)(1) of the Affordable Care Act, requires that, by no later than January 1, 2011, we develop a Physician Compare Internet Web site with information on physicians enrolled in the Medicare program under section 1866(j) of the Act, as well as information on other eligible professionals who participate in the Physician Quality Reporting System (PQRS) under section 1848 of the Act.

CMS launched the first phase of Physician Compare on December 30, 2010 (*www.medicare.gov/physiciancompare*). In the initial phase, we posted the names of eligible professionals that satisfactorily submitted quality data for the 2009 PQRS, as required by section 1848(m)(5)(G) of the Act.

Section 10331(a)(2) of the Affordable Care Act also requires that, no later than January 1, 2013, and for reporting periods that begin no earlier than January 1, 2012, we implement a plan for making publicly available through Physician Compare information on physician performance that provides comparable information on quality and patient experience measures. We met this requirement in advance of January 1, 2013, as outlined below, and intend to continue to address elements of the plan through rulemaking.

To the extent that scientifically sound measures are developed and are available, we are required to include, to the extent practicable, the following types of measures for public reporting:

- Measures collected under the PQRS.
- An assessment of patient health outcomes and functional status of patients.
- An assessment of the continuity and coordination of care and care transitions, including episodes of care and risk-adjusted resource use.
- An assessment of efficiency.
- An assessment of patient experience and patient, caregiver, and family engagement.
- An assessment of the safety, effectiveness, and timeliness of care.
- Other information as determined appropriate by the Secretary.

As required under section 10331(b) of the Affordable Care Act, in developing and implementing the plan, we must include, to the extent practicable, the following:

- Processes to ensure that data made public are statistically valid, reliable, and accurate, including risk adjustment mechanisms used by the Secretary.
- Processes for physicians and eligible professionals whose information is being publicly reported to have a reasonable opportunity, as determined by the Secretary, to review their results before posting to Physician Compare. This would consist of a 30-day preview period for all measurement performance data that will allow physicians and other eligible professionals to view their data as it will appear on the Web site in advance of publication. Details of the preview process will be communicated on the Physician Compare Initiative page on CMS.gov in advance of the preview period.
- Processes to ensure the data published on Physician Compare provides a robust and accurate portrayal of a physician's performance.
- Data that reflects the care provided to all patients seen by physicians, under both the Medicare program and, to the extent applicable, other payers, to the extent such information would provide a more accurate portrayal of physician performance.
- Processes to ensure appropriate attribution of care when multiple physicians and other providers are involved in the care of the patient.
- Processes to ensure timely statistical performance feedback is provided to physicians concerning the data published on Physician Compare.
- Implementation of computer and data infrastructure and systems used to support valid, reliable and accurate reporting activities.

Section 10331(d) of the Affordable Care Act requires us to consider input from multi-stakeholder groups in selecting quality measures for Physician Compare, which we are working to accomplish through a variety of means including rulemaking and various forms of stakeholder outreach. In developing the plan for making information on physician performance publicly available through Physician Compare, section 10331(e) of the Affordable Care Act requires the Secretary, as the Secretary deems appropriate, to consider the plan to transition to value-based purchasing for physicians and other practitioners that was developed under section 131(d) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (Pub. L. 110–275, enacted on July 15, 2008).

Under section 10331(f) of the Affordable Care Act, we are required to submit a report to the Congress, by January 1, 2015, on Physician Compare development, and include information on the efforts and plans to collect and publish data on physician quality and efficiency and on patient experience of care in support of value-based purchasing and consumer choice. Initial work on this report is currently underway. Section 10331(g) of the Affordable Care Act provides that any time before that date, we may continue to expand the information made available on Physician Compare.

We believe section 10331 of the Affordable Care Act supports our overarching goals of providing consumers with quality of care information to make informed decisions about their healthcare, while encouraging clinicians to improve on the quality of care they provide to their patients. In accordance with section 10331 of the Affordable Care Act, we intend to utilize Physician Compare to publicly report physician performance results.

2. Public Reporting of Physician Performance Data

Since the initial launch of the Web site, we have continued to build on and improve Physician Compare. In 2013, we launched a full redesign of Physician Compare offering significant improvements including a complete overhaul of the underlying database and a new Intelligent Search feature, addressing two of our stakeholders' primary critiques of the site and considerably improving functionality and usability. The primary source of administrative information on Physician Compare is the Provider Enrollment, Chain, and Ownership System (PECOS); as the sole source of verified Medicare professional information, PECOS remains the primary information source. However, with the redesign, we incorporated the use of Medicare claims information to verify the information in PECOS to ensure only the most current and accurate information is included on the site. The following is a summary of general comments we received about the Web site and its redesign.

Comment: We received positive comments regarding our use of Medicare claims to verify information in PECOS; however, some commenters did express concerns with lingering data issues regarding basic demographic information, specialty classification, and hospital affiliation. Some commenters urged CMS to address these concerns prior to posting quality measure performance information on the site. Other commenters requested we implement a streamlined process by which professionals can correct their information in a timely manner.

Response: We appreciate the commenters' feedback regarding concerns over the accuracy of the information currently available on Physician Compare. CMS is committed to including accurate and up-to-date information on Physician Compare and continues to work to make improvements to the information presented.

The underlying database on Physician Compare is generated from the PECOS as well as Fee-For-Service (FFS) claims and it is therefore critical that physicians, other healthcare professionals, and group practices ensure that their information is up-to-date and as complete as possible in the national PECOS database. Currently, the

most immediate way to address inaccurate PECOS data on Physician Compare is by updating information via Internet-based PECOS at *https://pecos.cms.hhs.gov/pecos/login.do.* Please note that the specialties as reported on Physician Compare are those specialties reported to Medicare when a physician or other healthcare professional enrolls in Medicare and are limited to the specialties noted on the 855i Enrollment Form. And, all addresses listed on Physician Compare must be entered in and verified in PECOS. To update information not found in PECOS, such as hospital affiliation and foreign language, professionals and group practices should contact the Physician Compare team directly at *physiciancompare@westat.com.* Understanding the value of a more real-time option for updating information on Physician Compare and the ability to update all information in one place, we are evaluating the feasibility of such a mechanism for potential future development.

The following is a summary of the comments we received regarding the new Intelligent Search functionality:

Comment: We received comments concerning primary care specialties being listed with other specialties in the search results. One commenter noted that when they conducted a search for "neurosurgery" they were directed to select names of physicians from family practice, neurology and then neurosurgery—in that order. One commenter who searched for "general surgeons" was surprised that thirteen primary care physicians were listed as related to general surgery. Another commenter requested that CMS remove the "Search all Family Practice, General Practice, Geriatric Medicine, Internal Medicine, and Primary Healthcare Professionals" option as a result from searches for a specific type of specialist. They also requested that for searches where primary care may be applicable but not most appropriate, the all primary care option should be listed last.

Response: The purpose of Physician Compare is to connect users with a comprehensive list of physicians and other healthcare professionals that are capable of assisting them with their health-related concerns. Since primary care is generally the principal point of consultation for patients within the Medicare system, a link to search for all primary care specialties is always offered to patients as an option in the drop down list and/or results list. Based on feedback from both stakeholders and consumers received since the functionality went live, we are reevaluating how this information is presented on the site so it does not appear, for instance, that when you search for "neurosurgery" you are seeing primary care physicians because they are related to neurosurgery.

Comment: Some commenters felt that the search results were too broad and not actionable for patients. Commenters requested that CMS work with stakeholders such as state and national specialty societies to improve the accuracy of Physician Compare in associating specialists with different body parts and diseases.

Response: We appreciate the commenters' feedback on the Intelligent Search functionality. The development of this search function is an ongoing process and it will continue to evolve through quarterly updates. CMS values the input of stakeholders concerning the Intelligent Search. The Physician Compare team worked closely with specialty societies in the development of the initial Intelligent Search function and continues to seek input and conduct outreach to ensure that the terms and phrases powering the search function are as comprehensive and accurate as possible.

Comment: One commenter noted that the search function for group practices does not work, citing that if one enters a zip code that is close to the group practice's primary address, the group practice does not appear.

Response: Search results are displayed on the Web site based on proximity to the center of the location searched, therefore search results may vary depending on if a zip code or a city/state search is conducted. In addition, the search results are generated using an auto-expand feature. The distance will vary depending on the location and type of search. All searches start at one mile and if less than 10 individuals or groups are found within that distance, the search radius will automatically expand incrementally until it reaches a sufficient amount of results. If sufficient results are returned, however, the search will not expand. This may lead to a group practice nearby not being displayed because there are a sufficient number of practices closer to the center of the search radius to satisfy the search.

Currently, users can view information about approved Medicare professionals such as name, primary and secondary specialties, practice locations, group affiliations, hospital affiliations that link to the hospital's profile on Hospital Compare as available, Medicare Assignment status, education, languages spoken, and American Board of Medical Specialties (ABMS) board certification information. In addition, for group practices, users can also view group practice names, specialties, practice locations, Medicare Assignment status, and affiliated professionals.

Comment: We received two comments regarding the publication of the ABMS board certification information. One commenter suggested that we add additional information on board certification such as contextual information regarding the certification process, as well as identifying the certifying Board and not just the specialty. Another commenter urged CMS to include other board's certifications, in addition to ABMS.

Response: We appreciate the commenters' feedback. We will evaluate the feasibility of including a link to the ABMS Web site so that users can get additional information about certification, as well as certifying board information. And, we will evaluate the feasibility of potentially including data on Physician Compare from other board certification sources in a future Web site release, if the information is available and it is technically feasible.

As required by 1848(m)(5)(G) of the Act, we are required to post on a CMS Web site the names of eligible professionals who satisfactorily report under the PQRS, as well as those eligible professionals who are successful electronic prescribers under the Medicare Electronic Prescribing (eRx) Incentive Program. Physician Compare contains a link to the list of those names. In addition to the list of names, there is a section on each individual's profile page listing the quality programs under which the specific individual satisfactorily reported or if the individual was a successful electronic prescriber. The program name is listed and a green check mark clearly indicates which programs the individual satisfactorily or successfully participated in. These data will be updated annually with the most recent data available.

With the Physician Compare redesign, we have also added a quality programs section to each group practice profile page in order to indicate which group practices are satisfactorily reporting in Group Practice Reporting Option (GPRO) under the PQRS or are successful electronic prescribers under the eRx Incentive program. We have also included a notation and check mark for individuals that successfully participate in the Medicare EHR Incentive Program, as authorized by section 1848(o)(3)(D) of the Act. These data will be updated with the most recent data available.

Comment: One commenter urged CMS to reconsider its decision to publicly report on meaningful use data due to the ongoing issues related to the EHR program—including unresolved challenges related to interoperability of certified systems, concerns about the relevancy of meaningful use objectives to certain providers, and the large investment associated with EHR adoption that continues to make it cost prohibitive for small practices despite incentives.

Response: We appreciate the commenter's feedback on including EHR participation information. However, as this proposal was previously finalized, these data are currently available on Physician Compare. We believe the benefits of including these data, the growth of the program, and consumer interest in EHR adoption warrant the inclusion of these data on Physician Compare.

As we finalized in the 2013 PFS final rule with comment period (77 FR 69166), we will include the names of those eligible professionals who report the PQRS Cardiovascular Prevention measures group in support of the Million Hearts Initiative by including a check mark in the quality programs section of the profile page. Finally, we will also indicate in this manner those individuals who have earned the PQRS Maintenance of Certification Incentive starting with data reported for CY 2013. We will update this information annually moving forward.

Comment: One commenter requested that American Board of Optometry (ABO) certified optometrists who earn the PQRS MOC bonus be recognized on the Physician Compare Web site.

Response: We appreciate the commenter's feedback on including an indication on Physician Compare for participation in the additional PQRS Maintenance of Certification incentive for Optometrists. As all successful participants in the additional PQRS Maintenance of Certification incentive will have an indication of their participation on Physician Compare, this information will be included on the site when the information is published.

We are now instituting our plan for a phased approach to public reporting of performance information on Physician Compare. The first phase of our plan was finalized with the 2012 PFS final rule with comment period (77 FR 69166), where we established that PQRS GPRO measures collected through the GPRO web interface during 2012 would be publicly reported on Physician Compare. These measures will be publicly reported on Physician Compare in early CY 2014. We expanded our plan with the 2013 PFS final rule with comment period (77 FR 69166) where we established that the specific GPRO web interface measures that would be posted on Physician Compare include the Diabetes Mellitus (DM) and Coronary Artery Disease (CAD) PQRS GPRO measures, and that we would develop and report composite measures for these measure groups in future years, if technically feasible. Data reported in 2013 under the GPRO DM and GPRO CAD measures and composites collected via the GPRO web interface that meet the minimum sample size of 20 patients, and that prove to be statistically valid and reliable, will be publicly reported on Physician Compare in late CY 2014, if technically feasible. As we previously established, if the minimum threshold is not met for a particular measure, or the measure is otherwise deemed not to be suitable for public reporting, the group's performance rate on that measure will not be publicly reported.

Comment: Several commenters requested CMS ensure the data reported on Physician Compare be accurate and reliable, citing that inaccurate data can damage physicians' reputations, result in false assumptions about care, and potentially lead to harmful consequences for patients. Commenters also strongly urged CMS to risk adjust the measures. Some commenters noted that there is an overreliance on process measures that are not linked to outcomes and that provide minimal value to consumers in comparing providers, or for assuring that physicians are providing high quality care.

Response: We appreciate the commenters' feedback, and understand their concerns. As required under section 10331(b) of the Affordable Care Act, in developing and implementing the plan to include performance data on Physician Compare, we must include, to the extent practicable, processes to ensure that the posted data are statistically valid, reliable, and accurate, including risk adjustment mechanisms used by the Secretary, as well as processes to ensure appropriate attribution of care when multiple providers are involved in the care of the patient. We understand that this information is complex, and are committed to providing data on Physician Compare that are useful to beneficiaries in assisting them in making informed healthcare decisions, while being accurate, valid, reliable, and complete. We will closely evaluate all quality measures under consideration for public reporting on the Web site to ensure they are presented in a way that is helpful to beneficiaries and, through consumer testing and stakeholder outreach, work to present this information in an accurate and user-friendly way. We also appreciate the commenters' feedback and understand the interest in focusing more on patient-centered outcome measures versus process measures. CMS will take this feedback into consideration for future rulemaking.

In the Medicare Shared Savings Program final rule (76 FR 67948), we noted that because Accountable Care Organization (ACO) providers/suppliers that are eligible professionals are considered to be a group practice for purposes of qualifying for a PQRS incentive under the Shared Savings Program, we would publicly report ACO performance on quality measures on Physician Compare in the same way as we report performance on quality measures for PQRS GPRO group practices. Public reporting of performance on these measures will be presented at the ACO level only.

As part of our public reporting plan, in the CY 2013 PFS final rule with comment period (77 FR 69167), we also finalized our decision to publicly report Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG–CAHPS) data for group practices of 100 or more eligible professionals reporting data in 2013 under the GPRO, and for ACOs participating in the Shared Savings Program. We anticipate posting these data on Physician Compare as early as 2014.

3. Future Development of Physician Compare

We will continue to phase in an expansion of Physician Compare over the next several years by incorporating quality measures from a variety of sources, as technically feasible. We previously finalized a decision to publicly report on Physician Compare the performance rates on a limited set of web interface quality measures that group practices submit under the 2012 and 2013 PQRS GPRO web interface (76 FR 73417 and 77 FR 69166).

For 2014, we proposed to expand the quality measures posted on Physician Compare by publicly reporting in CY 2015 performance on all measures collected through the GPRO web interface for groups of all sizes participating in 2014 under the PQRS GPRO and for ACOs participating in the Medicare Shared Savings Program (78 FR 43354). These data would include measure performance rates for measures reported that met the minimum sample size of 20 patients, and that prove to be statistically valid and reliable. We noted

we will provide a 30-day preview period prior to publication of quality data on Physician Compare so that group practices and ACOs can view their data as it will appear on Physician Compare before it is publicly reported, and that we will detail the process for the 30-day preview and provide a detailed timeline and instructions for preview in advance of the start of the preview period.

Comment: We received both positive and negative comments regarding our proposal to expand public reporting to all performance measures collected through the GPRO web interface. Commenters in support of the expansion highlight that it will be easier to identify a core set of measures on which to gauge a group practice's overall rate of performance. Another commenter noted that the expansion will allow Physician Compare to report a wider selection of useful, actionable information to assist consumers in making informed choices about where they receive their care. Commenters opposed to the expansion felt that Physician Compare should revert to its original proposal to initially only report on a limited set of web interface measures noting that the public reporting of performance data should occur gradually and carefully to ensure the data are accurate and presented in a format that is easy to understand, meaningful, and actionable for consumers. Another commenter noted that the public reporting of physician performance data is a new undertaking for both CMS and the public and could have serious implications if it is not executed appropriately.

Response: We appreciate the commenters' feedback. We proposed an expanded set of web interface measures in 2014 as these measures provide an opportunity for more group practices to be able to have relevant data publically reported on Physician Compare and because this will provide consumers with more information to help them make informed healthcare decisions. Regarding concerns about gradually and carefully including additional quality of care information, 2014 will be the third year of data publicly reported on Physician Compare. The previous 2 years of public reporting will provide experience using a limited set of measures, allowing CMS to ensure an appropriate process and accurate data. Moving to a greater number of measures in 2014 is part of a gradual and phased approach. Also, CMS has been working to ensure the data are presented in a way that is both accurate and most useful to consumers through consumer testing and stakeholder outreach, starting with the 2012 data. Therefore, sufficient work in this area is being conducted to ensure the data are properly reported. We are thus finalizing this proposal to expand the quality measures posted on Physician Compare by publicly reporting in CY 2015 performance on all measures collected through the GPRO web interface for groups of all sizes participating in 2014 under the PQRS GPRO. For ACOs participating in the Medicare Shared Savings Program, performance on the ACO GPRO measures will be reported publicly on Physician Compare in the same manner as group practices that report under the PQRS GPRO (76 FR 67948).

Comment: We received several comments in support of the 30-day preview period prior to publication of quality data. Many commenters urged CMS to allow physicians, group practices, and ACOs the opportunity to correct and/or appeal any errors found in the performance information before it is posted on the site. Other commenters felt that a 30-day preview period was insufficient and requested that CMS extend the period up to 45, 60, or 90 days. One commenter recommends that CMS allow a preview period prior to any information being added to the Web site.

Response: We appreciate the commenters' feedback in support of the 30-day preview period for quality measures on Physician Compare. This 30-day period is in line with the preview period provided for other public reporting programs such as Hospital Compare. We will provide a 30-day preview period for confidential measure preview. If measure data have been collected and the measure has been deemed suitable for pubic reporting, the data will be published on Physician Compare. As such, there will not be a formal appeals process. However, if an error is found in the measure display during the preview period, there will be options to contact the Physician Compare team by both phone and email. Errors will be corrected prior to publication.

We also appreciate the commenters' feedback regarding extending the 30-day preview period for quality measures on Physician Compare. However, due to our commitment to make this information available to the public in as timely a manner as possible and the Web site development timeline, a longer preview period is not possible at this time. Groups and individuals that will have measure data posted will be informed in advance of the preview period and the logistics necessary to access the confidential preview, review their data, and contact the Physician Compare team if needed. We believe this 30-day period provides ample time to accomplish these goals as evidenced by other programs, such as Hospital Compare.

At this time it is not feasible to incorporate a 30-day preview period for non-measure data, such as address, phone number, specialty, etc., included on the Physician Compare Web site as this would produce an unacceptable lag and limit our ability to provide up-to-date information to consumers that can assist them in making informed healthcare decisions.

We also received comments regarding the patient sample size of 20 patients. A patient sample size of 20 patients was previously finalized (77 FR 69166) for publication of the Diabetes and CAD measures. As we are now expanding the PQRS GPRO measures available for public reporting on Physician Compare, this sample size would also apply to this expanded set of measures.

Comment: Two commenters expressed their concerns regarding the minimum patient sample size, citing that using such a small sample size will result in inaccurate and misleading information regarding the actual activities of the physician practice. One commenter recommended that we raise the sample size to 30. Another noted it was important to include sample size information on Physician Compare to help users better understand the measures being reported.

Response: We appreciate the commenters' feedback regarding the patient sample size and including this information on Physician Compare. We are committed to reporting quality of care data that is statistically valid, reliable, and accurate, and will only post data that meet this standard of reliability regardless of threshold, and regardless of measure type. Should we find a measure meeting the minimum threshold to be invalid or unreliable for any reason, the measure will not be reported.

We believe this threshold of 20 patients is sufficient. It is a large enough sample to protect patient privacy for reporting on the site, and it is the reliability threshold previously finalized for both the Value-Based Modifier (VBM) and the PQRS criteria for reporting measure groups (77 FR 69166). As we work to align quality initiatives and minimize reporting burden on physicians and other healthcare professionals, we are finalizing a patient sample size of 20 patients for the expanded set of PQRS GPRO measures available for public reporting on Physician Compare.

For 2013, we expanded PQRS GPRO to include a registry reporting option (77 FR 69166). For 2014, we are expanding the PQRS GPRO further to include an option to report data via EHR. Consistent with the requirement under section 10331(a)(2)(A) of the Affordable Care Act to make publicly available information on quality measures submitted by physicians and other eligible professionals under PQRS, we proposed to publicly report on Physician Compare performance on certain measures that groups report via registries and EHRs in 2014 for the PQRS GPRO (78 FR 43354). Specifically, we proposed to report, no earlier than 2015, performance on the GPRO registry and EHR measures identified below that can also be reported via the GPRO web interface in 2014. By proposing to include on Physician Compare performance on these measures reported by participants under the GPRO through registries and EHRs, as well as the GPRO web interface, we stated we would continue to provide beneficiaries with a consistent set of measures over time. For registry reporting, publicly reported measures would include:

- Diabetes: Hemoglobin A1c Poor Control.
- Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD).
- Medication Reconciliation.
- Preventive Care and Screening: Influenza Immunization.
- Pneumococcal Vaccination Status for Older Adults.
- Preventive Care and Screening: Breast Cancer Screening.
- Colorectal Cancer Screening.
- Coronary Artery Disease (CAD): Angiotensin-converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy—Diabetes or Left Ventricular Systolic Dysfunction (LVEF <40%).
- Adult Weight Screening and Follow-Up.
- Preventive Care and Screening: Screening for Clinical Depression.
- Coronary Artery Disease (CAD): Lipid Control.
- Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic.
- Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention.
- Hypertension (HTN): Controlling High Blood Pressure.
- Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control.
- Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented.

For EHR reporting, publicly reported measures would include:

- Diabetes: Hemoglobin A1c Poor Control.
- Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD).
- Preventive Care and Screening: Influenza Immunization.
- Pneumococcal Vaccination Status for Older Adults.
- Preventive Care and Screening: Breast Cancer Screening.
- Colorectal Cancer Screening.
- Adult Weight Screening and Follow-Up.
- Coronary Artery Disease (CAD): Lipid Control.
- Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic.
- Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention.
- Hypertension (HTN): Controlling High Blood Pressure.
- Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control.
- Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented.

Comment: Commenters were opposed to the expansion of public reporting to include measures reported through the registry and EHR reporting options. Some commenters expressed concern that measures reported through different reporting mechanisms may not be comparable. One commenter believes CMS should first validate that the measure specifications are interpreted consistently across groups and across reporting mechanisms. One commenter suggests that it is too soon to have reporting entities publicly post performance data from electronic clinical quality measures (eCQMs) citing that additional work should be done to verify the validity and accuracy of the measure results. Another commenter recommends that CMS include a notation specifying the selected reporting mechanism with a simplified descriptor and accompanying measure set. Such a notation would ensure that patients are made aware of the differences in measure sets across the different reporting mechanisms and it will allow them to know which providers reported on the same measures when comparing performance.

Response: We appreciate the commenters' feedback regarding including measures collected via both registries and EHRs. Though we understand concerns regarding including measures collected via different mechanisms, analyses are being conducted to ensure that these measures are consistently understood and the consistencies and inconsistencies across reporting mechanism are understood and appropriately addressed for the purposes of publicly reporting these measures. Analyses are also being conducted to ensure that the eCQMs produce valid and accurate results. Only those measures finalized to be published on Physician Compare that are proven to be comparable and most suitable for public reporting will be included on Physician Compare. Because we believe the appropriate steps are being taken to ensure that the proposed measures collected via registries and EHRs are comparable to the web interface measures, such as detailed analyses of the measure specifications across reporting mechanisms, and also valid and reliable, and for the various reasons we discussed previously, we are finalizing the proposal to publish in CY 2015 the measures identified above that are collected via registries and EHRs during 2014, if technically feasible.

CMS will also indicate the mechanism by which these data were collected, as we understand the concerns raised regarding potential differences in measures collected via different reporting mechanism. Analyses are ongoing to be sure these differences are fully understood.

Consistent with the requirement under section 10331(a)(2) of the Affordable Care Act to make comparable information on patient experience of care measures publicly available, we previously finalized a plan to post performance on patient experience survey-based measures from the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG–CAHPS) (77 FR 44804) including the following patient experience of care measures for group practices participating in the PQRS GPRO (77 FR 44964):

- CAHPS: Getting Timely Care, Appointments, and Information.
- CAHPS: How Well Your Doctors Communicate.
- CAHPS: Patients' Rating of Doctor.
- CAHPS: Access to Specialists.
- CAHPS: Health Promotion and Education.

These measures capture patients' experiences with clinicians and their staff, and patients' perception of care. We finalized a decision to publicly report performance on these measures on Physician Compare in CY 2014 for data collected for 2013 for group practices with 100 or more eligible professionals participating in the PQRS GPRO in 2013 and reporting data through the GPRO web interface (77 FR 69166). At least for data reported for

2013, we noted that we would administer and collect patient experience survey data on a sample of the group practices' beneficiaries.

Consistent with the PQRS policy of publicly reporting patient experience measures on Physician Compare starting with data collected for 2013, for ACOs participating in the Shared Savings Program, we will publicly report patient experience data in addition to the measure data reported through the GPRO web interface. Specifically, the patient experience measures that would be reported for ACOs include the CG–CAHPS measures in the Patient/Caregiver Experience domain finalized in the Shared Savings Program final rule (76 FR 67889):

- CAHPS: Getting Timely Care, Appointments, and Information.
- CAHPS: How Well Your Doctors Communicate.
- CAHPS: Patients' Rating of Doctor.
- CAHPS: Access to Specialists.
- CAHPS: Health Promotion and Education.
- CAHPS: Shared Decision Making
- CAHPS: Health Status/Functional Status

For data reported for 2014, we proposed to continue public reporting CG–CAHPS data for PQRS GPRO group practices of 100 or more eligible professionals participating in the GPRO via the web interface and for Shared Savings Program ACOs reporting through the GPRO web interface or other CMS-approved tool or interface (78 FR 43355). Consistent with what we finalized for 2013 under the PQRS GPRO, we stated we would administer and fund the collection of data for these groups. Because we will be administering and collecting the data for these surveys, we did not anticipate public reporting to impose any notable burden on these groups.

We believe these patient surveys are important tools for assessing beneficiary experience of care and outcomes, and under our authority under section 1848(m)(3)(C) of the Act to select the measures for which a group practice must report under the PQRS, we stated that we sought to encourage groups of 25 or more eligible professionals to report CG–CAHPS by proposing to make these measures available for reporting under the PQRS and for the Value Based Payment Modifier. We proposed to publicly report 2014 CG–CAHPS data for any group practice (regardless of size) that voluntarily chooses to report CG–CAHPS; however, we stated that CMS would not fund the surveys for these groups of 2 to 99 eligible professionals. We proposed to publicly report comparable CG–CAHPS data collected by groups of any size collected via a certified CAHPS vendor in CY 2015 (78 FR 43355).

We are dedicated to publicly reporting accurate, valid, and reliable data on Physician Compare and are aware that each group practice is unique in size and scope. We have closely evaluated the available data collection mechanisms, and are confident that CG–CAHPS is a well-tested collection mechanism with strong support from the healthcare community, and that it provides the best opportunity to collect useful and accurate data for the largest number of group practices. We proposed to use only those survey domains that are applicable to group practices or ACOs respectively, and believed that these domains have been well tested, and would therefore provide the best data for the largest number of groups.

We received several comments related to our proposals to publicly report CG–CAHPS measures on Physician Compare. The following is a summary of the comments we received:

Comment: Several commenters support our proposal to continue posting data for groups of 100 or more eligible professionals. Commenters were also generally supportive of the proposal to publish patient experience data for smaller groups; however, some commenters requested clarification on the size of group practice that CMS intends to publicly report, noting that there is conflicting language within the proposed rule regarding groups of 25 or more versus groups "regardless of size." Several of the commenters expressed their disappointment that CMS will not fund the data collection for these smaller groups, noting that it is extremely costly and burdensome on smaller practices to implement CAHPS.

Response: We appreciate the commenters' feedback regarding our proposals to continue publicly reporting CG–CAHPS measures for groups of 100 or more eligible professionals with CY 2014 data and to begin publicly reporting CG–CAHPS measures for groups of 25 to 99 that voluntarily submit these data to meet PQRS reporting requirements.

We are dedicated to accurate, valid, and reliable public reporting on Physician Compare and are aware that each group practice is unique and that opinions vary across patients. However, as noted, we are confident that CG–CAHPS is a well-tested collection mechanism that produces valid and comparable measures of physician quality.

Per the requirement under section 10331(a)(2) of the Affordable Care Act to make comparable information on patient experience of care measures publicly available, as noted above, and due to the fact that these data are greatly valued by consumers and will assist consumers with making informed healthcare decisions, we are finalizing the proposal to continue to publicly report CG–CAHPS measures for groups of 100 or more eligible professionals who participate in PQRS GPRO, regardless of GPRO submission method, and for Shared Savings Program ACOs reporting through the GPRO web interface or other CMS-approved tool or interface. As in 2013, CMS will support this survey data collection for group practices who participate in PQRS GPRO via the Web interface. As patient experience data are required under section 10331(a)(2) of the Affordable Care Act, we are working to ensure that a greater set of measures are available for public reporting to help more group practices find measures that are relevant to them and to ease burden of reporting as some groups may already be collecting CG–CAHPS data under additional domains. For these reasons, we are finalizing that, if technically feasible, for these PQRS GPROs of 100 or more eligible professionals, we will collect data for additional summary survey measures. Specifically, we will collect data for the 12 summary survey measures also being finalized for groups of 25 to 99 for PQRS reporting requirements, namely:

- Getting timely care, appointments, and information;
- How well providers Communicate;
- Patient's Rating of Provider;
- Access to Specialists;
- Health Promotion & Education;
- Shared Decision Making;
- Health Status/Functional Status;
- Courteous and Helpful Office Staff;
- Care Coordination;
- Between Visit Communication;
- Helping Your to Take Medication as Directed; and
- Stewardship of Patient Resources.

For the same reasons noted above, for groups of 25 to 99 eligible professionals, we are finalizing the proposal to publicly report on Physician Compare the CG–CAHPS measures collected on the 12 summary survey measures noted above when collected via a certified CAHPS vendor, as technically feasible. We will evaluate the data collected and will only publish those measures deemed suitable for public reporting and that prove to be comparable. As with all measure data reported on Physician Compare, there will be a 30-day preview period where groups can preview their data prior to its publication on the site.

We appreciate the commenter's feedback and the fact that collecting CG–CAHPS data is an expense for smaller group practices. However, if smaller group practices are already collecting these data for internal use, we want to be sure that they are able to have the opportunity to have them published on the site. Therefore, we are finalizing this proposal. CMS will not fund collection of these data for groups of 25 to 99.

Comment: Several commenters opposed the publication of CAHPS measures citing that the measures are not relevant to their particular specialty. They request that CMS allow physicians the flexibility to select the survey instruments and patient satisfaction measures most appropriate for their practices. Many of the commenters recommended CMS use Surgical CAHPS as an optional patient experience of care measure.

Response: We appreciate the commenters' feedback regarding the request for CMS to be flexible in the CAHPS surveys publicly reported to ensure the measures are as relevant as possible to all specialties. We understand that CG–CAHPS is not the most applicable CAHPS survey for all specialties and service settings represented by groups on Physician Compare. Therefore, we will evaluate the feasibility of including additional CAHPS surveys, such as S–CAHPS, on the site in the future. However, at this time CG–CAHPS provides the best opportunity to reach the largest number of groups with a single survey instrument. CG–CAHPS measures are also being incorporated into the PQRS program, which means that there will more likely be a sufficient number of groups reporting on these measures to allow comparable reporting. For these reasons and because we are working to phase in measures over time, we will not be able to accommodate additional CAHPS measures on Physician Compare at this time.

In the CY 2013 PFS final rule with comment period (77 FR 44804), we indicated our intention to publicly report performance rates on quality measures included in the 2014 PQRS and for individual eligible professionals consistent with the requirements under section 10331 of the Affordable Care Act to provide information about physicians and other eligible professionals who participate in PQRS. We believe that individual-level measure data is important in helping consumers make informed healthcare decisions and that this information should be posted on the site as soon as technically feasible. Therefore, in the proposed rule, we proposed to publicly report comparable data, as noted below, collected for the 2014 PQRS via claims, EHR or registry from individual eligible professionals as early as CY 2015 (78 FR 43355). Specifically, we proposed to post individual measures reported by individual eligible professionals in line with those measures reported by groups through the GPRO web interface. We proposed to include the following measures:

- Diabetes: Hemoglobin A1c Poor Control.
- Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD).
- Medication Reconciliation.
- Preventive Care and Screening: Influenza Immunization.
- Pneumococcal Vaccination Status for Older Adults.
- Preventive Care and Screening: Breast Cancer Screening.
- Colorectal Cancer Screening.
- Coronary Artery Disease (CAD): Angiotensin-converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy—Diabetes or Left Ventricular Systolic Dysfunction (LVEF < 40%).
- Adult Weight Screening and Follow-Up.
- Preventive Care and Screening: Screening for Clinical Depression.
- Coronary Artery Disease (CAD): Lipid Control.
- Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic.
- Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention.
- Hypertension (HTN): Controlling High Blood Pressure.
- Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control.
- Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented.
- Falls: Screening for Fall Risk.
- Diabetes Mellitus: Low Density Lipoprotein (LDL–C) Control.
- Diabetes Mellitus: High Blood Pressure Control.
- Diabetes Mellitus: Hemoglobin A1c Control (<8%).

Comment: Some commenters supported the CMS provision to provide quality information on the individual physician level as soon as feasible. The majority of commenters, however, were opposed to the proposal to report 2014 PQRS individual measure data in CY 2015. Some commenters are concerned that it may not be feasible to accurately represent a physician's performance, because at the individual physician/eligible professional level, there is not always an adequate sample size to make valid comparisons. Other commenters believe that since multiple physicians can be involved in the treatment of a patient, it can be difficult to assess who ultimately is responsible for the care of that patient when evaluating a specific measure. One commenter is concerned that by reporting individual quality measures providers would have an incentive to turn away patients with low health literacy, inadequate financial resources to afford treatment, and ethnic groups traditionally subject to healthcare inequities in order to improve their process measure performance. Other commenters encourage CMS to limit the publication of measure data to group practices until there is sufficient experience and data to determine what measures, if any, can be reported at the individual level. .

Response: We appreciate the commenters' feedback but believe strongly that individual-level measure data are important in helping consumers make informed healthcare decisions, and that this information should be posted on the site as soon as technically feasible. However, we appreciate the concerns raised by other commenters' regarding posting individual measures. We are committed to including only the most accurate, statistically reliable and valid quality of care measure data on Physician Compare when the data are publicly reported. Any data found to be invalid or inaccurate for any reason will not be publicly reported. And, we are confident that the sample size noted will produce comparable data as these measures have been in use in the PQRS program and have undergone significant review. We understand that attribution of care is a concern at the individual physician level, but believe that it can be appropriately determined for the purposes of these measures. We do not believe that collecting data at the individual physician level will cause physicians to turn away patients just as data collection at the hospital and group practice level have not. And, to further help mitigate this concern, we will evaluate risk adjustment to ensure that those physicians that serve a more complex patient population are not unduly penalized. In future years, we will continue to evaluate the available measures and work to ensure that the data on Physician Compare are those best suited for public reporting. We will ensure that these data are collected and presented appropriately, regardless of the mechanism through which they are collected, and that they accurately reflect performance. Only those measures that are reported for the

accepted sample size will be publicly reported. And, CMS will work to ensure that the measures are presented in a way that is understood by consumers. We will also evaluate the inclusion of language to help users understand why not all individuals will have quality data reported. Given the importance of making individual eligible professional-level measure data available to the public, CMS is finalizing this proposal to publicly report 2014 PQRS individual measure data in CY 2015 for individual PQRS quality measures listed, if technically feasible.

Additionally, and in support of the HHS-wide Million Hearts Initiative, we proposed to publicly report, no earlier than CY 2015, performance rates on measures in the PQRS Cardiovascular Prevention measures group (see Table 116 at 77 FR 69280) at the individual eligible professional level for data collected in 2014 for the PQRS (see Table 74 of this rule).

Comment: We received three comments regarding the publication of the PQRS Cardiovascular Prevention measures group. Two commenters request that CMS clearly and prominently state that certain physicians or groups are not included in the Million Hearts initiative for numerous reasons. One commenter encouraged CMS to limit public reporting of these measures to the group practice level, citing concerns that these measures if collected via EHRs are new for physicians to report, and thus CMS should allow at least two more years of data collection on these measures before publicly reporting them.

Response: We appreciate the commenters' feedback. We appreciate the concern that reporting via an EHR is new for many physicians and it may take time to become comfortable with the reporting mechanism. However, these measures are not new to PQRS and thus have been previously reported. As noted above concerning individual PQRS measures, we recognize the importance of making individual eligible professional-level measure data available to the public, and find these measures to be specifically relevant to the Physician Compare audience, and are, therefore, finalizing this proposal to publicly report in CY 2015 the individual Cardiovascular Prevention measures in support of the Million Hearts Initiative, if technically feasible. We are evaluating the feasibility of including clarification language to explain why it may not be appropriate for physicians or groups to report these Cardiovascular Prevention measures and will include this language if feasible.

Please note that, during the comment period following the proposed rule, we received comments that were not related to our specific proposals for Physician Compare in the CY 2014 PFS proposed rule. While we appreciate the commenters' feedback and intend to use these comments to better develop Physician Compare, these comments will not be specifically addressed in this CY 2014 PFS final rule with comment period, as they are beyond the scope of this rule. However, we will take these comments into consideration when developing policies and program requirements for future years.

H. Physician Payment, Efficiency, and Quality Improvements—Physician Quality Reporting System

This section contains the final requirements for the Physician Quality Reporting System (PQRS). The PQRS, as set forth in sections 1848(a), (k), and (m) of the Act, is a quality reporting program that provides incentive payments and payment adjustments to eligible professionals and group practices based on whether or not they satisfactorily report data on quality measures for covered professional services furnished during a specified reporting period. The regulation governing the PQRS is located at § 414.90. The program requirements for the 2007 through 2014 PQRS incentives and the 2015 PQRS payment adjustment that were previously established, as well as information on the PQRS, including related laws and established requirements, are available at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html.* In addition, the 2011 PQRS and eRx Experience Report, which provides information about eligible professional participation in PQRS, is available for download at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html.*

We note that eligible professionals in critical access hospitals (CAHs) were previously not able to participate in the PQRS. Due to a change we are making in the manner in which eligible professionals in CAHs are reimbursed by Medicare, it is now feasible for eligible professionals in CAHs to participate in the PQRS.

In the CY 2013 PFS final rule with comment period (77 FR 69170), we finalized certain requirements for the 2013 and 2014 PQRS incentives, as well as 2015 and 2016 PQRS payment adjustments. We also finalized certain requirements for future years, such as the reporting periods for the PQRS payment adjustment, as well as requirements for the various PQRS reporting mechanisms. In the CY 2014 PFS proposed rule, we proposed to change some requirements for the 2014 PQRS incentive and 2016 PQRS payment adjustment, as well as to make changes to the PQRS measure set. Furthermore, we introduced our proposals for a new PQRS reporting option—satisfactory participation in a qualified clinical data registry. This final rule with comment period addresses these proposals and specifically outlines the final requirements for the 2014 PQRS incentive and 2016 PQRS payment adjustment.

Please note that, during the comment period following the proposed rule, we received comments that were not related to our specific proposals for PQRS in the CY 2014 PFS proposed rule. In addition, we also solicited comment on a general plan for future years for PQRS, so that we may continue to consider stakeholder feedback as we develop policies and proposals for the future. While we appreciate the commenters' feedback and intend to use these comments to better develop PQRS, these comments will not be specifically addressed in this CY 2014 PFS final rule with comment period, as they are beyond the scope of this rule. However, we will take these comments into consideration when developing policies and program requirements for future years.

1. Changes to § 414.90

As noted previously, the regulation governing the PQRS is located at § 414.90. We proposed the following changes and technical corrections to § 414.90 (78 FR 43357):

- Under § 414.90(b), we proposed to modify the definition of administrative claims to eliminate the words "the proposed" in the phrase "on the proposed PQRS quality measures." We proposed to make this technical change because this language was inadvertently included in the final regulation despite the fact that the quality measures that eligible professionals report under the PQRS were finalized in the CY 2013 PFS final rule with comment period (77 FR 69364).
- We proposed to modify § 414.90(f) to include the phrase "for satisfactory reporting" after the title "Use of consensus-based quality measures." We proposed to add the phrase "for satisfactory reporting" so that it is clear that the paragraph refers to satisfactory reporting, not the new standard of satisfactorily participating in a qualified clinical data registry.

• We proposed to modify the paragraph heading of § 414.90(g) to add the phrase "satisfactory reporting", so that the title of the paragraph reads "Satisfactory reporting requirements for the incentive payments." We proposed to make this change so that it is clear that the paragraph refers to satisfactory reporting, not the new standard of satisfactorily participating in a qualified clinical data registry. Please note that, due to additional changes we are making to § 414.90, paragraph § 414.90(g) is now designated as § 414.90(h).

• We proposed to modify the paragraph heading of § 414.90(h) to add the phrase "satisfactory reporting", so that the title of the paragraph reads "Satisfactory reporting requirements for the incentive payments." We proposed to make this change so that it is clear that the paragraph refers to satisfactory reporting, not the new standard of satisfactorily participating in a qualified clinical data registry. Please note that, due to additional changes we are making to § 414.90, paragraph § 414.90(g) is now designated as § 414.90(j).

• We proposed to delete paragraph § 414.90(i)(4), because § 414.90(i)(4) list requirements that are identical to § 414.90(i)(3), and therefore, redundant.

In addition, we considered further revising the regulation at § 414.90 to list all the specific satisfactory reporting requirements for the 2014 PQRS incentive and 2016 PQRS payment adjustment, so that the different reporting requirements are specified in the regulation. We are making this change. Therefore, we are adding newly redesignated paragraphs § 414.90(h)(3), § 414.90(h)(5), § 414.90(j)(3), and § 414.90(j)(5) to list all the specific satisfactory reporting requirements for the 2014 PQRS incentive and 2016 PQRS payment adjustment.

We solicited but received no public comment on these proposals. Therefore, we are finalizing these proposed technical changes.

In the course of revising the regulation text to address the technical changes and final policies we are adopting in this final rule, we discovered a number of drafting errors and technical issues. In addition to the technical changes and corrections noted above, as well as the substantive changes discussed in the sections that follow, we also are modifying § 414.90 as follows:

• Changing references to the Physician Quality Reporting System to its acronym, the PQRS, throughout § 414.90 to shorten the regulation. This technical change is consistent with the references to the program we have made in the proposed rule.

• Deleting the phrase "as defined in paragraph (b) of this section" when referring to group practices throughout § 414.90, because it is redundant to refer back to the definition of a group practice.

• Amending § 414.90(d) to indicate that, in lieu of satisfactory reporting, an eligible professional may also satisfactorily participate in a qualified clinical data registry in 2014.

• Changing the title of § 414.90(f) currently titled "Use of consensus-based quality measures" to "Use of appropriate and consensus-based quality measures for satisfactory reporting" to indicate criteria for measure selection for measures available under the group practice reporting option (GPRO).

• Combining § 414.90(f)(1) and § 414.90(f)(2) as measures under the PQRS may fit either of these two criteria.

• Adding paragraph (n) entitled "Limitations on review." This "limitations on review" paragraph, previously designated in § 414.90 as paragraph (k) was inadvertently deleted from § 414.90 in the CY 2013 PFS final rule with comment period. In lieu of this section, a duplicate paragraph (k) describing the PQRS informal review process was inserted. We are therefore deleting the duplicate informal review paragraph (k) and restoring paragraph (n).

In addition, the previously established paragraph entitled "limitations on review" included the following paragraph at § 414.90(k)(2): "The determination of the payment limitation." This provision pertains to the Electronic Prescribing (eRx) Incentive Program and is irrelevant to the PQRS. Therefore, we are deleting that reference. Moreover, to be consistent section 1848(m)(5)(E) of the Act, we are adding to the "limitations on review" paragraph the following: "The determination of satisfactory reporting.", which was inadvertently left out (presumably because we inadvertently listed an element of the eRx Incentive Program instead, as noted above). This technical change also necessary so that newly designated paragraph (l) will be consistent with section 1848(m)(5)(E) of the Act.

Although we did not include these technical changes in the proposed rule, we believe it is unnecessary to undergo notice and comment rulemaking given that these changes are purely technical in nature and correct errors inadvertently made previously to the regulation, and do not substantively change the regulation. Finally, we note that we have made further structural and conforming changes to the regulation (for example, adding, deleting, and redesignating paragraphs) consistent with the changes and final policies we are adopting in this final rule.

2. Participation as a Group Practice in the Group Practice Reporting Option (GPRO)—Changes to the Self-nomination, or Registration, Requirement for Group Practices To Be Selected To Participate in the GPRO

In the CY 2013 PFS final rule with comment period (77 FR 69172), we finalized requirements regarding the self-nomination process group practices must follow to participate in the PQRS GPRO. In the CY 2014 PFS final rule with comment period, we proposed (78 FR 43357) to make the changes to those requirements for group practices to self-nominate. First, we proposed to change the deadline of October 15 of the year in which the reporting period occurs for group practices to submit a self-nomination statement, or register, to participate in the PQRS GPRO. Starting with reporting periods occurring in 2014, we proposed (78 FR 43357) to change this deadline to September 30 of the year in which the reporting period occurs (that is, September 30, 2014, for reporting periods occurring in 2014).

We solicited and received the following public comments regarding our proposal to change the deadline that a group practice must register to participate in the GPRO:

Comment: Several commenters did not support our proposal to change the deadline that a group practice must register to participate in the GPRO by September 30 of the year in which the reporting period occurs (that is September 30, 2014 for reporting periods occurring in 2014) suggesting that it is important that group practices are allowed more time to decide on whether they should participate in PQRS as a group practice or as individuals. The commenters felt that the later registration deadline of October 15 of the year in which the reporting period occurs or later allows more time for group practices to make a more informed decision, as well as account for changes in the composition of the group practice, such as changes in a group practice's Taxpayer Identification Number (TIN).

Response: While we understand the commenters' concerns and proposed a deadline of September 30 of the year in which the reporting period occurs, we noted in the proposed rule (78 FR 43357) that CMS needs additional time

to identify group practices wishing to participate in the GPRO for a year in order to allow for more time to populate the GPRO web interface for those group practices that select the GPRO web interface reporting mechanism. Unfortunately,we cannot finalize a deadline later than September 30. Despite the comments we received requesting a later deadline, based on the reasons previously mentioned, we are requiring that group practices register to participate in the GPRO by September 30 of the year in which the reporting period occurs (that is September 30, 2014 for reporting periods occurring in 2014), as proposed.

We note that we received comments related to proposals for the Value-based Payment Modifier (discussed in section III.K. of this final rule with comment period) requesting more timely feedback on group practice reporting, particularly information related Clinician Group Consumer Assessment of Healthcare Providers and Systems (CG CAHPS) survey. Since the performance of a group practice in the Value-based Payment Modifier is determined, in part, by a group practice's participation in the PQRS, to provide timelier feedback to these group practices, in order for eligible professionals to be able to receive feedback on CG CAHPS data and assess by the Value-based Payment Modifier, it would be necessary for CMS to identify which groups will be participating in the PQRS under the GPRO earlier than September 30 of the year in which the reporting period occurs. Therefore, to respond to the commenters concerns to provide timelier feedback on performance on CG CAHPS in the future, we anticipate proposing an earlier deadline for group practices to register to participate in the GPRO in future years.

Second, we proposed (78 FR 43357) that group practices comprised of 25 or more individual eligible professionals that wish to report the CG CAHPS survey measures (which are discussed later in this section) would be required via the web to elect to report the CG CAHPS survey measures. We solicited and received no comments on this proposal. Therefore, we are finalizing our proposal to require group practices of 25 or more individual eligible professionals that wish to report the CG CAHPS survey measures to indicate their intent to do so upon registration.

Furthermore, we proposed (78 FR 43357) that the Web site that a group practice would use to elect to report the CG CAHPS survey measures would be the same Web site used by group practices to register to participate in the PQRS GPRO. We believe that providing a single Web site whereby group practices may make multiple elections (such as submitting the self-nomination statement to register to participate in the PQRS GPRO and be evaluated for the PQRS GPRO using CG CAHPS measures would be desirable for group practices.

We solicited and received the following public comments on this proposal:

Comment: Several commenters supported our proposal to use a single Web site to register to participate in the PQRS GPRO. The commenters believed that using a single Web site for functions relating to different CMS programs furthers CMS' goal of alignment, as well as aids in the group practice's management in participation in CMS' various quality reporting programs. Commenters urged CMS to further align and create a single Web site that will manage participation in the PQRS, EHR Incentive Program, and the Value-based Payment Modifier.

Response: We appreciate the commenters' feedback and the support for this proposal. For the reasons stated above, we are finalizing our proposal to use a single Web site whereby a group practice of 25 or more individual eligible professionals may register to participate in the PQRS GPRO and elect to be evaluated for the PQRS GPRO by reporting CG CAHPS measures.

3. Requirements for the PQRS Reporting Mechanisms

The PQRS includes the following reporting mechanisms: claims; registry; EHR (including direct EHR products and EHR data submission vendor products); administrative claims; and the GPRO web-interface. Under the existing PQRS regulation, section 414.90(g) and (h) govern which reporting mechanisms are available for use by individuals and group practices for the PQRS incentive and payment adjustment. This section contains the changes we are finalizing for these PQRS reporting mechanisms. In addition, this section contains the final requirements for two new PQRS reporting mechanisms—a new certified survey vendor reporting mechanism for purposes of reporting CG CAHPS measures and a qualified clinical data registry reporting mechanism under the new PQRS "satisfactory participation" reporting option.

a. Registry-based Reporting Mechanism

In the CY 2013 PFS final rule with comment period, we finalized the following requirement for registries to become qualified to participate in PQRS for 2013 and beyond: Be able to collect all needed data elements and transmit to CMS the data at the TIN/NPI level for at least 3 measures (77 FR 69180). In the proposed rule, since we proposed (78 FR 43358) to increase the number of measures eligible professionals would be required to report for the 2014 PQRS incentive from 3 to 9 measures covering at least 3 of the National Quality Strategy (NQS) domains, we proposed (78 FR 43358) to change this registry requirement as follows: A qualified registry must be able to collect all needed data elements and transmit to CMS the data at the TIN/NPI level for at least 9 measures covering at least 3 of the NQS domains. We solicited but received no public comment on this proposal. Therefore, as we describe in detail below, since we are finalizing our proposal to increase the number of measures eligible professionals would be required to report for the 2014 PQRS incentive via qualified registry from 3 to 9 measures covering at least 3 of the NQS domains, we are finalizing this proposal.

b. Certified Survey Vendors

We proposed (78 FR 43358) to allow group practices composed of 25 or more eligible professionals to report CG CAHPS survey measures. The data collected on these CAHPS survey measures would not be transmitted to CMS via the previously established PQRS group practice reporting mechanisms (registry, EHR, or GPRO web interface). Rather, the data must be transmitted through a survey vendor. Therefore, to allow for the survey vendor to transmit survey measures data to CMS, we proposed to modify § 414.90(b), § 414.90(g)(3), and § 414.90(h)(3) to propose a new reporting mechanism—the certified survey vendor (78 FR 43358). We solicited and received the following public comment on this proposal:

Comment: Several commenters supported our proposal to allow group practices of 25–99 eligible professionals to report the CG CAHPS survey measures and therefore generally supported our proposal to create a new reporting mechanism—the CMS-certified survey vendor—to administer the CG CAHPS survey measures.

Response: We appreciate the commenters' feedback and are finalizing the creation of a new reporting mechanism, the CMS-certified survey vendor, to report the CG CAHPS survey measures. Therefore, we are finalizing our proposal to modify § 414.90(b), newly designated § 414.90(h)(3), and newly designated § 414.90(j)(3) to indicate a group practice's ability to use a new reporting mechanism—the CMS-certified survey vendor.

Comment: Although commenters supported our proposal to allow group practices of 25–99 eligible professionals to report the CG CAHPS survey measures, the commenters opposed our proposal to require these group practices to report the CG CAHPS survey measures via a CMS-certified survey vendor. The commenters believed that group practices should have the flexibility to report CG CAHPS measures in any way the group practices choose, not solely through a CMS-certified survey vendor.

Response: While we appreciate the commenters' concern to allow flexibility in allowing group practices to report the CG CAHPS measures, we must create parameters surrounding how the CG CAHPS survey measures would be reported to CMS. Similar to our other reporting mechanisms, we believe it is also important to ensure that vendors are able to test submission of CG CAHPS measures data prior to the submission period. We believe that requiring that the vendor be certified by CMS to submit CG CAHPS survey measures data furthers this goal. Therefore, we are requiring that group practices use a CMS-certified survey vendor if the group practice wishes to report CG CAHPS survey measures data for purposes of the PQRS.

In addition, § 414.90(g)(3), and § 414.90(h)(3) currently requires group practices to use only one mechanism to meet the requirements for satisfactory reporting (that is, CMS will not combine data submitted under multiple reporting mechanism to determine if the requirements for satisfactory reporting are met). However, for the proposed certified survey vendor option, we also proposed that a group practice choosing to report CG CAHPS survey measures would be required to select an additional reporting mechanism to meet the requirements for satisfactory reporting for both the 2014 PQRS incentive and the 2016 PQRS payment adjustment (78 FR 43358). Therefore, we proposed to modify § 414.90(g)(3), and § 414.90(h)(3) to indicate that groups selecting to use the certified survey vendor would be the exception to this requirement. We received no public comment on this proposal and therefore, for the reasons we previously stated, are finalizing our proposal to modify newly designated § 414.90(h)(3), and § 414.90(j)(3) to indicate that groups selecting to use the certified survey vendor would be required to meet the criteria for satisfactory reporting using an additional reporting mechanism to report additional measures.

For purposes of PQRS, we proposed to modify § 414.90(b) to define a certified survey vendor as a vendor that is certified by CMS for a particular program year to transmit survey measures data to CMS (78 FR 43358). To obtain CMS certification, we proposed that vendors would be required to undergo training, meet CMS standards on how to administer the survey, and submit a quality assurance plan. CMS would provide the identified vendor with an appropriate sample frame of beneficiaries from the group. The vendor would also be required to administer the survey according to established protocols to ensure valid and reliable results. Survey vendors would be supplied with mail and telephone versions of the survey in electronic form, and text for beneficiary pre-notification and cover letters. Surveys can be administered in English, Spanish, Cantonese, Mandarin, Korean, Russian and/or Vietnamese. Vendors would be required to use appropriate quality control, encryption, security and backup procedures to maintain survey response data. The data would then be securely sent back to CMS for scoring and/or validation. To ensure that a vendor possesses the ability to transmit survey measures data for a particular program year, we proposed to require survey vendors to undergo this certification process for each year in which the vendor seeks to transmit survey measures data to CMS. We solicited and received no public comment on these proposals. Therefore, we are finalizing these proposals, as well as the proposed change at § 414.90(b).

4. Changes to the Criteria for the Satisfactory Reporting for Individual Eligible Professionals for the 2014 PQRS Incentive—Individual Quality Measures Submitted via Claims and Registries and Measures Groups Submitted via Claims

For 2014, in accordance with § 414.90(c)(3), eligible professionals that satisfactorily report data on PQRS quality measures are eligible to receive an incentive equal to 0.5 percent of the total estimated Medicare Part B allowed charges for all covered professional services furnished by the eligible professional or group practice during the applicable reporting period. Individual eligible professionals may currently report PQRS quality measures data to meet the criteria for satisfactory reporting for the 2014 PQRS incentive via the claims, registry, and EHR-based reporting mechanisms. This section contains our final changes to the criteria for satisfactory reporting of individual quality measures via claims and registries by individual eligible professionals for the 2014 PQRS incentive. Please note that we did not propose to modify and are therefore not modifying the criteria for satisfactory reporting of individual quality measures via EHR that were established in the CY 2013 PFS final rule with comment period (see Table 91, 77 FR 69194). For ease of reference, these criteria for satisfactory reporting of individual quality measures via EHR for the 2014 PQRS incentive are also identified again in Table 47 of this final rule with comment period.

a. Proposed Changes to the Criterion for Satisfactory Reporting of Individual Quality Measures via Claims for Individual Eligible Professionals for the 2014 PQRS Incentive

In the CY 2013 PFS final rule with comment period (see Table 91, 77 FR 69194), to maintain the reporting criterion with which individual eligible professionals are familiar, we finalized the same satisfactory reporting criterion for the submission of individual quality measures via claims that we finalized in previous years: For the 12-month reporting period for the 2014 PQRS incentive, report at least 3 measures, OR, if less than 3 measures apply to the eligible professional, report 1–2 measures, AND report each measure for at least 50 percent of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted. For an eligible professional who reports fewer than 3 measures via the claims-based reporting mechanism, the eligible professional would be subject to the Measures Applicability Validation (MAV) process, which would allow us to determine whether an eligible professional should have reported quality data codes for additional measures (77 FR 69188).

Under our authority to revise the criteria for satisfactory reporting for the 2014 PQRS incentive under section 1848(m)(3)(d) of the Act, we proposed (78 FR 43358) to change the criterion for the satisfactory reporting of individual, claims-based measures by individual eligible professionals for the 2014 PQRS incentive as follows: For the 12-month reporting period for the 2014 PQRS incentive, report at least 9 measures, covering at least 3 of the NQS domains, OR, if less than 9 measures apply to the eligible professional, report 1–8 measures, AND report each measure for at least 50 percent of the Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted. For an

eligible professional who reports fewer than 9 measures covering less than 3 NQS domains via the claims-based reporting mechanism, the eligible professional would be subject to the MAV process, which would allow us to determine whether an eligible professional should have reported quality data codes for additional measures. We proposed to allow eligible professionals to report fewer than 9 measures so that eligible professionals who do not have at least 9 claims-based PQRS measures applicable to his/her practice would still have an opportunity to still meet the criteria for satisfactory reporting for the 2014 PQRS incentive by reporting on as many applicable claims-based measures as the eligible professionals can report.

We solicited public comment on the proposed change to the criterion for the satisfactory reporting of individual quality measures via claims for individual eligible professionals for the 2014 PQRS incentive and received the following comments:

Comment: Several commenters supported our proposal to increase the number of measures to be reported via claims, as requiring an eligible professional to report on more measures would better capture the quality of care provided by an eligible professional.

Response: We appreciate the commenters' feedback and, based on the supportive comments received and for the reasons mentioned above and in the proposed rule (78 FR 43358), are finalizing this proposed criterion.

Comment: While several commenters generally supported our proposal to increase the number of measures and NQS domains to be reported via claims, the commenters urged CMS to take a more gradual approach to increasing the number of measures that must be reported via claims. These commenters suggested requiring the reporting of either 4 measures covering at least 1 NQS domain, 5 measures covering at least 2 NQS domains, or 6 measures covering at least 2 NQS domains.

Response: We appreciate the commenters' support for our desire to increase the number of measures to be reported via claims, as well as their alternative suggestions on how to increase the number of measures to be reported via claims. As we explain in more detail when we discuss our final requirements for the 2016 PQRS payment adjustment, we agree that a more gradual increase in the number of measures to be reported may be necessary for purposes of meeting the criteria for satisfactory reporting for the PQRS payment adjustments. However, since the PQRS program has provided incentives for satisfactory reporting since 2007, we believe it is appropriate to increase the number of measures to be reported via claims from 3 measures covering 1 NQS domain to 9 measures covering 3 NQS domains for the 2014 PQRS incentive. We believe 6 years is enough time for eligible professionals to familiarize themselves with the reporting options for satisfactory reporting under the PQRS. Additionally, we point out that we will be using a MAV process for individual eligible professionals who report less than 9 measures via claims, given that an eligible professional who does not have at least 9 measures covering less than 3 NQS domains applicable to his/her practice may report the number of measures applicable to the eligible profession (i.e., fewer than 9 measures) to attempt to meet the criteria for satisfactory reporting for the 2014 PQRS incentive via claims. Through the MAV process, we will determine whether the eligible professional reported the measures applicable to the eligible professional. For the commenters' suggested alternative criteria, while we understand the commenters' concerns, we believe our interest in aligning the satisfactory reporting criteria of individual measures via claims with the satisfactory reporting criteria of individual measures via EHR for the 2014 PQRS incentive outweighs the need for such a gradual increase in the number of measures required to be reported via claims.

Comment: One commenter stated that we should not align the PQRS reporting criteria for reporting mechanisms other than the EHR-based reporting mechanisms with the reporting criteria for the EHR Incentive Program, as the objectives for the two programs are different.

Response: We respectfully disagree. Although the standards and criteria for which the PQRS and EHR Incentive Program provide incentives and relieve eligible professionals from payment adjustments are different, the two programs are both dedicated to the promotion of EHR technology and the collection of meaningful and quality data.

Comment: The majority of commenters opposed our proposal to increase the number of measures to be reported via claims from 3 measures covering 1 NQS domain to 9 measures covering 3 NQS domains. Several of these commenters generally opposed any proposal that would increase the number of measures to be reported via claims from 3 measures covering 1 NQS domain. Some of these commenters noted that they have been successful at meeting the criteria for satisfactory reporting in the PQRS via claims in the past, and increasing the number of measures to be reported via claims would make it more difficult for these eligible professionals to meet the criteria for satisfactory reporting for the 2014 PQRS incentive. Other commenters urged CMS not to increase the criteria for satisfactory reporting until participation in PQRS increases, as the commenters feared that increasing the criteria for satisfactory reporting in PQRS would discourage eligible professionals from participating in the PQRS. Still some of the commenters opposing this proposal noted that certain eligible professionals did not have 9 measures covering 3 NQS domains for which to report. These commenters stressed that being able to report at least 9 measures covering 3 NQS domains via claims for the 2014 PQRS incentive would be particularly difficult since we are proposing to eliminate the claims-based reporting mechanism as an option to report certain PQRS measures. Some of these commenters also expressed concern that certain practices having a limited number of applicable measures will not have applicable measures covering at least 3 NQS domains.

Response: We understand the commenters' concerns. As we noted above and in the proposed rule (78 FR 43358), we believe that we have provided eligible professionals with enough time to familiarize themselves with the reporting options for satisfactory reporting under the PQRS, particularly for the PQRS incentives.

For the commenters who urge us not to increase the satisfactory reporting criteria for the PQRS until participation in PQRS increases, we understand that, as discussed in this final rule below and in the 2011 PQRS and eRx Reporting Experience, participation in the PQRS has fluctuated around 25 percent among those eligible to participate in the PQRS. Indeed, it is one of our major goals to increase participation in the PQRS. While increasing the satisfactory reporting threshold for the 2014 PQRS incentive may deter or discourage eligible professionals from participating, we do not believe increased threshold we are finalizing will significantly deter eligible professionals from participating in the PQRS primarily given that the 2016 PQRS payment adjustment is applicable, and the reporting periods of the 2016 PQRS payment adjustment run concurrently with the reporting periods for the 2014 PQRS incentive. Since eligible professionals are required to meet the criteria for satisfactory reporting for the 2016 PQRS payment

adjustment to avoid a reduction to the physician fee schedule payments, we believe these eligible professionals will also attempt to report for the 2014 PQRS incentive regardless of whether we increase the measure threshold from 3 measures covering 1 NQS domain to 9 measures covering 3 NQS domains. For the commenters' concerns on not having at least 9 PQRS measures covering 3 NQS domains for which to report via claims, particularly since we proposed to eliminate the claims-based reporting mechanism as a mechanism for which to report certain measures, we note that our proposal, which we are finalizing, allows eligible professionals to report 1–8 measures that are applicable, if the eligible professional does not have 9 applicable measures to report. If an eligible professional does not have 9 applicable measures to report, the eligible professional must report on as many measures covering as many domains as are applicable to his/her practice. For example, if an eligible professional only has 7 measures covering 2 NQS domains applicable to his/her practice, he/she must report all 7 measures covering 2 NQS domains in order to meet the criteria for satisfactory reporting for the 2014 PQRS incentive. It would not be sufficient for the eligible professional to report on, for example, 6 measures covering 2 NQS domains or 6 measeures covering 1 NQS domain.

Given this aspect of the satisfactory reporting criterion, which would address these commenters concerns, we believe it is appropriate to finalize this satisfactory reporting criterion and the general increase in measures to up to 9. Also, we note that for eligible professionals who report 1–8 measures, we will use the MAV process. The current claims MAV process for the 2013 PQRS incentive is only triggered when an eligible professional reports on 1 or 2 measures covering 1 NQS domain via claims since, to meet the criteria for satisfactory reporting for the 2013 PQRS incentive, an eligible professional is only required to report on 3 measures covering 1 NQS domain (77 FR 69189). Since we are increasing the satisfactory reporting threshold from 3 measures covering 1 NQS domain to 9 measures covering at least 3 NQS domains, we are amending the 2013 MAV process for claims so that the 2014 claims MAV process will be triggered when an eligible professional reports on less than 9 measures covering at least 3 NQS domains. Therefore, the MAV process will be triggered when an eligible professional reports on either less than 9 measures or measures covering less than 3 NQS domains. If an eligible professional reports on less than 9 measures, the MAV process will also check to determine whether the eligible professional is reporting of the maximum amount of NQS domains (up to 3 NQS domains) applicable.

For example, if an eligible professional reports on 8 measures covering 2 NQS domains, the MAV process will be triggered to determine whether an eligible professional could have reported on at least 9 measures and covering at least 3 NQS domains. Likewise, if an eligible professional reports on 9 measures covering 2 domains, the MAV process will be triggered to determine whether an eligible professional could have reported on measures covering an additional domain. As in previous years, the MAV process will use a two-part test—(1) a "clinical relation" test, and (2) a "minimum threshold" test—to determine whether an eligible professional could have reported on more measures.

To get a better sense of how the 2014 MAV process for claims will be implemented by CMS, please see our documentation explaining the current 2013 MAV process for claims. A description of the current claims MAV process is available at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2013_PQRS_MeasureApplicabilityValidation_Docs_030413.zip*. Please note that we will post a guidance document on the 2014 claims MAV process, which will include a list of the measure clusters that are used for the "minimum threshold" test, prior to January 1, 2014 (the start of the 2014 reporting periods).

In summary, we are adding paragraph § 414.90(h)(3) to specify that, to meet the criterion for satisfactory reporting of individual, claims-based measures by individual eligible professionals for the 2014 PQRS incentive an eligible professional must, for the 12-month reporting period for the 2014 PQRS incentive, report at least 9 measures covering at least 3 NQS domains, OR, if less than 9 measures covering at least 3 NQS domains apply to the eligible professional, report 1–8 measures covering 1–3 NQS domains as applicable, AND report each measure for at least 50 percent of the Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted. For an eligible professional who reports fewer than 9 measures covering less than 3 NQS domains, the eligible professional would be subject to the MAV process, which would allow us to determine whether an eligible professional should have reported quality data codes for additional measures and/or covering additional NQS domains.

b. Changes to the Criterion for Satisfactory Reporting of Individual Quality Measures Via Registry for Individual Eligible Professionals for the 2014 PQRS Incentive

In the CY 2013 PFS final rule with comment period, to maintain reporting criterion with which individual eligible professionals are familiar, we finalized the same satisfactory reporting criterion for individual eligible professionals to report individual quality measures via registry that we finalized in previous years: For the 12-month reporting period for the 2014 PQRS incentive, report at least 3 measures AND report each measure for at least 80 percent of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted (77 FR 69189). In the proposed rule, we proposed (78 FR 43359) to change this reporting criterion for individual eligible professionals reporting via registry for the 2014 PQRS incentive to the following: For the 12-month reporting period for the 2014 PQRS incentive, report at least 9 measures covering at least 3 of the NQS domains AND report each measure for at least 50 percent of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted (78 FR 43359).

We solicited and received the following public comments on the proposed changes to the criterion for the satisfactory reporting of individual quality measures via registry for individual eligible professionals for the 2014 PQRS incentive:

Comment: The majority of commenters supported our proposal to decrease the percentage of patients that must be reported via registry from 80 percent to 50 percent. The commenters supported our proposal specifically because it aligns with the option to report individual measures via the claims-based reporting mechanism.

Response: We appreciate the commenters' feedback and, based on the support received and for the reasons stated in the proposed rule (78 FR 43359), we are finalizing this proposal with regard to the percent threshold. Therefore, to meet the criteria for satisfactory reporting for the 2014 PQRS incentive, an eligible professional

reporting individual quality measures via registry will be required to report each measure for at least 50 percent of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies.

Comment: One commenter stated that we should not align the PQRS reporting criteria for reporting mechanisms other than the EHR-based reporting mechanisms with the reporting criteria for the EHR Incentive Program, as the objectives for the two programs are different.

Response: We respectfully disagree. Although the standards and criteria for which the PQRS and EHR Incentive Program provide incentives and relieve eligible professionals from payment adjustments are different, the two programs are both dedicated to the promotion of EHR technology and the collection of quality data.

Comment: The majority of commenters opposed our proposal to increase the number of measures to be reported via registry from 3 measures covering 1 NQS domain to 9 measures covering 3 NQS domains. Several of these commenters generally opposed any proposal that would increase the number of measures to be reported via registry from 3 measures covering 1 NQS domain. Some of these commenters noted that they have been successful at meeting the criteria for satisfactory reporting in the PQRS via registry in the past, and increasing the number of measures to be reported via registry would make it more difficult for these eligible professionals to meet the criteria for satisfactory reporting for the 2014 PQRS incentive. Other commenters urged CMS not to increase the criteria for satisfactory reporting until participation in PQRS increases, as the commenters feared that increasing the criteria for satisfactory reporting in PQRS would discourage eligible professionals from participating in the PQRS. Still some of these commenters opposing this proposal noted that certain eligible professionals did not have 9 measures covering 3 NQS domains for which to report.

Response: We understand the commenters' concerns about increasing the number of measures to be reported via registry from 3 measures covering 1 NQS domain to 9 measures covering 3 NQS domains. However, we believe it is important to collect data that provides a broad picture of the quality of care provided by an eligible professional, specifically since, as discussed in section K of this final rule with comment period, the Value-based Payment Modifier will use participation in PQRS to determine upward, downward, and neutral adjustments based on physician performance. We also believe it is important to cover 3 NQS domains. As we noted above and in the proposed rule (78 FR 43359), we believe that we have provided eligible professionals with enough time to familiarize themselves with the reporting options for satisfactory reporting under the PQRS, particularly for the PQRS incentives, and thefore, we find this increase appropriate.

For the commenters who urge us not to raise the satisfactory reporting criteria for the PQRS until participation in PQRS increases, we understand that, as discussed in this final rule below and in the 2011 PQRS and eRx Reporting Experience, participation in the PQRS has fluctuated around 25 percent among those eligible to participate in the PQRS. Indeed, it is one of our major goals to increase participation in the PQRS. While increasing the satisfactory reporting threshold for the 2014 PQRS incentive may deter or discourage some eligible professionals from participating, we believe that this increase to the satisfactory reporting threshold will not significantly deter eligible professionals from participating in the PQRS. In particular, eligible professionals will be required to report PQRS quality measures data in 2014 to meet the criteria for satisfactory reporting for the 2016 PQRS payment adjustment, which we believe will be an incentive for participation. In addition, we note the reporting periods for the 2014 PQRS incentive and 2016 PQRS payment adjustment run concurrently. Since eligible professionals will already be required to meet the criteria for satisfactory reporting for the 2016 PQRS payment adjustment, we believe these eligible professionals will also attempt to report for the 2014 PQRS incentive regardless of whether we increase the measure threshold from 3 measures covering 1 NQS domain to 9 measures covering 3 NQS domains.

For the commenters' concerns about not having at least 9 PQRS measures covering 3 NQS domains for which to report via registry, we understand the commenters concerns. While we are still finalizing our proposal to increase the number of individual measures required to be reported via registry to meet the criteria for satisfactory reporting for the 2014 PQRS incentive to 9 measures covering 3 domains, to address the concern for those eligible professionals who fear they do not have 9 individual PQRS measures and/or measures covering at least 3 NQS domains applicable to their practice, we are modifying our proposal to allow eligible professionals to report fewer measures so that eligible professionals who do not have at least 9 PQRS measures applicable to their practice can still meet this criteria for satisfactory reporting for the 2014 PQRS incentive by reporting 1–8 measures covering for which there is Medicare patient data. If an eligible professional does not have 9 applicable measures to report, the eligible professional must report on as many measures covering as many NQS domains (up to 3 NQS domains) as are applicable to his/her practice. For example, if an eligible professional only has 7 measures covering 2 NQS domains applicable to his/her practice, he/she must report all 7 measures covering 2 NQS domains in order to meet the criteria for satisfactory reporting for the 2014 PQRS incentive. It would not be sufficient for the eligible professional to report on, for example, 6 measures covering 1 NQS domains.

Given that change, we will analyze eligible professionals who report 1–8 measures using a Measures Application Validity (MAV) process (similar to the claims MAV process we discussed above) to ensure whether the eligible professionals could have reported on the applicable measures. This is consistent with our practice for applying this process to the claims-based reporting option for eligible professionals to report individual measures.

Specifically, if fewer than 9 measures and/or measures covering fewer than 3 NQS domains apply to the eligible professional, an eligible professional must report 1–8 measures covering 1–3 NQS domains for which there is Medicare patient data. The MAV process will be triggered when an eligible professional reports on less than 9 measures. For example, if an eligible professional reports on 8 measures covering 3 NQS domains, the MAV process will be triggered to determine whether an eligible professional could have reported on an additional measure to report on a total of 9 measures covering 3 NQS domains.

The 2014 registry MAV process that will determine whether an eligible professional could have reported on more measures and/covering more NQS domains will be similar to the "clinical relation" test used in the 2013 claims MAV process. To get a better sense of how the 2014 registry MAV process will be implemented by CMS, a description of the "clinical relation" test in the current 2013 claims MAV process is available at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2013_PQRS_Measure ApplicabilityValidation_Docs_*

030413.zip. Please note that we will post a guidance document on the 2014 registry MAV process, which will include a list of the measure clusters that are used for the "clinical relation" test, prior to January 1, 2014 (the start of the 2014 reporting periods).

We believe the changes we are finalizing will address commenters concerns, while still maintaining our general goal of increasing the measures reported to 9 measures covering 3 NQS domains. This also will increase the likelihood that more eligible professionals will be able to take advantage of this reporting option.

Comment: Several commenters supported our proposal to increase the number of measures to be reported via registry, as requiring an eligible professional to report on more measures would better capture the quality of care provided by an eligible professional.

Response: We appreciate the commenter's feedback with regard to the increase in measures. However, as discussed below, we are making a change in the final rule with regard to the applicable measures that must be reported under this satisfactory reporting criterion.

Comment: While several commenters generally supported our proposal to increase the number of measures to be reported via registry, the commenters urged CMS to provide a more gradual approach to increasing the number of measures that must be reported via registry. These commenters suggested requiring the reporting of either 4 measures covering at least 1 NQS domain, 5 measures covering at least 2 NQS domains, or 6 measures covering at least 2 NQS domains.

Response: We appreciate the commenters' support for our desire to increase the number of measures to be reported via registry, as well as their alternative suggestions on how to increase the number of measures to be reported via registry. While we agree that a more gradual increase in the number of measures to be reported may be necessary for purposes of meeting the criteria for satisfactory reporting for the 2016 PQRS payment adjustment, since 2016 would only be the second year in which an eligible professional could be subject to a PQRS payment adjustment, we do not believe this reasoning applies to satisfactory reporting criteria related to the 2014 PQRS incentive. For the 2014 PQRS incentive, as we stated with claims-based reporting, the PQRS program has provided incentives for satisfactory reporting since 2007, and we believe 6 years is a reasonable amount of time to allow eligible professionals to become familiar with the requirements for earning a PQRS incentive. In fact, eligible professionals have traditionally been successful in meeting the criteria for satisfactory reporting using the registry-based reporting mechanism. According to the 2011 PQRS and eRx Experience Report, 88 percent of eligible professionals reporting individual measures using the registry-based reporting mechanism in 2011 met the criteria for satisfactory reporting for the 2011 PQRS incentive. Therefore, our concerns on gradually phasing in an increased reporting threshold for the 2016 PQRS payment adjustment does not apply here with the 2014 PQRS incentive. We believe it is appropriate to increase the number of measures to be reported via registry from 3 measures covering 1 NQS domain to 9 measures covering 3 NQS domains for the 2014 PQRS incentive.

For the commenters' suggested alternative criteria, while we understand the commenters' concerns, we believe our interest in aligning the satisfactory reporting criteria of individual measures via registry with the satisfactory reporting criteria of individual measures via EHR for the 2014 PQRS incentive outweighs the need for a gradual increase in the number of measures required to be reported via registry.

For the reasons stated above, we are finalizing at § 414.90(h)(3) the following criterion for individual eligible professionals reporting individual PQRS quality measures via registry for the 2014 PQRS incentive: For the 12-month reporting period for the 2014 PQRS incentive, report at least 9 measures covering at least 3 of the NQS domains, OR, if less than 9 measures covering at least 3 NQS domains apply to the eligible professional, report 1–8 measures covering 1–3 NQS domains for which there is Medicare patient data, AND report each measure for at least 50 percent of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate will not be counted. For an eligible professional who reports fewer than 9 measures covering less than 3 NQS domains, the eligible professional would be subject to the MAV process, which would allow us to determine whether an eligible professional should have reported on additional measures and/or measures covering additional NQS domains.

c. Changes to the Criterion for Satisfactory Reporting of Measures Groups Via Claims for Individual Eligible Professionals for the 2014 PQRS Incentive

In the CY 2013 PFS final rule with comment period, we finalized the following criteria for satisfactory reporting for individual eligible professionals to report measures groups via claims: Report at least 1 measures group AND report each measures group for at least 20 Medicare Part B FFS patients. Measures groups containing a measure with a 0 percent performance rate will not be counted (77 FR 69192). Since finalizing this criterion, we published and analyzed the 2011 PQRS and eRx Experience Report, which provides a summary of PQRS reporting trends from 2007 through 2011, to determine where we may work to further streamline the reporting options available under the PQRS. The PQRS and eRx Experience Report stated that the number of eligible professionals who participated via claims-based measures groups reporting mechanism grew more than three-fold between 2008 and 2011. However, according to Appendix 8 of the PQRS and eRx Experience Report titled "Eligible Professionals who Participated by Reporting Measures Groups through the Claims Reporting Mechanism for the Physician Quality Reporting System, by Specialty (2008 to 2011)," only 4,472 eligible professionals used this reporting option. Meanwhile, the Experience Report further shows that the option to report measures groups via registry has grown at an even faster rate with 12,894 participants in 2011. Therefore, in an effort to streamline the reporting options available under the PQRS and to eliminate reporting options that are not widely used, we proposed to remove this satisfactory reporting criterion for the 2014 PQRS incentive (78 FR 43359). We solicited and received the following public comments on this proposal:

Comment: Some commenters supported our proposal to eliminate the option to report measures groups via claims for the 2014 PQRS incentive in an effort to streamline the reporting options available under the PQRS.

Response: We appreciate the commenters' feedback and are finalizing this proposal.

Comment: Several commenters opposed our proposal to eliminate the option to report measures groups via claims for the 2014 PQRS incentive. Commenters stressed the need to maintain the claims-based reporting option, as some commenters are weary that moving away from the claims-based

reporting mechanism will eliminate a free way to report quality measures under the PQRS (as most registries charge a fee to report PQRS quality measures data on behalf of its eligible professionals to CMS). Other commenters stressed the need to maintain a wide range of reporting options.

Response: We understand the commenters' desire to have free options to report under the PQRS. However, we do not believe it is necessary to maintain this reporting option, because an eligible professional may still use the free option of claims-based reporting to report individual quality measures for the 2014 PQRS incentive. In addition, we note that, while many qualified registries charge a fee for use of the registry, not all registries may charge a fee to use the registry to report quality measures for the PQRS. As you can see, although we are eliminating the option to report measures groups via claims, there are still ways to participate in the PQRS that are free.

For the commenters' desire to keep a wide range of PQRS reporting options available to eligible professionals, as we stated in the proposed rule (78 FR 43359), we simply do not see the need to keep this option available since this is not a widely used reporting option. We note that, although we are eliminating this reporting option, there are several other ways to participate in the PQRS either as an individual eligible professional or as part of a group practice under the GPRO. In fact, as we describe below, we are adding the option to earn a 2014 PQRS incentive based on an eligible professional's satisfactory participation in a qualified clinical data registry.

For the reasons stated above, we are finalizing our proposal to eliminate the following criteria for satisfactory reporting for individual eligible professionals to report measures groups via claims for the 2014 PQRS incentive: Report at least 1 measures group AND report each measures group for at least 20 Medicare Part B FFS patients. Measures groups containing a measure with a 0 percent performance rate will not be counted. Please note that, as a result of our final decision to remove this satisfactory reporting criterion, the only manner in which an eligible professional will be able to report PQRS measures groups are via registry.

5. Criteria for Satisfactory Reporting for the 2016 PQRS Payment Adjustment for Individual Eligible Professionals Using the Claims and Registry Reporting Mechanisms

Section 1848(a)(8) of the Act provides that for covered professional services furnished by an eligible professional during 2015 or any subsequent year, if the eligible professional does not satisfactorily report data on quality measures for covered professional services for the quality reporting period for the year, the fee schedule amount for services furnished by such professional during the year shall be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services. For 2016 and subsequent years, the applicable percent is 98.0 percent.

In the CY 2013 PFS final rule, we finalized seven different criteria for the satisfactory reporting by individual eligible professionals of data in PQRS quality measures for the 2016 PQRS payment adjustment (see 77 FR 69200–69204 and Table 91 at 77 FR 69194). In the proposed rule, we proposed (78 FR 43360) to eliminate two criteria, revise another, and include two additional criteria (based on two of the existing criteria).

Specifically, corresponding with our proposal (78 FR 43360) to eliminate a reporting criterion for the 2014 PQRS incentive to streamline the program and eliminate criteria for reporting options that are not widely used, we proposed to remove the following criterion we previously finalized for the CY 2016 payment adjustment for individual eligible professionals reporting measures groups through claims (77 FR 69200 and Table 91, 77 FR 69164): Report at least 1 measures group AND report each measures group for at least 20 Medicare Part B FFS patients (Measures groups containing a measure with a 0 percent performance rate will not be counted). We solicited and received the following public comments on this proposal:

Comment: Some commenters supported our proposal to eliminate the option to report measures groups via claims for the 2016 PQRS payment adjustment in an effort to streamline the reporting options available under the PQRS.

Response: We appreciate the commenters' feedback and, based on the commenters' support and the reasons stated above, are finalizing this proposal.

Comment: Several commenters opposed our proposal to eliminate the option to report measures groups via claims for the 2016 PQRS payment adjustment. Commenters stressed the need to maintain the claims-based reporting option, as some commenters are weary that moving away from the claims-based reporting mechanism will eliminate a free way to report quality measures under the PQRS (as most registries charge a fee to report PQRS quality measures data on behalf of its eligible professionals to CMS).

Response: Although we understand the commenters' desire to have free options to report under the PQRS, we do not believe it is necessary to maintain this reporting option, because, as is also the case for reporting for the 2014 PQRS incentive, an eligible professional may still use the free option of claims-based reporting to report individual quality measures for the 2016 PQRS payment adjustment. In addition, we note that, while many qualified registries charge a fee for use of the registry, not all registries may charge a fee to use the registry to report quality measures for the PQRS. Although we are finalizing our decition to eliminate the option to report measures groups via claims, there are still ways to participate in the PQRS that are free.

As for the commenters' desire to keep a wide range of PQRS reporting options available to eligible professionals, we simply do not see the need to keep this option available since this is not a widely used reporting option. We note that, although we are eliminating this reporting option, there are several other ways to participate in the PQRS either as an individual eligible professional or as part of a group practice under the GPRO. In fact, as we describe below, we are adding the option to avoid the 2016 PQRS payment adjustment based on an eligible professional's satisfactory participation in a qualified clinical data registry.

In summary, we are modifying § 414.90(j)(3) to reflect our final decision to eliminate the following criteria for satisfactory reporting for individual eligible professionals to report measures groups via claims for the 2016 PQRS payment adjustment: Report at least 1 measures group AND report each measures group for at least 20 Medicare Part B FFS patients. Measures groups containing a measure with a 0 percent performance rate will not be counted. Please note that, since we are removing this reporting criterion, the only manner under which an eligible professional would be able to report a PQRS measures group would be via registry.

We also proposed (78 FR 43360) to remove the following criterion we previously finalized for the 2016 PQRS payment adjustment for individual

eligible professionals reporting individual measures through a qualified registry: Report at least 3 measures, AND report each measure for at least 80 percent of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measures applies. Measures with a 0 percent performance rate will not be counted. We solicited and received the following public comments on this proposal:

Comment: While several commenters supported our proposal to increase the number of measures to be reported via registry, these commenters generally did not support eliminating this reporting criterion. Some commenters did not support eliminating this reporting criterion as eligible professionals have previously met the criteria for satisfactory reporting using this criterion and therefore do not want to modify they manner in which they report. Other commenters expressed concern that there are still eligible professionals who do not have 3 measures applicable to their practice. These commenters therefore suggested that this criterion be modified to require the reporting of only 1 measure covering 1 NQS domain for the 2016 PQRS payment adjustment, similar to the criterion that was finalized for the 2015 PQRS payment adjustment (77 FR 69201), as some commenters are concerned that there are still eligible professionals who do not have 3 measures applicable to their practice.

Response: We understand the commenters' concerns regarding eliminating this reporting criterion. Although we still desire to move towards the reporting of more measures, we understand that eligible professionals may need another year to adjust to the reporting of additional measures. We believe it is pertinent to allow time for eligible professionals to adjust to the reporting of additional measures for purposes of the 2016 PQRS payment adjustment as opposed to the 2014 PQRS incentive, because earning a 2014 PQRS incentive results in a positive payment adjustment whereas being subject to the 2016 PQRS payment adjustment results in a downward payment adjustment. Therefore, based on the concerns expressed by commenters, we are not finalizing our proposal to eliminate this reporting criterion for the 2016 PQRS payment adjustment. We note, however, that it is our intention to move towards the reporting of 9 measures covering at least 3 NQS domains for the 2017 PQRS payment adjustment.

Since we are maintaining this satisfactory reporting criterion under the PQRS, and given that, as noted above, we are finalizing our proposal to reduce the percentage threshold of reporting measures via registry for purposes of the 2014 PQRS incentive from 80 to 50 percent, we are finalizing the same change for this reporting criterion for the 2016 PQRS payment adjustment. That is, to coincide with the registry reporting criterion for the 2014 PQRS incentive, we are also lowering the percentage threshold for the reporting of measures at least 3 measures via registry for the 2016 PQRS payment adjustment from 80 to 50 percent. We do not believe this change negatively affects eligible professionals who intend to report using this reporting criterion as this modification reduces reporting burden on eligible professionals. In addition, we note that, since the percentage threshold for the 2014 PQRS incentive typically coincides with the percentage threshold for the 2016 PQRS payment adjustment, it was foreseeable that we would lower the percentage threshold of reporting measures via registry for the 2016 PQRS payment adjustment from 80 to 50 percent since we proposed to lower the percentage threshold for the 2014 PQRS incentive.

For the commenters' who expressed concern that there are still eligible professionals who do not have 3 measures applicable to their practice, we are further modifing this satisfactory reporting criterion to allow EPs to report 1–2 applicable measures if 3 measures are not applicable to the eligible professional. As a result, and consistent with the other similar criteria we are finalizing in this final rule with comment for the 2014 PQRS incentive, we will apply a registry MAV process for the 2016 PQRS payment adjustment. For purposes of this reporting criterion, the registry MAV process will be triggered when an eligible professional reports on less than 3 measures covering 1 NQS domain. For example, if an eligible professional reports on 1–2 measures, the MAV process will be triggered to determine whether an eligible professional could have reported on at least 3 measures covering 1 NQS domain.

This registry MAV process that will determine whether an eligible professional could have reported on more measures will be similar to the "clinical relation" test used in the 2013 claims MAV process. To get a better sense of how the registry MAV process for the 2016 PQRS payment adjustment will be implemented by CMS, a description of the "clinical relation" test in the current 2013 claims MAV process is available at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2013_PQRS_MeasureApplicabilityValidation_Docs_030413.zip*. Please note that we will post a guidance document on the registry MAV process for the 2016 PQRS payment adjustment, which will include a list of the measure clusters that are used for the "clinical relation" test, prior to January 1, 2014 (the start of the 2014 reporting periods).

In summary, for the reasons we noted above and in response to comments, we are not eliminating the following reporting criterion: Report at least 3 measures, AND report each measure for at least 80 percent of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measures applies. Measures with a 0 percent performance rate will not be counted. Instead, we are retaining this reporting criterion for the 2016 payment adjustment for individual eligible professionals reporting individual measures through a qualified registry but modifying this reporting criterion in the following manner: For the 12-month reporting period for the 2016 PQRS payment adjustment, report at least 3 measures covering at least 1 of the NQS domains, OR, if less than 3 measures apply to the eligible professional, report 1–2 measures covering 1 NQS domain for which there is Medicare patient data, AND report each measure for at least 50 percent of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted. For an eligible professional who reports fewer than 3 measures covering 1 NQS domain via the registry-based reporting mechanism, the eligible professional would be subject to the MAV process, which would allow us to determine whether an eligible professional should have reported on additional measures.

Finally, to maintain some consistency and to otherwise align with the criteria we proposed for the 2014 PQRS incentive for individual eligible professionals, we proposed two other criteria for satisfactory reporting by individual eligible professionals for the 2016 PQRS payment adjustment using the claims reporting mechanism (78 FR 43360). We proposed (78 FR 43360) the following criterion for reporting individual measures via claims by individual eligible professionals for the 2016 PQRS payment adjustment: For the 12-month reporting period for the 2014 PQRS incentive, report at least 9 measures, covering at least 3 of the National Quality Strategy domains, OR, if less than 9 measures covering at least

3 NQS domains apply to the eligible professional, report 1–8 measures, and report each measure for at least 50 percent of the Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted. We solicited and received the following comment on this proposed criterion:

Comment: One commenter stressed the importance of aligning the reporting criteria for the 2014 PQRS incentive with the reporting criteria for the 2016 PQRS payment adjustment, so that eligible professionals would be able to use one reporting option for the 2014 PQRS incentive and the 2016 PQRS payment adjustment.

Response: We appreciate the commenters' support regarding our desire to align reporting options for the 2014 PQRS incentive and 2016 PQRS payment adjustment. Based on the reasons previously stated and the positive feedback to align reporting options for the 2014 PQRS incentive and 2016 PQRS payment adjustment, we are finalizing the following criterion for reporting individual measures via claims by individual eligible professionals for the 2016 PQRS payment adjustment: Report at least 9 measures covering at least 3 NQS domains, OR, if less than 9 measures covering at least 3 NQS domains apply to the eligible professional, report 1–8 measures covering 1–3 NQS domains, AND report each measure for at least 50 percent of the Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted. For an eligible professional who reports fewer than 9 measures covering at least 3 NQS domains via the claims-based reporting mechanism, the eligible professional would be subject to the MAV process, which would allow us to determine whether an eligible professional should have reported quality data codes for additional measures and/or covering additional NQS domains.

With respect to an eligible professional who reports on less than 9 measures and/or covering less than 3 NQS domains, the eligible professional must report on ALL measures covering as many domains as are applicable to the eligible professional's practice. In other words, with respect to an eligible professional who does not have 9 measures covering 3 NQS domains to report, the EP must report 1–8 measures, as applicable, and hit the maximum number of domains. For example, if an eligible professional has only 7 measures covering at least 3 NQS domains applicable to the eligible professional's practice, the eligible professional must report on all 7 measures covering at least 3 NQS domains.

We also proposed (78 FR 43360) the following criterion for reporting individual measures via qualified registry by individual eligible professionals for the 2016 PQRS payment adjustment: For the 12-month reporting period for the 2016 PQRS payment adjustment, report at least 9 measures covering at least 3 of the NQS domains and report each measure for at least 50 percent of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted. We solicited and received the following public comment on this proposed criterion:

Comment: One commenter stressed the importance of aligning the reporting criteria for the 2014 PQRS incentive with the reporting criteria for the 2016 PQRS payment adjustment, so that eligible professionals would be able to use one reporting option for the 2014 PQRS incentive and the 2016 PQRS payment adjustment.

Response: We appreciate the commenters' feedback and are aligning reporting options for the 2014 PQRS incentive and 2016 PQRS payment adjustment to report individual measures via registry by individual eligible professionals.

Comment: The majority of commenters supported our proposal to decrease the percentage of patients that must be reported via registry from 80 percent to 50 percent. The commenters supported our proposal specifically because it aligns with the option to report individual measures via the claims-based reporting mechanism.

Response: We appreciate the commenters' feedback and, based on the support received and for the reasons stated in the proposed rule (78 FR 43360), we are finalizing this proposal with regard to the percent threshold. Therefore, to meet the criteria for satisfactory reporting for the 2016 PQRS payment adjustment, an eligible professional reporting individual quality measures via registry will be required to report each measure for at least 50 percent of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies.

Comment: One commenter stated that we should not align the PQRS reporting criteria for reporting mechanisms other than the EHR-based reporting mechanisms with the reporting criteria for the EHR Incentive Program, as the objectives for the two programs are different.

Response: We respectfully disagree. Although the standards and criteria for which the PQRS and EHR Incentive Program provide incentives and relieve eligible professionals from payment adjustments are different, the two programs are both dedicated to the promotion of EHR technology and the collection of quality data.

Comment: The majority of commenters opposed our proposal to increase the number of measures to be reported via registry from 3 measures covering 1 NQS domain to 9 measures covering 3 NQS domains. Several of these commenters generally opposed any proposal that would increase the number of measures to be reported via registry from 3 measures covering 1 NQS domain. Some of these commenters noted that they have been successful at meeting the criteria for satisfactory reporting in the PQRS via registry in the past, and increasing the number of measures to be reported via registry would make it more difficult for these eligible professionals to meet the criteria for satisfactory reporting for the 2016 PQRS payment adjustment. Other commenters urged CMS not to increase the criteria for satisfactory reporting until participation in PQRS increases, as the commenters feared that increasing the criteria for satisfactory reporting in PQRS would discourage eligible professionals from participating in the PQRS. Still some of these commenters opposing this proposal noted that certain eligible professionals did not have 9 measures covering 3 NQS domains for which to report. These commenters suggested requiring the reporting of either 4 measures covering at least 1 NQS domain, 5 measures covering at least 2 NQS domains, or 6 measures covering at least 2 NQS domains. Many of these commenters suggested requiring the reporting of only 1 measure covering 1 NQS domain for the 2016 PQRS payment adjustment, similar to the criterion that was finalized for the 2015 PQRS payment adjustment (*see* Table 91 at 77 FR 69194), as some commenters are concerned that there are still eligible professionals who do not have 3 measures applicable to their practice.

Response: We understand the commenters' concerns. As stated above, we are not finalizing our proposal to eliminate the option to report 3 measures covering 1 NQS domain (and further modifying it to allow the reporting of 1–2 meaures if 3 are not applicable). This should address some of the concerns raised regarding the

proposed satisfactory criterion described above regarding increasing and moving away from reporting 3 meausures. That also affords varying levels of reporting criteria from which to choose—particularly as participation increased. Therefore, eligible professionals will, at least for the 2016 PQRS payment adjustment, have the option to use an alternative, less stringent reporting criterion to generally report 3 individual quality measures for the 2016 PQRS payment adjustment via registry in lieu of this criterion.

As for this criterion and commenters' concerns about not having at least 9 PQRS measures covering 3 NQS domains, we are finalizing a modification to our proposal to allow eligible professionals to report fewer measures so that eligible professionals who do not have at least 9 PQRS measures or measures covering at least 3 NQS domains applicable to their practice. Specifically, if fewer than 9 measures covering less than 3 NQS domains apply to the eligible professional, an eligible professional must report 1–8 measures covering 1–3 NQS domains for which there is Medicare patient data. This is consisten with what we are finalizing with regard to certain 2014 PQRS incentive criteria. Similarly, the MAV process will be triggered when an eligible professional reports on less than 9 measures. For example, if an eligible professional reports on 8 measures covering 2 NQS domains, the MAV process will be triggered to determine whether an eligible professional could have reported on an additional measure to report on at least 9 measures covering 2 or 3 NQS domains.

In summary, we are finalizing at § 414.90(j)(3) the following criterion for reporting individual measures via qualified registry by individual eligible professionals for the 2016 PQRS payment adjustment: Report at least 9 measures covering at least 3 of the NQS domains, OR, if less than 9 measures covering at least 3 NQS domains apply to the eligible professional, report 1–8 measures covering 1–3 NQS domains for which there is Medicare patient data, AND report each measure for at least 50 percent of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate will not be counted. For an eligible professional who reports fewer than 9 measures, the eligible professional will be subject to the MAV process, which will allow us to determine whether an eligible professional should have reported on additional measures and/or measures covering additional NQS domains.

Please note that if an individual eligible professional were to meet any of the criteria for satisfactory reporting for the 2014 PQRS incentive, the individual eligible professional would meet the requirements for satisfactory reporting for the 2016 PQRS payment adjustment (note, however, that the reverse would not necessarily be true since there are additional criteria for satisfactory reporting for the 2016 PQRS payment adjustment that would not apply to the 2014 PQRS incentive). As we continue to implement the PQRS payment adjustment and fully implement the value-based payment modifier in 2017, it is our intent to ramp up the criteria for satisfactory reporting for the 2017 PQRS payment adjustment to be on par or more stringent than the criteria for satisfactory reporting for the 2014 PQRS incentive.

6. Satisfactory Participation in a Qualified Clinical Data Registry by Individual Eligible Professionals

Section 601(b) of the American Taxpayer Relief Act of 2012 (ATRA) (Pub. L. 112–240, enacted January 2, 2013) amends section 1848(m)(3) of the Act, by redesignating paragraph (D) as subparagraph (F) and adding new subparagraph (D), to provide for a new standard for individual eligible professionals to satisfy the PQRS beginning in 2014, based on satisfactory participation in a qualified clinical data registry. In the CY 2014 PFS proposed rule (78 FR 43360), we set forth our proposals for implementing this provision, including the proposed requirements for qualified clinical data registries and our proposals for individual eligible professionals to satisfactorily participate in a qualified clinical data registry for the 2014 PQRS incentive and 2016 PQRS payment adjustment. Below, we address the final requirements related to satisfactory participation in a qualified clinical data registry by individual eligible professionals.

a. Definition of a Qualified Clinical Data Registry

Under section 1848(m)(3)(D) of the Act, as amended and added by section 601(b)(1) of the ATRA, for 2014 and subsequent years, the Secretary shall treat an eligible professional as satisfactorily submitting data on quality measures if, in lieu of reporting measures under subsection (k)(2)(C), the eligible professional is satisfactorily participating, as determined by the Secretary, in a qualified clinical data registry for the year. Section 1848(m)(3)(E) of the Act, as added by section 601(b)(1) of the ATRA, authorizes the Secretary to define a qualified clinical data registry under the PQRS. Specifically, the Secretary is required to establish requirements for an entity to be considered a qualified clinical data registry (including that the entity provide the Secretary with such information, at such times, and in such manner, as the Secretary determines necessary to carry out the provision). In establishing such requirements, the Secretary must take certain factors into consideration.

Based on CMS' authority to define a qualified clinical data registry under section 1848(m)(3)(E) of the Act, as added by section 601(b) of the ATRA, and accounting for the considerations addressed in section 1848(m)(3)(E)(ii) of the Act and for the reasons stated in the CY 2014 PFS proposed rule (78 FR 43361), we proposed to modify § 414.90(b) to add a proposed definition for a qualified clinical data registry. Specifically, we proposed to define a "qualified clinical data registry" for purposes of the PQRS as a CMS-approved entity (such as a registry, certification board, collaborative, etc.) that collects medical and/or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care furnished to patients.

First, we proposed that a qualified clinical data registry must be able to submit quality measures data or results to CMS for purposes of demonstrating that, for a reporting period, its eligible professionals have satisfactorily participated in PQRS. We proposed that a qualified clinical data registry must have in place mechanisms for the transparency of data elements and specifications, risk models, and measures. We solicited and received the following public comment on this proposed aspect of the definition we proposed for a qualified clinical data registry:

Comment: Some commenters opposed our proposed requirement that an entity who seeks to become a qualified clinical data registry must be able to submit quality measures data or results to CMS for purposes of demonstrating that, for a reporting period, its eligible professionals have satisfactorily participated in PQRS. The commenters were generally opposed to requiring qualified clinical data registries to report on measures on behalf of its participating eligible professionals. These commenters believed that CMS should not require that a qualified clinical data registry be able to report on quality measures data if a clinical data

registry is able to perform other important functions, such as benchmarking.

Response: We appreciate the commenters' feedback but respectfully disagree. We believe possessing the ability to submit quality measures data to CMS is an essential, not optional, aspect of a qualified clinical data registry. We believe collecting quality measures data from a qualified clinical data registry is essential, particularly so that the data received could be compared against eligible professionals participating in PQRS using other reporting options to determine application of an upward, downward, or neutral adjustment under the Value-based Payment Modifier.

Second, with regard to the consideration under section 1848(m)(3)(E)(ii)(II) of the Act, as added by section 601(b) of the ATRA that allows the submission of data from participants for multiple payers, we proposed that the data a qualified clinical data registry submitted to CMS for purposes of demonstrating satisfactory participation be quality measures data on multiple payers, not just Medicare patients. We solicited and received the following public comment on this proposed aspect of our proposed definition of a qualified clinical data registry:

Comment: Several commenters supported our proposal to allow the reporting of quality measures data on multiple payers, not just Medicare patients.

Response: We appreciate the commenters' positive feedback and agree. Therefore, we are finalizing our proposal to include in the definition of a qualified clinical data registry the requirement that the data a qualified clinical data registry submitted to CMS for purposes of demonstrating satisfactory participation be quality measures data on multiple payers, not just Medicare patients.

Comment: Some commenters were weary of collecting quality measures data on multiple payers. One of the commenters expressed concern that this could compel eligible professionals to collect and submit to a qualified clinical data registry patient data on multiple payers with no plan for utilizing the non-Medicare data or informing other payers that quality measure data have been collected on their patients.

Response: We respectfully disagree with the commenters. Please understand that, although the PQRS is a pay-for-reporting program, the data collected under the PQRS is used to measure performance and the quality of care an eligible professional provides. In fact, as specified in this final rule, the data collected under the PQRS reported by qualified clinical data registries will be used to measure performance of certain eligible professionals under the Value-based Payment Modifier.

Third, with regard to the consideration under section 1848(m)(3)(E)(ii)(III) of the Act, as added by section 601(b) of the ATRA, that a qualified clinical data registry provide timely performance reports to participants at the individual participant level, we proposed that a qualified clinical data registry must provide timely feedback at least quarterly on the measures for which the qualified clinical data registry would report on the individual eligible professional's behalf for purposes of the eligible professional meeting the criteria for satisfactory participation under PQRS. We solicited and received the following public comment on this proposal:

Comment: Some commenters supported our proposal to require a qualified clinical data registry to provide timely feedback at least quarterly on the measures for which the qualified clinical data registry would report on the individual eligible professional's behalf for purposes of the eligible professional meeting the criteria for satisfactory participation under PQRS. However, other commenters expressed concern with this proposal, as it is costly and resource-intensive to provide quarterly feedback to all eligible professionals participating in a qualified clinical data registry. Some commenters requested clarification on the meaning of providing timely feedback at least quarterly on the measures for which the qualified clinical data registry would report on the individual eligible professional's behalf for purposes of the eligible professional meeting the criteria for satisfactory participation under PQRS. These commenters asked whether certain registries that allow users to generate reports on an "on demand" basis rather than directly pushing out feedback reports to its participate eligible professionals would meet the requirement of providing timely feedback at least quarterly to its eligible professionals.

Response: We appreciate the commenters' support, as well as concerns regarding this proposal. We understand the cost and resources a qualified clinical data registry would undergo to provide quarterly feedback to its participating eligible professionals. However, regardless of the cost, we believe that the ability to provide timely and frequent feedback to participating eligible professionals is critically important to fostering quality care. Please note that we currently require traditional qualified registries to provide at least 2 feedback reports to its participating eligible professionals per year. Since we view a qualified clinical data registry as an entity that is more robust than a traditional qualified registry and goes further to drive the quality of care provided to patients than only reporting quality measures data for the PQRS, we believe that requirements for an entity to become a qualified clinical data registry should be more stringent than the requirements for a registry to be qualified under the PQRS. Therefore, we believe that a qualified clinical data registry should provide its participating eligible professionals with more than 2 feedback reports each year in which the clinical data registry is qualified. While we will not require a qualified clinical data registry to provide quarterly feedback reports, we are still requiring that a qualified clinical data registry provide at least 4 feedback reports to each of its participating eligible professionals during the year in which the clinical data registry is qualified (that is, if a qualified clinical data registry is qualified to report quality measures data for reporting periods occurring in 2014, the qualified clinical data registry must provide each participating eligible professional with at least 4 feedback reports in 2014).

We understand that some entities do not directly send feedback reports to its participating eligible professionals. Rather, these entities have feedback reports that are readily available for viewing at any time via the web or other communication mechanism. As one commenter specified, certain registries allow users to generate reports on an "on demand" basis rather than directly pushing out feedback reports to its participating eligible professionals. We note that this would fulfill the requirement that an entity seeking to be a qualified clinical data registry provide each participating eligible professional with at least 4 feedback reports per year.

Fourth, to address section 1848(m)(3)(E)(ii)(IV) of the Act, as added by section 601(b) of the ATRA, regarding whether a qualified clinical data registry supports quality improvement initiatives for its participants, we proposed (78 FR 43362) to require that a qualified clinical data registry possess a method to benchmark the quality of care measures an eligible professional provides with that of other eligible professionals performing the same or similar functions. Benchmarking would require that a qualified clinical data registry provide

metrics to compare the quality of care its participating eligible professional provides. For example, the National Committee for Quality Assurance (NCQA) provides national and regional benchmarks for certain measures. Adopting benchmarks such as those provided by NCQA could serve to satisfy this requirement.

In addition to the comments received on our proposed definition of a qualified clinical data registry, we received the following general comments on the implementation of this new qualified clinical data registry option:

Comment: Several commenters supported the addition of the option to meet the criteria for satisfactory participation in a qualified clinical data registry for the PQRS. However, some commenters opposed this new option. Commenters were concerned that participation in a qualified clinical data registry requires considerable resources, ranging from subscription fees to the expertise of clinical personnel to abstract and report data.

Response: We understand the commenters' concerns regarding the expense of participating in a qualified clinical data registry. However, we note that it is voluntary for eligible professionals participate in the PQRS using a qualified clinical data registry. Rather, it is one of several reporting mechanisms that may be used to report quality measures data under the PQRS.

Comment: One commenter generally opposed the implementation of the option to satisfactorily participate in a qualified clinical data registry for purposes of the PQRS. The commenter stressed that adding another reporting option would add to the complexity of the program.

Response: We understand the commenters' concerns regarding adding complexity to the PQRS. Indeed, we have worked to streamline the PQRS to eliminate complexity in the program. However, under section 1848(m)(3)(D) of the Act, we are required to provide for a new standard for individual eligible professionals to satisfy the PQRS beginning in 2014, based on satisfactory participation in a qualified clinical data registry. Furthermore, we disagree with the commenter that this new qualified clinical data registry reporting option will add complexity to the PQRS, as this new option provides more flexibility than all other PQRS reporting options. For example, as explained in further detail in the PQRS measures section below, if reporting via a qualified clinical data registry, an eligible professional is not required to report on measures within the PQRS measure set.

In summary, we are amending § 414.90(b) to define a qualified clinical data registry as a CMS-approved entity that has self-nominated and successfully completed a qualification process that collects medical and/or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care provided to patients. A qualified clinical data registry must perform the following functions:

(1) Submit quality measures data or results to CMS for purposes of demonstrating that, for a reporting period, its eligible professionals have satisfactorily participated in PQRS. A qualified clinical data registry must have in place mechanisms for the transparency of data elements and specifications, risk models, and measures.

(2) Submit to CMS, for purposes of demonstrating satisfactory participation, quality measures data on multiple payers, not just Medicare patients

(3) Provide timely feedback, at least four times a year, on the measures at the individual participant level for which the qualified clinical data registry reports on the eligible professional's behalf for purposes of the individual eligible professional's satisfactory participation in the clinical quality data registry.

(4) Possess benchmarking capacity that measures the quality of care an eligible professional provides with other eligible professionals performing the same or similar functions.

Please note that it is possible for an entity to serve as both a traditional, qualified registry or a data submission vendor and a qualified clinical data registry under the PQRS.

b. Requirements for a Qualified Clinical Data Registry

As we noted above, we are required, under section 1848(m)(3)(E)(i) of the Act, to establish requirements for an entity to be considered a qualified clinical data registry. Such requirements shall include a requirement that the entity provide the Secretary with such information, at such times, and in such manner, as the Secretary determines necessary to carry out this subsection. Section 1848(m)(3)(E)(iv) of the Act, as added by section 601(b) of the ATRA, requires CMS to consult with interested parties in carrying out this provision.

Under this authority to establish the requirements for an entity to be considered a qualified clinical data registry, we proposed (78 FR 43362) the following requirements that an entity must meet to serve as a qualified clinical data registry under the PQRS:

Comment: Some commenters generally supported the stringent requirements we proposed for an entity to become a qualified clinical data registry.

Response: We appreciate the commenters' support for our proposals.

We proposed (78 FR 43362) the following requirements to ensure that the entity seeking to become a qualified clinical data registry is well-established:

- Be in existence as of January 1 the year prior to the year for which the entity seeks to become a qualified clinical data registry (for example, January 1, 2013, to be eligible to participate for purposes of data collected in 2014). This proposed requirement is also required of a traditional qualified registry.

We solicited and received the following public comments on this proposed requirement:

Comment: While some commenters generally supported this proposal as it help ensures that entities seeking to become qualified clinical data registries are established entities with experience in driving quality improvement in healthcare, a few commenters opposed our proposed requirement that, to become a qualified clinical data registry an entity must be in existence as of January 1 the year prior to the year for which the entity seeks to become a qualified clinical data registry (for example, January 1, 2013, to be eligible to participate for purposes of data collected in 2014). The commenters noted that this may alienate new and developing entities that already perform the functions required of a qualified clinical data registry.

Response: We understand that finalizing this requirement may exclude new entities that could perform the functions we require of a qualified clinical data registry. However, as we noted in the CY 2014 PFS proposed rule (78 FR 43362), we believe it is important for an entity to test out its business practices to ensure that the practices it adopts truly foster the improvement of quality care prior to seeking to become a qualified clinical data registry. We believe that entities that have been in existence for less than 1 year prior to the year for which the entity seeks to become a qualified clinical data registry have not had an adequate opportunity to do so. We believe our reasons for proposing this requirement outweigh the commenters' concerns. Therefore, we are finalizing this proposal. For an entity to become qualified for a given year, the entity must be in existence as of January 1 the year prior to the year

for which the entity seeks to become a qualified clinical data registry (for example, January 1, 2013, to be eligible to participate for purposes of data collected in 2014).

• Have at least 100 clinical data registry participants by January 1 the year prior to the year for which the entity seeks to submit clinical quality measures data (for example, January 1, 2013, to be eligible to participate under the program with regard to data collected in 2014). Please note that not all participants would be required to participate in PQRS (78 FR 43362).

We solicited and received the following public comments on this proposal:

Comment: Some commenters opposed this proposed requirement that an entity have at least 100 participants, because the commenters believe this requirement would effectively exclude smaller registries that perform important functions that provide for the advancement of quality care. Commenters felt that this proposed requirement unfairly favors larger entities that perform similar tasks.

Response: As we stated in the CY 2014 PFS proposed rule (78 FR 43362), we proposed this requirement to ensure that the entity seeking to become a qualified clinical data registry is sufficient in size and technical capability. Because we believe that a qualified clinical data registry should be more robust in technical capabilities than a traditional PQRS-qualified registry, we believe that a qualified clinical data registry should be sufficiently larger in size than a traditional PQRS-qualified registry, which is required to have at least 25 registry participants (77 FR 69179). Nonetheless, we understand the commenters' concerns. Although we do not believe we should drop the minimum threshold to 25, we believe it is reasonable to drop this proposed participation threshold to 50 participants. We believe that doubling the number of participants would ensure that the entities seeking to become qualified as a qualified clinical data registry would achieve our goal of attracting entities that are more robust in technical capabilities. In addition, we believe that the other requirements we are finalizing—such as the requirement that an entity seeking to become a qualified clinical data registry possess benchmarking capabilities—will help to ensure that an entity seeking to become a qualified clinical data registry is well established. Therefore, for an entity to become qualified for a given year, we are adopting the requirement that the entity must have at least 50 clinical data registry participants by January 1 the year prior to the year for which the entity seeks to submit clinical quality measures data (for example, January 1, 2013, to be eligible to participate under the program with regard to data collected in 2014). Please note that not all participants would be required to participate in PQRS.

Comment: One commenter requested that we only require that an entity seeking to become a qualified clinical data registry have at least 100 clinical data registry participants by January 1 the year in which the entity seeks to submit clinical quality measures data (for example, January 1, 2014, to be eligible to participate under the program with regard to data collected in 2014) rather than the year prior to which the entity seeks to submit clinical quality measures data, because the commenter believes that this sufficiently ensures the legitimacy of an entity while providing entities with more time to gain participants.

Response: We appreciate the commenter's feedback. However, as we are requiring that a entity be in existence as of the year prior to which the entity seeks to participate in the PQRS as a qualified clinical data registry, we believe it is important that an entity have at least 50 participants the year prior to which the entity seeks to submit clinical quality measures data (for example, January 1, 2013 to be eligible to participate under the program with regard to data collected in 2014) to ensure that the entity is adequately established to participate in the PQRS as a qualified clinical data registry prior to the start of the reporting periods occurring in 2014.

• Not be owned or managed by an individual, locally-owned, single-specialty group (for example, single-specialty practices with only 1 practice location or solo practitioner practices would be precluded from becoming a qualified clinical data registry) (78 FR 43362). We solicited and received the following public comment on this proposed requirement:

Comment: Some commenters supported this proposal, as it encouraged shared care across specialties and groups. However, one commenter opposed this proposal, as the commenter does not believe that a registry that covers patients within only a single group, even if multi-specialty or covering multiple states or regions, should meet the definition of a registry.

Response: We appreciate the commenter's support and, based on the commenters' support, are finalizing this requirement, as proposed.

In addition, for transparency purposes, we proposed (78 FR 43362) that a qualified clinical data registry must:

• Enter into and maintain with its participating professionals an appropriate Business Associate agreement that provides for the qualified clinical data registry's receipt of patient-specific data from the eligible professionals, as well as the qualified clinical data registry's public disclosure of quality measure results. We solicited and received the following public comment on this proposed requirement:

Comment: One commenter expressed concern with this proposed requirement, as the commenter believes that many registries will have to modify their business agreements to account for public disclosure of quality measure results.

Response: We understand the commenter's concerns on proposing to require that an entity's business agreement account for public disclosure of quality measure results. However, we believe that our desire for transparency in reporting outweighs the commenter's concerns. Therefore, we are finalizing this requirement, as proposed.

• Describe to CMS the cost for eligible professionals that the qualified clinical data registry charges to submit data to CMS (78 FR 43362). We solicited and received the following public comment on this proposed requirement:

Comment: One commenter supported this proposal.

Response: We appreciate the commenter's positive feedback and are finalizing this requirement, as proposed.

We also proposed (78 FR 43362) to require qualified clinical data registries to meet the following requirements pertaining to the transmission of quality measures data to CMS:

• To ensure that the qualified clinical data registry is compliant with applicable privacy and security laws and regulations, the entity must describe its plan to maintain Data Privacy and Security for data transmission, storage and reporting (78 FR 43362).

Comment: One commenter supported this proposal. Some commenters requested clarification as to how to successfully comply with certain security and privacy laws, as CMS has not provided specific guidance on how to maintain compliance with these laws.

Response: We understand the commenters' concerns regarding security and privacy laws related to the transmission of patient data. As addressing how to comply with applicable privacy and security laws and regulations is outside the scope of

this final rule, we are simply finalizing a requirement that an entity seeking to be a qualified clinical data registry comply with these laws. Therefore, we are not providing additional guidance on this proposed requirement. However, we would expect that in developing a plan to maintain data privacy and security for data transmission, storage, and reporting, qualified clinical data registries would assess the laws and regulations governing such requirements and incorporate appropriate safeguards into their plans. We are finalizing these requirements, as proposed.

• Comply with a CMS-specified secure method for quality data submission (78 FR 43362). We solicited and received the following public comment on this proposed requirement:

Comment: One commenter supported this proposal.

Response: We appreciate the commenter's positive feedback and are finalizing this requirement, as proposed.

• Provide information on each measure to be reported by an eligible professional, including a summary of supporting evidence/rationale, title, numerator, denominator, exclusions/exceptions, data elements and value sets in addition to measure level reporting rates, patient-level demographic data and/or the data elements needed to calculate the reporting rates by TIN/NPI (78 FR 43362). We solicited and received the following public comment on this proposed requirement:

Comment: While one commenter supported the collection of aggregate quality measures data, the commenter opposed providing to CMS specific information that this proposed requirement suggests as it is akin to requiring the reporting of patient-level data. The commenter requests clarification on this proposed requirement.

Response: Please note that this proposed requirement does not require reporting of patient-level data. Rather, this proposed requirement requires a qualified clinical data registry to provide the measure specifications on each measure to be reported by an eligible professional. For more information on what level of specificity is needed, please refer to the 2013 PQRS Measures List available at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html.* For the reasons we explained, and since we received no direct opposition to this proposal, are finalizing this requirement, as proposed.

• Submit an acceptable "validation strategy" to CMS by March 31 of the reporting year the entity seeks qualification (for example, if an entity wishes to become qualified for participation with regard to data collected in 2014, this validation strategy would be required to be submitted to CMS by March 31, 2014). A validation strategy would detail how the qualified clinical data registry will determine whether eligible professionals succeed in reporting clinical quality measures. Acceptable validation strategies often include such provisions as the entity being able to conduct random sampling of their participant's data, but may also be based on other credible means of verifying the accuracy of data content and completeness of reporting or adherence to a required sampling method (78 FR 43362). For a template for data validation and integrity, please also see the requirements for certification of an EHR product by the Office of the National Coordinator for Health Information Technology (ONC) that are explained at *http://www.healthit.gov/policy-researchers-implementers/2014-edition-final-test-method.*

Comment: Some commenters supported this proposed requirement. Other commenters requested clarification on the definition of an acceptable "validation strategy."

Response: Please note that, to maintain flexibility, we did not identify a specific validation strategy. Rather, we outlined what such a validation strategy would need to demonstrate—namely, to determine whether eligible professionals succeed in reporting clinical quality measures. Should entities wishing to become qualified clinical data registries for 2014 require additional guidance and to vet their strategies, CMS will provide guidance in subregulatory communication. Therefore, we are finalizing this proposal, as proposed.

• Perform the validation outlined in the strategy and send evidence of successful results to CMS by June 30 of the year following the reporting period (for example, June 30, 2015, for data collected in the reporting periods occurring in 2014) (78 FR 43363). We solicited and received the following public comment on this proposed requirement:

Comment: One commenter supported this proposed requirement.

Response: We appreciate the commenter's positive feedback and are finalizing this requirement, as proposed.

• Obtain and keep on file for at least 7 years signed documentation that each holder of an NPI whose data are submitted to the qualified clinical data registry has authorized the registry to submit quality measure results and numerator and denominator data and/or patient-specific data on beneficiaries to CMS for the purpose of PQRS participation. This documentation would be required to be obtained at the time the eligible professional signs up with the qualified clinical data registry to submit quality measures data to the qualified clinical data registry and would be required to meet any applicable laws, regulations, and contractual business associate agreements (78 FR 43363). We solicited and received the following public comment on this proposal:

Comment: One commenter supported this proposed requirement.

Response: We appreciate the commenter's positive feedback and are finalizing this requirement, as proposed.

• Upon request and for oversight purposes, provide CMS access to the qualified clinical data registry's database to review the beneficiary data on which the qualified clinical data registry-based submissions are based or provide to CMS a copy of the actual data (78 FR 43363). We solicited and received the following public comment on this proposal:

Comment: Several commenters opposed this proposed requirement, as the commenters fear that this would violate patient privacy laws. One of the commenters believes that both eligible professionals and their patients would be opposed to this proposed requirement, as it provides CMS access to patient-level data.

Response: CMS shares the commenters' interest in ensuring the protection of individually identifiable health information. As a HIPAA Covered Entity, the Medicare program fully intends to limit its data demands to the minimum data necessary to achieve a statistically valid audit of the registry's submissions. We believe that such disclosures are well within the Privacy Rule's provisions governing "oversight" disclosures. For the reasons stated previously, we are finalizing this requirement, as proposed.

• Prior to CMS posting the list of qualified clinical data registries for a particular year, verify the information contained on the list (includes names, contact information, measures, cost, etc.) and agree to furnish/support all of the services listed on the list (78 FR 43363). We solicited and received the following public comment on this proposal:

Comment: One commenter supported this proposed requirement.

Response: We appreciate the commenter's positive feedback and are finalizing this requirement, as proposed.

• Make available to CMS samples of patient level data to audit the entity for purposes of validating the data submitted to CMS by the qualified clinical data registry, if determined to be necessary (78 FR 43363). We proposed this requirement to be able to conduct audits on clinical data registries for oversight purposes.

Comment: Several commenters opposed this proposed requirement, as the commenters fear that this would violate patient privacy laws. One commenter opposed this proposed requirement as it is duplicative of the proposed requirement to submit a validation strategy to CMS.

Response: CMS is tasked with overseeing the appropriate dispersal of funds from the Medicare trust fund, including the funds issued as PQRS payment incentives or adjustments made to fee schedule payments, as a result of PQRS reporting via qualified clinical data registries. This oversight is achieved through auditing the records CMS receives that serve as the basis for an amount paid out of the trust fund. CMS intends to exercise its oversight authority in full conformance with the HIPAA Privacy Rule's provisions governing an oversight authority's access to the data to carry out their oversight functions.

With respect to the commenter who believes that this proposed requirement is unnecessary as it is duplicative of the proposed requirement to submit a validation strategy to CMS, we disagree. We are finalizing the requirement to submit a validation strategy to CMS so that CMS can determine whether the validation strategy used is sufficient to help ensure that accurate data is submitted to CMS. Although we proposed both requirements for oversight purposes, the requirement to make available to CMS samples of patient level data to audit the entity for purposes of validating the data submitted to CMS by the qualified clinical data registry, if determined to be necessary, would require more specific data to be made available to CMS. We note that, in all cases, we are requiring entities wishing to become qualified clinical data regsitries to submit its validation strategy to CMS, whereas we would only require that data be made available under this requirement only "if necessary." For the reasons stated previously, we are finalizing this requirement, as proposed.

• The entity must provide information on how the entity collects quality measurement data, if requested (78 FR 43363). We solicited and received the following public comment on this proposal:

Comment: One commenter supported this proposed requirement.

Response: We appreciate the commenter's positive feedback and are finalizing this requirement, as proposed.

• By March 31 of the year in which the entity seeks to participate in PQRS as a qualified clinical data registry, the entity must publically post (on the entity's Web site or other publication available to the public) a detailed description (rationale, numerator, denominator, exclusions/exceptions, data elements) of the quality measures it collects to ensure transparency of information to the public (78 FR 43363). We solicited and received the following public comment on this proposed requirement:

Comment: One commenter opposed the proposed March 31 deadline for an entity seeking to participate in the PQRS as a qualified clinical data registry to publically post a detailed description (rationale, numerator, denominator, exclusions/exceptions, data elements) of the quality measures it collects to ensure transparency of information to the public. The commenter requested that this deadline be extended to June 1 of the year in which the entity seeks to participate in the PQRS as a qualified clinical data registry to allow time for these entities to prepare its measures for submission under this new reporting mechanism.

Response: We understand the commenter's concerns regarding the March 31 deadline. However, it is not technically feasible to accept this information later than the proposed March 31 deadline, as CMS must have time to be able to analyze the measure to determine how the measures data would be captured by CMS. Therefore, we are finalizing this requirement, as proposed.

• The entity must report, on behalf of its individual eligible professional participants, a minimum of 9 measures that cross 3 NQS domains (78 FR 43363). We solicited but received no public comment on this proposed requirement, as most comments were more specifically directed to our proposed criteria for satisfactory participation in a qualified clinical data registry for the 2014 PQRS incentive and 2016 PQRS payment adjustment, which we address below. However, since, as we specify below, we are not allowing a qualified clinical data registry to report less than 9 measures covering 3 NQS domains if less than 9 measures are applicable to its eligible professional participants, we are modifying this requirement in the following manner: the entity must report, on behalf of its individual eligible professional participants, a minimum of 9 measures that cross 3 NQS domains.

• The entity, on behalf of its individual eligible professional participants, must report on at least one outcomes-based measure (defined in this section below) (78 FR 43363). We solicited and received the following public comment on this proposed requirement (please note that most comments related to this proposed requirement were more specifically directed to our proposed criteria for satisfactory participation in a qualified clinical data registry for the 2014 PQRS incentive and 2016 PQRS payment adjustment):

Comment: One commenter supported this proposal as it furthers our focus on quality improvement. Other commenters requested clarification as to the definition of an outcome measure and requested that certain measures be considered outcome measures for purposes of reporting these measures for the PQRS via a qualified clinical data registry.

Response: We appreciate the commenter's feedback and are finalizing this requirement, as proposed. Please note that we further clarify the definition of an outcome measure in the section below that describes the final parameters surrounding the measures for which a qualified clinical data registry may report for purposes of the PQRS.

• The entity, on behalf of its individual eligible professional participants, must report on a set of measures from one or more of the following categories: CG–CAHPS; NQF endorsed measures (information of which is available at *http://www.qualityforum.org/Home.aspx*); current PQRS measures; measures used by boards or specialty societies; and measures used in regional quality collaboratives (78 FR 43363). We solicited and received the following public comment on this proposed requirement:

Comment: One commenter supported this proposal as it furthers our focus on quality improvement.

Response: We appreciate the commenter's feedback and are finalizing this requirement, as proposed.

• The entity must demonstrate that it has a plan to publicly report its quality data through a mechanism where the public and registry participants can view data about individual eligible professionals, as well as view regional and national benchmarks. As an alternative, we considered requiring that the entity must benchmark within its own registry for purposes of

determining relative quality performance where appropriate (78 FR 43363).

We solicited and received the following public comments on this proposal:

Comment: Several commenters opposed this proposed requirement, claiming that publicly reporting measures would be very costly to an entity. The commenters also stated that, if the entity did not already have an existing plan to publicly report measures, it would take entities a significant amount of time (over a year) to establish a plan to publicly report its measures.

Response: We understand the commenters' concerns regarding the cost, time, and other expenses associated with publicly reporting quality measures data. Please note that CMS only proposed that an entity demonstrate that a plan be developed, but did not explicitly propose that an entity wishing to become a qualified clinical data registry publicly report measures in 2014. Rather, as a first step, CMS was merely proposing that the entity have a plan in place to eventually publicly report their quality measures data. Regardless, due to the commenters' concerns, we are not finalizing this proposal at this time. We note, however, that CMS encourages these qualified clinical data registries to move towards the public reporting of quality measures data. We plan to establish such a requirement in the future and will revisit this proposed requirement as part of CY 2015 rulemaking.

- The entity must demonstrate that it has a plan to risk adjust the quality measures data for which it collects and intends to transmit to CMS, where appropriate. Risk adjustment has been described as a corrective tool used to level the playing field regarding the reporting of patient outcomes, adjusting for the differences in risk among specific patients (*http://www.sts.org/patient-information/what-risk-adjustment*). Risk adjustment also makes it possible to compare performance fairly. For example, if an 86 year old female with diabetes undergoes bypass surgery, there is less chance for a good outcome when compared with a relatively healthier 40 year old male undergoing the same procedure. To take factors into account which influence outcomes, for example, advanced age, emergency operation, previous heart surgery, a risk adjustment model is used to report surgery results (78 FR 43363).

Comment: Several commenters supported this proposal as the commenters believe that risk adjustment is a critical component to ensure that the quality measures data submitted to CMS provides an accurate picture of the quality of care the eligible professional provides to its patients. Several other commenters, however, opposed the proposed requirement that the entity be required to demonstrate that it has a plan to risk adjust. While the commenters recognize that risk adjustment is a critical component of quality measurement, the commenters do not believe it should be a requirement for qualified clinical data registries currently since it is a resource intensive task and one for which there is no single proven model to ensure accuracy.

Response: We understand the costs associated with risk adjustment. However, we note that several comments responding to the Request for Information titled "Medicare Program; Request for Information on the Use of Clinical Quality Measures (CQMs) Reported Under the Physician Quality Reporting System (PQRS), the Electronic Health Record (EHR) Incentive Program, and Other Reporting Programs" (at 78 FR 9057) stressed the need to risk adjust quality measures data, and we agree. We believe this is especially important as the quality data submitted to CMS by qualified clinical data registries will be used to assess physician performance under the Value-based Payment Modifier. Therefore, for the reasons stated above, we are finalizing this proposal.

Please note that we are only requiring that the entity have a plan to risk adjust measures for which risk adjustment may be appropriate. If an entity has a plan to risk adjust its measures, we strongly encourage that this plan be made available to the public (such as having it posted on the entity's Web site). Please note that there are certain measures, such as process measures that only indicate the processes taken when performing a service, for which risk adjustment may not be appropriate.

Should CMS find, pursuant to an audit, that a qualified clinical data registry has submitted inaccurate data, CMS also proposed (78 FR 43363) to disqualify the qualified clinical data registry, meaning the entity would not be allowed to submit quality measures data on behalf of its eligible professionals for purposes of meeting the criteria for satisfactory participation for the following year. Should an entity be disqualified, we proposed that the entity must again become a qualified clinical data registry before it may submit quality measures data on behalf of its eligible professionals for purposes of the individual eligible professional participants meeting the criteria for satisfactory participation under the PQRS. Additionally, we proposed that the inaccurate data collected would be discounted for purposes of an individual eligible professional meeting the criteria for satisfactory participation in a qualified clinical data registry. We sought and received the following public comments on these proposals.

Comment: Some commenters opposed our proposal not to allow a qualified clinical data registry to re-submit quality measures data on behalf of its eligible professionals if CMS discovers the qualified clinical data registry has submitted inaccurate data. The commenters believe that this proposal unnecessarily and negatively affects eligible professionals' success in the PQRS.

Response: We understand the commenters' concerns. However, it is not feasible to accept data later than the last Friday of the February immediately following the end of the respective reporting period (that is, February 27, 2015 for reporting periods occurring in 2014) and still be able to analyze the data in time to assess whether an eligible professional should be assessed a payment adjustment. Therefore, we are finalizing our proposal not to allow a qualified clinical data registry to re-submit quality measures data on behalf of its eligible professionals if CMS discovers the qualified clinical data registry has submitted inaccurate data, as proposed. We note that this limitation is consistent with other rules for reporting quality measures data via a qualified registry, a direct EHR product, or the EHR data submission vendor.

In summary, we are finalizing our proposals related to disqualification of a qualified clinical data registry, as proposed.

As we noted, section 1848(m)(3)(E)(i) of the Act, as added by section 601(b) of the ATRA, requires us to establish requirements for an entity to be considered a qualified clinical data registry, including that the entity provide us with such information, at such times, and in such manner, as we determine necessary to carry out the provision. Given the broad discretion afforded under the statute, we proposed that qualified clinical data registries provide CMS with the quality measures data it collects from its eligible professional participants. We believe it is important that a qualified clinical data registry provide such data for a number of reasons. As we discuss in greater detail below, we believe such information is necessary for purposes of

determining whether individual eligible professionals have satisfactorily participated in a clinical qualified data registry under the PQRS. In addition, we proposed (78 FR 43485) to use the quality measures data reported under the PQRS to assess eligible professionals with regard to applying the value-based payment modifier in an upward, downward, and neutral adjustment to an eligible professional's Medicare Part B PFS charges. Therefore, we proposed to require that qualified clinical data registries submit quality measures data to CMS (78 FR 63363–43364). Specifically, to further ensure that the quality measures data elements are reported to CMS in a standardized manner, we proposed to require that qualified clinical data registries be able to collect all needed data elements and transmit the data on quality measures to CMS, upon request, in one of two formats, either via a CMS-approved XML format or via the Quality Reporting Document Architecture (QRDA) category III format. The CMS-approved XML format is consistent with how traditional qualified registries under the PQRS transmit data on quality measures to CMS. Although our preference would be to receive data on quality measures via the QRDA category III format only, since the QRDA category III format is one of the formats we require for an EP's EHR or an EHR data submission vendor to submit quality measures data (see 77 FR 69183), we noted that we understood that the quality measures data collected by qualified clinical data registries vary and that these qualified clinical data registries may not be equipped to submit quality measures data to CMS using the QRDA category III format. We stated that in future years, it was our intention to require all qualified clinical data registries to provide quality measures data via the QRDA category III format.

We solicited and received the following public comments on our proposal to accept quality measures data from a qualified clinical data registry in one of two formats, either via a CMS-approved XML format or via the QRDA category III format:

Comment: Several commenters supported our proposal to accept quality measures data in a CMS-approved XML format. Some commenters suggested clarification as to whether an qualified clinical data registry would have to be able to separate the reporting of Medicare vs. non-Medicare patients when submitting quality measures data to CMS.

Response: We appreciate the commenters' support, and based on the comments received and for the reasons stated above, are finalizing our proposal to accept quality measures data from a qualified clinical data registry in a CMS-approved XML format. Please note that CMS will not require the qualified clinical data registry submitting quality measures data on an eligible professional's behalf to separate the reporting of measures on the eligible professional's Medicare vs. non-Medicare patients.

Comment: Several commenters supported our proposal to accept quality measures data via the QRDA category III format, as this aligns with the format accepted under the EHR Incentive Program.

Response: We appreciate the commenters' feedback. However, after exploring the technological capabilities of our analysis systems, we have discovered that it is not technically feasible to accept quality measures data via a QRDA III format other than the electronically specified clinical quality measures (eCQMs) that may be reported to meet the CQM component of meaningful use under the EHR Incentive Program in 2014. In the future, we hope to further develop our analysis systems so that we are capable of accepting quality measures data via the QRDA category III format for additional measures. Therefore, for the reasons stated previously and based on the comments received, we are finalizing our proposal to accept quality measures data via the QRDA category III format exclusively for the 64 eCQMs that may be reported to meet the CQM component of meaningful use under the EHR Incentive Program in 2014 that are also reportable under the PQRS in 2014. We are finalizing the option to submit quality measures data via the QRDA category III format exclusively for the 64 eCQMs that may be reported to meet the CQM component of meaningful use under the EHR Incentive Program in 2014 because, unlike potential non-PQRS measures that may be reported by eligible professionals in a qualified clinical data registry, we are already able to analyze the measures specifications for these measures. Since we do not currently have the measures specifications for the non-PQRS measures that will be submitted via a qualified clinical data registry, it is not feasible to test these measures to determine whether we are able to accept these measures data in a QRDA category III format.

To ensure that the data provided by the qualified clinical data registry is correct, we proposed to require that qualified clinical data registries provide CMS a signed, written attestation statement via email which states that the quality measure results and any and all data including numerator and denominator data provided to CMS are accurate and complete (78 FR 43364). We solicited and received the following public comment on this proposal:

Comment: One commenter supported this proposed requirement.

Response: We appreciate the commenter's feedback and, based on the comments received and for the reasons stated above, are therefore finalizing this requirement, as proposed.

We proposed (78 FR 43364) that, regardless of whether the eligible professional uses the XML or QRDA III format to report quality measures data to CMS, the qualified clinical data registry would be required to submit this data no later than the last Friday occurring 2 months after the end of the respective reporting period (that is, February 27, 2015 for reporting periods occurring in 2014). We also proposed that, if a qualified clinical data registry is submitting quality measures data on behalf of individual eligible professionals that are part of the same group practice (but not participating in the PQRS GPRO), the qualified clinical data registry would have the option to report the quality measures data to CMS in a batch containing data for each of the individual eligible professionals within the group practice, rather than submitting individual files for each eligible professional (78 FR 43364). We solicited and received the following public comment on this proposal:

Comment: Some commenters requested that qualified clinical data registries be given more time to submit quality measures data to CMS, particularly since the qualified clinical data registry reporting mechanism is new. Some of these commenters requested that we extend the deadline to March 31 following the end of the respective reporting period (that is, March 31, 2015 for reporting periods occurring in 2014), at least for the first year in which a qualified clinical data registry must submit quality measures data to CMS.

Response: We appreciate the commenters' concerns. However, it is not technically feasible to accept quality measures data from qualified clinical data registries any later than the last Friday occurring 2 months after the end of the respective reporting period (that is, February 27, 2015 for reporting periods occurring in 2014). The additional time is needed to complete a thorough analysis of the submitted data prior to the application of the 2016 PQRS payment adjustment. Therefore, we are finalizing our proposal that a qualified clinical data registry would be

required to submit this data no later than the last Friday occurring 2 months after the end of the respective reporting period (that is, February 27, 2015 for reporting periods occurring in 2014), as proposed.

In conjunction with our proposal to require that qualified clinical data registries be able to provide data on quality measures in a CMS-approved XML format, we proposed to require that qualified clinical data registries report back to participants on the completeness, integrity, and accuracy of its participants' data (78 FR 43364). We believe that it would be beneficial to the participants to receive feedback on the data transmission process so that the participants are aware of any inaccuracies transmitted to CMS. We solicited and but received no public comment on this proposal. Therefore, we are finalizing this requirement, as proposed.

Alternatively, for the information CMS would require a qualified clinical data registry to furnish to CMS to determine that the eligible professionals have met the criteria for satisfactory participation for the 2014 PQRS incentive and 2016 PQRS payment adjustment, in lieu of accepting quality measures data for reporting periods occurring in 2014 only, we considered proposing (78 FR 43364) that a qualified clinical data registry provide CMS with a list of the eligible professionals (containing the respective eligible professionals' TIN/NPI information) who participated in and reported quality data to the qualified clinical data registry to determine which individual eligible professionals met the criteria for satisfactory participation for the 2014 PQRS incentive and 2016 PQRS payment adjustment. We considered this alternative because we do not have experience collecting data from qualified clinical data registries, we are unfamiliar with the type of quality data qualified clinical data registries collect, and we are still building out our data infrastructure. We solicited and received the following public comment on this alternative:

Comment: Several commenters preferred requiring a qualified clinical data registry provide CMS with a list of the eligible professionals (containing the respective eligible professionals' TIN/NPI information) who participated in and reported quality data to the qualified clinical data registry to determine which individual eligible professionals met the criteria for satisfactory participation for the 2014 PQRS incentive and 2016 PQRS payment adjustment in lieu of submitting actual quality measures data. Some of the commenters were concerned that a qualified clinical data registry seeking to participate in the PQRS would not be able to submit actual quality measures data to CMS in 2014, as the entities would not have enough time to adjust its systems to submit quality measures data in this initial year.

Response: We appreciate the commenters' feedback and understand the tight timeline that must be adhered to for a qualified clinical data registry to submit quality measures data to CMS for the 12-month reporting period occurring in 2014 for the 2014 PQRS incentive and 2016 PQRS payment adjustment. However, as for the reasons we noted above, we believe it is important to collect such data under the PQRS. Additionally, we note that for the Value-based Payment Modifier, which is based off of data submitted via the PQRS, to be able to accurately compare performance in the PQRS across eligible professionals, it is necessary to receive actual quality measures data from qualified clinical data registries. Therefore, we are not adopting this alternative.

Please note that we will post additional guidance and information on the requirements to become a qualified clinical data registry, as well as information on how a qualified clinical data registry will submit quality measures data for reporting periods occurring in 2014 on the PQRS Web site at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html.*

c. Process for Being Designated as a Qualified Clinical Data Registry

Section 1848(m)(3)(E)(v) of the Act, as added by section 601(b) of the ATRA, requires the Secretary to establish a process to determine whether or not an entity meets the requirements established under section 1848(m)(3)(E)(i) of the Act. Such process may involve one or both of the following: (I) A determination by the Secretary; (II) A designation by the Secretary of one or more independent organizations to make such determination. This section sets forth our proposals for our process to determine whether or not an entity should be designated as a qualified clinical data registry.

Consistent with what we require of traditional qualified registries under the PQRS, we proposed that an entity must submit a self-nomination statement that indicates its intent to participate in PQRS as a qualified clinical data registry (78 FR 43364). We believe this self-nomination statement is necessary for CMS to anticipate how many clinical data registries would participate for a certain year, as well as provide information to eligible professionals about potential participating clinical data registries. We proposed that the self-nomination statement contain the following information:

- The name of the entity seeking to become a qualified clinical data registry.
- The entity's contact information, including phone number, email, and mailing address.
- A point of contact, including the contact's email address and phone number, to notify the entity of the status of its request to be considered a qualified clinical data registry.
- The measure title, description, and specifications for each measure the qualified clinical data registry would require its eligible professionals to report for purposes of participating in PQRS. In addition, the qualified clinical data registry must describe the rationale and evidence basis to support each measure it would require its eligible professionals to report.
- The reporting period start date the entity will cover as a clinical data registry.

Since we believe that accepting these statements via email would be the most efficient method for collecting and processing self-nomination statements, we proposed to accept self-nomination statements via email only (78 FR 43364). However, in the event that it is not technically feasible to collect this self-nomination statement via email, we proposed that entities seeking to become qualified clinical data registries submit its self-nomination statement via a mailed letter to CMS. The self-nomination statement would be mailed to the following address: Centers for Medicare & Medicaid Services, Center for Clinical Standards and Quality, Quality Measurement and Health Assessment Group, 7500 Security Boulevard, Mail Stop S3–02–01, Baltimore, MD 21244–1850.

To ensure that CMS is able to process these self-nomination statements as early as possible, we proposed (78 FR 43364) that these self-nomination statements must be received by CMS by 5:00 p.m. Eastern Standard Time (e.s.t.) on January 31 of the year in which the clinical data registry seeks to be qualified (that is, January 31, 2014 for purposes of becoming a qualified clinical data registry for the reporting periods for the 2014 PQRS incentive and 2016 PQRS payment adjustment). We indicated that we anticipated posting a list of the entities that are designated by CMS as qualified clinical

data registries in fall of the same year (78 FR 43365).

Since participation in a qualified clinical data registry is a new option for individual eligible professionals, we stated that we anticipated making changes to the requirements for becoming a qualified clinical data registry in future rulemaking as we gain more experience with this option. Since we believe it is important that the entity keep up with these changes, at this time, we proposed that entities seeking to serve as qualified clinical data registries must self-nominate for each year that the entity seeks to participate (78 FR 43365). In the future, we noted we anticipated moving towards a multi-year self-nomination process as the requirements for qualified clinical data registries become firmly established; however, at this time, we proposed self-nomination for any year in which a qualified clinical data registry intends to participate under the PQRS.

We solicited and received the following public comment on these proposals:

Comment: Some commenters opposed our proposed deadline to receive self-nomination statements by January 31 of the year in which the clinical data registry seeks to be qualified. These commenters believed that this proposed deadline did not provide entities with enough time to decide whether they should seek to become a qualified clinical data registry, particularly since the final requirements for an entity to become a qualified clinical data registry would not be made available until the CY 2014 PFS final rule with comment period is displayed (approximately November 2013).

Response: We understand the commenters' concerns. However, as it is the first year in which this reporting mechanism will be implemented, it is not feasible to accept self-nomination statements later than Jaunary 31 of the year in which an entity seeks to become a qualified clinical data registry. CMS needs sufficient time to allow system updates to accommodate entities seeking to be qualified clinical data registries as well as work with entities who are seeking to become qualified clinical data registries. Therefore, we are finalizing our proposed deadline to receive self-nomination statements from entities wishing to become qualified clinical data registry by 5:00 p.m. (e.s.t.) on January 31 of the year in which the clinical data registry seeks to be qualified (that is, January 31, 2014 for purposes of becoming a qualified clinical data registry for the reporting periods for the 2014 PQRS incentive and 2016 PQRS payment adjustment), as proposed.

Comment: Some commenters generally supported the proposed self-nomination process for entities wishing to become qualified as a qualified clinical data registry.

Response: We appreciate the commenters' response and, for the reasons stated above and based on the comments received, are finalizing this proposed process for being designated as a qualified clinical data registry, as proposed.

d. Reporting Period for the Satisfactory Participation by Individual Eligible Professionals in a Qualified Clinical Data Registry for the 2014 PQRS Incentive

Section 1848(m)(3)(D) of the Act, as redesignated and added by section 601(b) of the ATRA, authorizes the Secretary to treat an individual eligible professional as satisfactorily submitting data on quality measures under section 1848(m)(A) of the Act if the eligible professional is satisfactorily participating in a qualified clinical data registry for the year. Given that satisfactory participation is with regard to the year, and to provide consistency with the reporting period applicable to individual eligible professionals who report quality measures data under section 1848(m)(3)(A), we proposed to modify § 414.90(c)(5) to specify a 12-month, calendar year (CY) reporting period from January 1, 2014 through December 31, 2014 for individual eligible professionals to satisfactorily participate in a qualified clinical data registry for purposes of the 2014 PQRS incentive (78 FR 43365). We invited and received the following public comment on the proposed 12-month, CY 2014 reporting period for the satisfactory participation of individual eligible professionals in a qualified clinical data registry for the 2014 PQRS incentive:

Comment: Some commenters provided general suggestions to align reporting periods for various CMS quality reporting programs wherever possible.

Response: We agree with the commenters. In fact, the proposed 12-month, CY 2014 reporting period for the satisfactory participation of individual eligible professionals in a qualified clinical data registry for the 2014 PQRS incentive aligns with the 12-month CY 2014 reporting period for meeting the criteria for satisfactory reporting for the 2014 PQRS incentive. Therefore, we are adding paragraph § 414.90(i)(1) to specify a 12-month, CY 2014 reporting period for the satisfactory participation of individual eligible professionals in a qualified clinical data registry for the 2014 PQRS incentive, as proposed.

e. Criteria for Satisfactory Participation for Individual Eligible Professionals in a Qualified Clinical Data Registry for the 2014 PQRS Incentive

For 2014, in accordance with § 414.90(c)(3), eligible professionals that satisfactorily report data on PQRS quality measures are eligible to receive an incentive equal to 0.5 percent of the total estimated Medicare Part B allowed charges for all covered professional services furnished by the eligible professional or group practice during the applicable reporting period. Section 1848(m)(3)(D) of the Act, as redesignated and added by section 601(b) of the ATRA, authorizes the Secretary to treat an individual eligible professional as satisfactorily submitting data on quality measures under section 1848(m)(A) of the Act if, in lieu of reporting measures under section 1848(k)(2)(C) of the Act, the eligible professional is satisfactorily participating in a qualified clinical data registry for the year. "Satisfactory participation" is a new standard under the PQRS and is a substitute for the underlying standard of "satisfactory reporting" data on covered professional services that eligible professionals must meet to earn a PQRS incentive or avoid the PQRS payment adjustment. Therefore, we proposed to modify § 414.90 to add paragraph (c)(5) to indicate that individual eligible professionals shall be treated as satisfactorily reporting data on quality measures if individual eligible professionals satisfactorily participate in a qualified clinical data registry for purposes of the PQRS incentive (78 FR 43365). We solicited but received no public comment on this proposal. Therefore, we are finalizing our proposal to modify § 414.90 to add paragraph (c)(5) to indicate that individual eligible professionals shall be treated as satisfactorily reporting data on quality measures if individual eligible professionals satisfactorily participate in a qualified clinical data registry for purposes of the PQRS incentive, as proposed.

In addition, to establish a standard for satisfactory participation in a qualified clinical data registry, we proposed that, to meet the criteria for satisfactory participation for the 2014 PQRS incentive, an individual eligible professional would be required to: For the 12-month 2014 reporting period, report at least 9 measures available for reporting under the qualified clinical data registry covering at least 3 of the NQS domains, OR, if less than 9

measures apply to the eligible professional, report 1–8 measures, AND report each measure for at least 50 percent of the eligible professional's applicable patients. Of the measures reported via a qualified clinical data registry, the eligible professional must report on at least 1 outcome measure (78 FR 43365). We solicited and received the following public comment for these proposals:

Comment: Several commenters opposed our proposal to require that, of the measures reported via a qualified clinical data registry, the eligible professional must report on at least 1 outcome measure. Some of these commenters noted that, there are many specialties for which outcomes measures may not yet be available, hindering these specialties from participating in the PQRS via a qualified clinical data registry.

Response: We understand that certain specialties may not have outcome measures for which they may report. However, we believe it is important to emphasize the reporting of outcomes measures, as we believe they provide better metrics in the quality of care an eligible professional provides than process measures do. To encourage the reporting of outcome measures, we are therefore finalizing our proposal to require that, of the measures reported via a qualified clinical data registry to meet the criteria for satisfactory participation in a qualified clinical data registry for the 2014 PQRS incentive, the eligible professional must report on at least 1 outcome measure.

Comment: Several commenters supported our proposal to require that an eligible professional report each measure for at least 50 percent of the eligible professional's applicable patients. The commenters supported our proposal specifically because it aligns with the option to report individual measures via the claims-based reporting mechanism. One commenter, however, opposed this proposal. Instead, the commenter suggested that CMS allow a qualified clinical data registry to submit its verifiable, statistically supported sampling methodology to CMS for review and require eligible professionals to report a sufficient number of cases as determined by the individual registry's sampling requirements.

Response: We appreciate the commenters' positive feedback. For the suggestion to allow a qualified clinical data registry to submit quality measures data based on an approved sampling methodology created by the clinical data registry, we do not believe this is sufficient for the PQRS at this time. Particularly since the quality measures data received through the PQRS will be used to assess eligible professionals under the Value-based Payment Modifier, we believe it is important to receive data consistent with the data we are receiving via the claims and registry-based reporting mechanisms. Therefore, we are finalizing this proposal. For the 2014 PQRS incentive, an eligible professional reporting individual quality measures via a qualified clinical data registry will be required to report each measure for at least 50 percent of the eligible professional's applicable patients. Please note, however, that as the program evolves, we anticipate increasing the reporting threshold for the qualified clinical data registry reporting mechanism.

Comment: While several commenters generally supported our proposal to require the reporting of more than 3 measures, the commenters believed that requiring the reporting of at least 9 measures covering at least 3 of the NQS domains is too onerous. These commenters suggested requiring the reporting of either 4 measures covering at least 1 NQS domain, 5 measures covering at least 2 NQS domains, or 6 measures covering at least 2 NQS domains.

Response: We appreciate the commenters' support for our desire to require the reporting of more than 3 measures to meet the criteria for satisfactory participation in a qualified clinical data registry for the 2014 PQRS incentive. For purposes of the 2014 PQRS incentive, we believe that requiring the reporting of 9 measures is appropriate for satisfactory participation, as the proposal is consistent with the requirement for an eligible professional to report on at least 9 individual measures to meet the criteria for satisfactory reporting for the 2014 PQRS incentive. In fact, while we understand the commenters' concerns that an eligible professional reporting via the claims or traditional registry may not have 9 relevant measures for which to report, we do not believe the same argument can be made for an eligible professional reporting quality measures data via a qualified clinical data reporting. An eligible professional reporting via a qualified clinical data registry is not limited to reporting on measures within the PQRS measure set. Rather, an eligible professional using the qualified clinical data registry reporting mechanism may report on measures that are outside of the PQRS measure set. Based on the comments received and for the reasons stated previously, we are finalizing our proposal to require an individual eligible professional using a qualified clinical data registry to report on at least 9 measures for the PQRS incentive.

Comment: Several commenters generally supported the reporting of measures across multiple NQS domains, as reporting on a variety of measures provides eligible professionals with a better picture of the full continuum of care provided.

Response: We agree with the commenters. Based on the comments received, we are finalizing our proposal to require an individual eligible professional using a qualified clinical data registry to report on at least 9 measures covering at least 3 of the NQS domains for the 2014 PQRS incentive.

Comment: Several commenters supported our proposal to allow an eligible professional to report less than 9 measures, should less than 9 measures be applicable to the eligible professional. Several of the commenters sought clarification on how CMS would determine whether additional measures could be reported by an eligible professional.

Response: We appreciate the commenters' feedback. Unfortunately, at this time, it is not feasible for us to finalize an option to report on less than 9 measures via a qualified clinical data registry for the 2014 PQRS incentive. In order to do so, we believe we would need to apply the MAV process. Although we are able to implement a MAV process for the claims and registry-based reporting mechanisms to determine whether an eligible professional could have reported on additional measures, we are unable to implement a similar process for the qualified clinical data registry-based reporting mechanism as the measures that may be reported via a qualified clinical data registry are not required to be measures found in the PQRS measure set. Therefore, it would be difficult for CMS to determine appropriate measure clusters for the MAV process. Until we can implement a MAV process where we are able to accurately identify the measure clusters, we do not believe it is appropriate to adopt such a change to the criterion. Therefore, eligible professionals must report on at least 9 measures covering at least 3 of the NQS domains.

Comment: Several commenters urged CMS to allow the reporting of measures groups under the qualified clinical data registry reporting mechanism for the 2014 PQRS incentive.

Response: We agree with the commenters. However, please note that we are not restricting this reporting criterion to individual measures. Rather, as we discuss in greater detail in the PQRS measures section below, a

qualified clinical data registry is free to choose which measures its participants will report for purposes of the PQRS. Should a qualified clinical data registry require its eligible professionals to report on a cluster of measures similar to PQRS measures groups, the measures within the measures group would count as separate, individual measures.

Based on the comments received and for the reasons explained previously, as we specify in § 414.90(i), we are finalizing the following criteria for an individual eligible professional to meet the criteria for satisfactory participation for the 2014 PQRS incentive: For the 12-month 2014 reporting period, report at least 9 measures available for reporting under the qualified clinical data registry covering at least 3 of the NQS domains AND report each measure for at least 50 percent of the eligible professional's applicable patients. Of the measures reported via a qualified clinical data registry, the eligible professional must report on at least 1 outcome measure.

We further proposed that a qualified clinical data registry may submit data on more than 9 quality measures on behalf of an eligible professional (78 FR 43365). However, we proposed that a qualified clinical data registry may not submit data on more than 20 measures on behalf of an eligible professional. We proposed to place a limit on the number of measures that a qualified clinical data registry may submit on behalf of an eligible professional at this time because we have no experience with qualified clinical data registries and the types of data on quality measures that they collect. We solicited and but received no public comment on this proposal.

Although we have the capacity to accept quality measures data from all measures finalized in the PQRS measure set specified in Table 52, in analyzing our capability to accept quality measures data, we discovered that it would not be feasible for CMS to accept quality measures data on more than 20 measures not specified in Table 52 from a qualified clinical data registry at this time. CMS needs to have adequate time to analyze the measures provided to determine how the quality measures data will be calculated. We solicited but received no public comment on this proposal. Therefore, for the reasons stated above, we are capping the number of non-PQRS measures CMS may receive from each qualified clinical data registry to 20 so as not to be inundated with measures whose specifications must be analyzed prior to the submission deadline for qualified clinical data registries to submit quality measures data to CMS. Therefore, we are limiting the number of quality measures a qualified clinical data registry may submit to no more than 20 measures not specified in Table 52 on behalf of an eligible professional. Qualified clinical data registries may submit quality measures data on any or all measures specified in Table 52 of this final rule with comment period. As the qualified clinical data registry reporting option develops, we hope to be able to accept data on more quality measures outside of the PQRS measure set in the future. Please note that this restriction also applies to measures being reported to meet the criteria for satisfactory participation in a qualified clinical data registry for the 2016 PQRS payment adjustment.

f. Reporting Period for the Satisfactory Participation for Individual Eligible Professionals in a Qualified Clinical Data Registry for the 2016 PQRS Payment Adjustment

Section 1848(m)(3)(D) of the Act, as redesignated and added by section 601(b) of the ATRA, authorizes the Secretary to treat an individual eligible professional as satisfactorily submitting data on quality measures under section 1848(m)(A) of the Act if the eligible professional is satisfactorily participating in a qualified clinical data registry for the year. Given that satisfactory participation is with regard to the year, and to provide consistency with how individual eligible professionals report quality measures data to a qualified clinical data registry, we proposed to modify § 414.90(e)(2) to specify a 12-month, calendar year (CY) reporting period from January 1, 2014 through December 31, 2014, for individual eligible professionals to satisfactorily participate in a qualified clinical data registry for purposes of the 2016 PQRS payment adjustment (78 FR 43366). We invited and received the following public comments on the proposed 12-month, CY 2014 reporting period (that is, January 1, 2014–December 31, 2014) for the satisfactory participation of individual eligible professionals in a qualified clinical data registry for the 2016 PQRS payment adjustment:

Comment: Several commenters opposed our proposal to base the 2016 PQRS payment adjustment year on a reporting period occurring 2 years prior to the payment adjustment year. The commenters believe that the reporting period should occur closer to the payment adjustment year.

Response: We understand the commenters' concerns on establishing a reporting period 2 years prior to the payment adjustment year. However, it is not operationally feasible to create a full calendar year reporting period for the 2016 PQRS payment adjustment any later than 2 years prior to the adjustment year and still avoid retroactive payments or the reprocessing of claims. Section 1848(a)(8) of the Act requires that a payment adjustment be applied to covered professional services furnished by an eligible professional in the particular payment adjustment year. Therefore, we believe it is necessary to reduce the PFS amount concurrently for PFS allowed charges for covered professional services furnished in 2016. If we do not reduce the PFS amount concurrently with claims submissions in 2016, we would need to potentially recoup or provide added payments after the determination is made about whether the payment adjustment applies, or alternatively, hold claims until such a determination is made. In addition, we note that if such retroactive adjustments were made it may require a reconciliation of beneficiary copayments. As a result, we need to determine whether eligible professionals have satisfactorily reported under the PQRS based on a reporting period that occurs prior to 2016. For the reasons stated here and above, we are specifying under § 414.90(k) a 12-month, CY 2014 reporting period (that is, January 1, 2014–December 31, 2014) for the satisfactory participation of individual eligible professionals in a qualified clinical data registry for the 2016 PQRS payment adjustment. As we stated in the proposed rule (78 FR 43366), this final reporting period for the 2016 PQRS payment adjustment is consistent with the 2016 PQRS payment adjustment reporting periods for all other reporting mechanisms.

g. Criteria for the Satisfactory Participation for Individual Eligible Professionals in a Qualified Clinical Data Registry for the 2016 PQRS Payment Adjustment

Section 1848(a)(8) of the Act provides that for covered professional services furnished by an eligible professional during 2015 or any subsequent year, if the eligible professional does not satisfactorily report data on quality measures for covered professional services for the quality reporting period for the year, the fee schedule amount for services furnished by such professional during the year shall be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services. For 2016 and subsequent years, the applicable percent is 98.0 percent.

Section 1848(m)(3)(D) of the Act, as redesignated and added by section

601(b) of the ATRA, authorizes the Secretary to treat an individual eligible professional as satisfactorily submitting data on quality measures under section 1848(m)(A) of the Act if, in lieu of reporting measures under section 1848(k)(2)(C) of the Act, the eligible professional is satisfactorily participating in a qualified clinical data registry for the year. "Satisfactory participation" is a new standard under the PQRS and is a substitute for the underlying standard of "satisfactory reporting" data on covered professional services that eligible professionals must meet to earn a PQRS incentive or avoid the PQRS payment adjustment. Therefore, we proposed to modify § 414.90 to add paragraph (e)(2) to indicate that individual eligible professionals shall be treated as satisfactorily reporting data on quality measures, if the individual eligible professional satisfactorily participates in a qualified clinical data registry (78 FR 43366). We solicited but received no public comment on this proposal. Therefore, we are modifying § 414.90 to indicate that individual eligible professionals shall be treated as satisfactorily reporting data on quality measures, if the individual eligible professional satisfactorily participates in a qualified clinical data registry. However, as some of the paragraphs have changed since this proposal, we are not indicating this change in paragraph (e)(2). Rather, we are adding paragraph § 414.90(k) to indicate that individual eligible professionals shall be treated as satisfactorily reporting data on quality measures, if the individual eligible professional satisfactorily participates in a qualified clinical data registry.

For purposes of the 2016 PQRS payment adjustment (which would be based on data reported during the 12-month period that falls in CY 2014), we proposed the exact same requirement we proposed above for satisfactory participation for the 2014 PQRS incentive (78 FR 43366). Specifically, we proposed the following criteria for an individual eligible professional to meet the criteria for satisfactory participation for the 2016 PQRS payment adjustment: For the 12-month reporting period for the 2016 PQRS payment adjustment, report at least 9 measures available for reporting under the qualified clinical data registry covering at least 3 of the NQS domains; AND report each measure for at least 50 percent of the eligible professional's applicable patients. Of the measures reported via a qualified clinical data registry, the eligible professional must report on at least 1 outcome measure (78 FR 43367, Table 25). We solicited and received the following public comments on the proposed criterion for the satisfactory participation by individual eligible professionals in a qualified clinical data registry for the 2016 PQRS payment adjustment:

Comment: Several commenters urged CMS to allow the reporting of measures groups under the qualified clinical data registry reporting mechanism for the 2016 PQRS payment adjustment.

Response: We agree with the commenters. However, please note that we are not restricting this reporting criterion to individual measures. Rather, as we discuss in greater detail in the PQRS measures section below, a qualified clinical data registry is free to choose which measures its participants will report for purposes of the PQRS. Should a qualified clinical data registry require its eligible professionals to report on a cluster of measures similar to PQRS measures groups, the measures within the measures group would count as separate, individual measures.

Comment: Several commenters supported our proposal to require that an eligible professional report each measure for at least 50 percent of the eligible professional's applicable patients. The commenters supported our proposal specifically because it aligns with the option to report individual measures via the claims-based reporting mechanism. One commenter, however, opposed this proposal. Instead, the commenter suggested that CMS allow a qualified clinical data registry to submit its verifiable, statistically supported sampling methodology to CMS for review and require eligible professionals to report a sufficient number of cases as determined by the individual registry's sampling requirements.

Response: We appreciate the commenters' positive feedback. For the suggestion to allow a qualified clinical data registry to submit quality measures data based on an approved sampling methodology created by the clinical data registry, we do not believe this is sufficient for the PQRS at this time. Particularly since the quality measures data received through the PQRS will be used to assess eligible professionals under the Value-based Payment Modifier, we believe it is important to receive data consistent with the data we are receiving via the claims and registry-based reporting mechanisms. Therefore, we are finalizing our proposal to use a 50 percent threshold. For the 2016 PQRS payment adjustment, an eligible professional reporting individual quality measures via a qualified clinical data registry will be required to report on at least 3 measures and report each measure for at least 50 percent of the eligible professional's applicable patients.

Comment: While several commenters generally supported our proposal to require the reporting of more than 3 measures, the commenters believed that requiring the reporting of at least 9 measures covering at least 3 of the NQS domains is too onerous, especially for the PQRS payment adjustment. These commenters suggested requiring the reporting of either 4 measures covering at least 1 NQS domain, 5 measures covering at least 2 NQS domains, or 6 measures covering at least 2 NQS domains.

Response: We appreciate the commenters' support for our desire to require the reporting of more than 3 measures to meet the criteria for satisfactory participation in a qualified clinical data registry for the 2014 PQRS incentive. To be consistent with the criterion we are finalizing for the 2014 PQRS incentive, we are requiring that an eligible professional report on at least 9 measures covering at least 3 NQS domains.

However, we believe it is appropriate to finalize less stringent criteria for the 2016 PQRS payment adjustment, particularly since the qualified clinical data registry is a new reporting mechanism for 2014. We believe this is especially helpful for those eligible professionals who use current qualified registries that will seek to become qualified clinical data registries for 2014 that have traditionally reported 3 measures covering 1 domain to meet the criteria for satisfactory reporting in the PQRS. Therefore, to be consistent with the criterion we are finalizing for individual eligible professionals to reporting individual measures registry for the 2016 PQRS payment adjustment, an individual eligible professional using a qualified clinical data registry may report on at least 3 measures for at least 50 percent of the eligible professional's applicable patients to satisfy the criteria for satisfactory participation in a qualified clinical data registry for the 2016 PQRS payment adjustment. Please note that it is our intention to fully move towards the reporting of 9 measures covering at least 3 domains to meet the criteria for satisfactory participation for the 2017 PQRS payment adjustment.

Comment: Several commenters opposed our proposal to require that, of the measures reported via a qualified clinical data registry, the eligible professional must report on at least 1 outcome measure. Some of these commenters noted that, there are many

specialties for which outcomes measures may not yet be available, hindering these specialties from participating in the PQRS via a qualified clinical data registry.

Response: To be consistent with criterion we are finalizing for the 2014 PQRS incentive, if an eligible professional wants to meet the criteria for satisfactory participation for the 2014 PQRS incentive AND 2016 PQRS payment adjustment, we are requiring that an eligible professional who reports at least 9 measures covering at least 3 NQS domains report on at least 1 outcome measure.

However, for eligible professionals who only seek to meet the criteria for satisfactory participation for the 2016 PQRS payment adjustment (for example, not seek to earn a 2014 PQRS incentive), we understand that not all entities seeking to become qualified clinical data registries may have outcome measures available for its eligible professionals to report. For example, we understand that registries created for eligible professionals whose primary function is to perform imagining scans have found it difficult to develop outcome measures, as outcomes are usually measures not with those particular eligible professionals but by other eligible professionals for which a patient primarily sees. Unlike the PQRS incentive, we believe that, for purposes of the 2016 PQRS payment adjustment only, it is appropriate for this initial year not to finalize the requirement to report an outcome measure. Therefore, if reporting for the 2016 PQRS payment adjustment only and not seeking to earn a 2014 PQRS incentive, if an eligible professional is reporting 3 measures covering at least 1 NQS domain, we will not require an eligible professional to report on at least 1 outcome measure. Please note, however, that it is our intention to require the reporting of 1 outcome measure if reporting via a qualified clinical data registry for the 2017 PQRS payment adjustment. Therefore, we encourage these registries that do not currently require the reporting of an outcome measure to find ways for which an outcome measure may be developed.

Comment: Several commenters generally supported the reporting of measures across multiple NQS domains, as reporting on a variety of measures provides eligible professionals with a better picture of full continuum of care provided.

Response: We agree with the commenters. To be consistent with the criterion we are finalizing for the 2014 PQRS incentive, we are requiring that an eligible professional report on measures covering at least 3 NQS domains.

However, since we are also finalizing an alternative criterion only requiring that an eligible professional using a qualified clinical data registry report on at least 3 measures for the 2016 PQRS payment adjustment, as well as to be consistent with the criterion we finalized for an individual eligible professional reporting individual quality measures via registry for the 2016 PQRS payment adjustment, for purposes of the 2016 PQRS payment adjustment only, we are finalizing a decision to require that an eligible professional using a qualified clinical data registry report on at least 3 measures covering only 1 NQS domain.

Comment: Several commenters supported our proposal to implement a MAV process, in the event an eligible professional reports 1–8 measures because less than 9 measures are applicable to the eligible professional. Several of the commenters sought clarification on how CMS would determine whether additional measures could be reported by an eligible professional.

Response: We appreciate the commenters' feedback and support for implementing a MAV process for eligible professionals reporting via a qualified clinical data registry. Unfortunately, although we are able to implement a MAV process for the claims and registry-based reporting mechanisms to determine whether an eligible professional could have reported on additional measures, we are unable to implement a similar process for the qualified clinical data registry-based reporting mechanism as the measures that may be reported via a qualified clinical data registry are not required to be measures found in the PQRS measure set. Unfortunately, we will not receive measure information from clinical data registries in time to develop the measure clusters needed to implement such a MAV process. Therefore, it would be difficult for CMS to determine appropriate measure clusters for the MAV process.

In summary, based on the comments received and for the reasons explained previously, we are finalizing the following criteria for an individual eligible professional to meet the criteria for satisfactory participation in a qualified clinical data registry for the 2016 PQRS payment adjustment:

For the 12-month 2016 PQRS payment adjustment reporting period, report at least 9 measures covering at least 3 NQS domains AND report each measure for at least 50 percent of the applicable patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted. Of the measures reported via a qualified clinical data registry, the eligible professional must report on at least 1 outcome measure; OR

For the 12-month 2016 PQRS payment adjustment reporting period, report at least 3 measures covering at least 1 NQS domain AND report each measure for at least 50 percent of the applicable patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted.

Tables 47 and 48 provide a summary of the final criteria for satisfactory reporting and satisfactory participation we discussed above for individual eligible professionals for the 2014 PQRS incentive and 2016 PQRS payment adjustment, respectively.

TABLE 47—SUMMARY OF REQUIREMENTS FOR THE 2014 PQRS INCENTIVE: INDIVIDUAL REPORTING CRITERIA FOR SATISFACTORY REPORTING OF INDIVIDUAL QUALITY MEASURES VIA CLAIMS, QUALIFIED REGISTRIES, AND EHRS AND SATISFACTORY PARTICIPATION CRITERION IN QUALIFIED CLINICAL DATA REGISTRIES

Reporting period	Measure type	Reporting mechanism	Satisfactory reporting criteria/satisfactory participation criterion
12-month (Jan 1–Dec 31).	Individual Measures.	Claims	Report at least 9 measures covering at least 3 NQS domains, OR, if less than 9 measures covering at least 3 NQS domains apply to the eligible professional, report 1–8 measures covering 1–3 NQS domains, AND report each measure for at least 50 percent of the Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted.

TABLE 47—SUMMARY OF REQUIREMENTS FOR THE 2014 PQRS INCENTIVE: INDIVIDUAL REPORTING CRITERIA FOR SATISFACTORY REPORTING OF INDIVIDUAL QUALITY MEASURES VIA CLAIMS, QUALIFIED REGISTRIES, AND EHRS AND SATISFACTORY PARTICIPATION CRITERION IN QUALIFIED CLINICAL DATA REGISTRIES—Continued

Reporting period	Measure type	Reporting mechanism	Satisfactory reporting criteria/satisfactory participation criterion
			* For an eligible professional who reports fewer than 9 measures covering 3 NQS domains via the claims-based reporting mechanism, the eligible professional will be subject to the MAV process, which would allow us to determine whether an eligible professional should have reported quality data codes for additional measures and/or covering additional NQS domains.
12-month (Jan 1–Dec 31).	Individual Measures.	Qualified Registry	Report at least 9 measures covering at least 3 of the NQS domains, OR, if less than 9 measures covering at least 3 NQS domains apply to the eligible professional, report 1–8 measures covering 1–3 NQS domains for which there is Medicare patient data, AND report each measure for at least 50 percent of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted. * For an eligible professional who reports fewer than 9 measures covering 3 NQS domains via the registry-based reporting mechanism, the eligible professional will be subject to the MAV process, which would allow us to determine whether an eligible professional should have reported on additional measures and/or measures covering additional NQS domains.
** 12-month (Jan 1–Dec 31).	Individual Measures.	Direct EHR product that is CEHRT and EHR data submission vendor that is CEHRT.	Report 9 measures covering at least 3 of the NQS domains. If an eligible professional's CEHRT does not contain patient data for at least 9 measures covering at least 3 domains, then the eligible professional must report the measures for which there is Medicare patient data. An eligible professional must report on at least 1 measure for which there is Medicare patient data.
** 12-month (Jan 1–Dec 31).	Measures Groups.	Qualified Registry	Report at least 1 measures group, AND report each measures group for at least 20 patients, a majority of which much be Medicare Part B FFS patients.
** 6-month (Jul 1–Dec 31).	Measures Groups.	Qualified Registry	Report at least 1 measures group, AND report each measures group for at least 20 patients, a majority of which much be Medicare Part B FFS patients.
12-month (Jan 1–Dec 31).	Measures selected by Qualified Clinical Data Registry.	Qualified Clinical Data Registry	Report at least 9 measures covering at least 3 NQS domains AND report each measure for at least 50 percent of the eligible professional's applicable patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted. Of the measures reported via a qualified clinical data registry, the eligible professional must report on at least 1 outcome measure.

* Subject to the MAV process.
** Finalized in the CY 2013 PFS final rule (see Table 91 at 77 FR 69194).

TABLE 48—SUMMARY OF REQUIREMENTS FOR THE 2016 PQRS PAYMENT ADJUSTMENT: INDIVIDUAL REPORTING CRITERIA FOR SATISFACTORY REPORTING OF INDIVIDUAL QUALITY MEASURES VIA CLAIMS, REGISTRIES, AND EHRS AND SATISFACTORY PARTICIPATION CRITERION IN QUALIFIED CLINICAL DATA REGISTRIES

Reporting period	Measure type	Reporting mechanism	Satisfactory reporting criteria/satisfactory participation criterion
12-month (Jan 1–Dec 31).	Individual Measures.	Claims	Report at least 9 measures covering at least 3 NQS domains, OR, if less than 9 measures covering at least 3 NQS domains apply to the eligible professional, report 1–8 measures covering 1–3 NQS domains, AND report each measure for at least 50 percent of the Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted. * For an eligible professional who reports fewer than 9 measures covering 3 NQS domains via the claims-based reporting mechanism, the eligible professional will be subject to the MAV process, which would allow us to determine whether an eligible professional should have reported quality data codes for additional measures and/or covering additional NQS domains.
** 12-month (Jan 1–Dec 31).	Individual Measures.	Claims	Report at least 3 measures, OR, If less than 3 measures apply to the eligible professional, report 1–2 measures*; AND Report each measure for at least 50 percent of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies.

TABLE 48—SUMMARY OF REQUIREMENTS FOR THE 2016 PQRS PAYMENT ADJUSTMENT: INDIVIDUAL REPORTING CRITERIA FOR SATISFACTORY REPORTING OF INDIVIDUAL QUALITY MEASURES VIA CLAIMS, REGISTRIES, AND EHRS AND SATISFACTORY PARTICIPATION CRITERION IN QUALIFIED CLINICAL DATA REGISTRIES—Continued

Reporting period	Measure type	Reporting mechanism	Satisfactory reporting criteria/satisfactory participation criterion
12-month (Jan 1–Dec 31).	Individual Measures.	Qualified Registry	Measures with a 0 percent performance rate will not be counted. Report at least 9 measures covering at least 3 of the NQS domains, OR, if less than 9 measures covering at least 3 NQS domains apply to the eligible professional, report 1–8 measures covering 1–3 NQS domains for which there is Medicare patient data, AND report each measure for at least 50 percent of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted. * For an eligible professional who reports fewer than 9 measures covering at least 3 NQS domains via the registry-based reporting mechanism, the eligible professional will be subject to the MAV process, which would allow us to determine whether an eligible professional should have reported on additional measures and/or measures covering additional NQS domains.
12-month (Jan 1–Dec 31).	Individual Measures.	Qualified Registry	Report at least 3 measures covering at least 1 of the NQS domains, OR, if less than 3 measures apply to the eligible professional, report 1–2 measures covering at least 1 NQS domain for which there is Medicare patient data, AND report each measure for at least 50 percent of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted. * For an eligible professional who reports fewer than 3 measures covering 1 NQS domain via the registry-based reporting mechanism, the eligible professional will be subject to the MAV process, which would allow us to determine whether an eligible professional should have reported on additional measures.
** 12-month (Jan 1–Dec 31).	Individual Measures.	Direct EHR product that is CEHRT and EHR data submission vendor that is CEHRT.	Report 9 measures covering at least 3 of the NQS domains. If an eligible professional's CEHRT does not contain patient data for at least 9 measures covering at least 3 domains, then the eligible professional must report the measures for which there is Medicare patient data. An eligible professional must report on at least 1 measure for which there is Medicare patient data.
** 12-month (Jan 1–Dec 31).	Measures Groups.	Qualified Registry	Report at least 1 measures group, AND report each measures group for at least 20 patients, a majority of which much be Medicare Part B FFS patients.
** 6-month (Jul 1–Dec 31).	Measures Groups.	Qualified Registry	Report at least 1 measures group, AND report each measures group for at least 20 patients, a majority of which much be Medicare Part B FFS patients.
12-month (Jan 1–Dec 31).	Measures selected by Qualified Clinical Data Registry.	Qualified Clinical Data Registry	Report at least 9 measures covering at least 3 NQS domains AND report each measure for at least 50 percent of the eligible professional's applicable patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted. Of the measures reported via a qualified clinical data registry, the eligible professional must report on at least 1 outcome measure.
12-month (Jan 1–Dec 31).	Measures selected by Qualified Clinical Data Registry.	Qualified Clinical Data Registry	Report at least 3 measures covering at least 1 NQS domain AND report each measure for at least 50 percent of the eligible professional's applicable patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted.

* Subject to the MAV process.
** Finalized in the CY 2013 PFS final rule (see Table 91 at 77 FR 69194).

7. Criteria for Satisfactory Reporting for the 2014 PQRS Incentive for Group Practices in the GPRO

For 2014, in accordance with § 414.90(c)(3), eligible professionals that satisfactorily report data on PQRS quality measures are eligible to receive an incentive equal to 0.5 percent of the total estimated Medicare Part B allowed charges for all covered professional services furnished by the eligible professional or group practice during the applicable reporting period. We finalized criteria for the satisfactory reporting for group practices participating in the GPRO for the 2014 PQRS incentive in the CY 2013 PFS final rule with comment period (see Table 93, 77 FR 69195). In the CY 2014 PFS proposed rule, we proposed to change some of the criteria for satisfactory reporting for group practices under the GPRO using the registry and GPRO web interface reporting mechanisms (78 FR 43368).

Group practices may currently report PQRS quality measures data to meet the criteria for satisfactory reporting for the 2014 PQRS incentive via the registry, EHR, and GPRO web interface reporting

mechanisms. First, for the 2014 PQRS incentive, we previously finalized the following criterion for the satisfactory reporting of PQRS quality measures via the GPRO web interface for group practices comprised of 25–99 eligible professionals: Report on all measures included in the web interface; AND populate data fields for the first 218 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 218, then report on 100 percent of assigned beneficiaries (77 FR 69195). To streamline the PQRS and eliminate reporting options that are largely unused, in the CY 2014 PFS proposed rule, we proposed to eliminate this criterion under the GPRO for the 2014 PQRS incentive. As a result, group practices composed of 25–99 eligible professionals would no longer have the option to report PQRS quality measures using the GPRO web interface for the 2014 PQRS incentive (78 FR 43368). We solicited and received the following public comments on this proposal:

Comment: Several commenters opposed our proposal to eliminate the option for group practices comprised of 25–99 eligible professionals to report PQRS quality measures using the GPRO web interface for the 2014 PQRS incentive. The commenters request that, although there has been low participation in this reporting option, we keep this option for at least one more year. The commenters believe that group practices may increasingly use this option, particularly as the PQRS moves from an incentive-based to a program that solely provides payment adjustments.

Response: While we proposed to eliminate this reporting option due to low participation, we agree with the commenters. We understand that other commenters expressed similar concerns with our proposal to eliminate the option to report PQRS measures groups via registry, yet we are still finalizing our proposal to eliminate the option to report PQRS measures groups via registry for the 2014 PQRS incentive and 2016 PQRS payment adjustment. Unlike the option to report PQRS measures groups via registry, the option for group practices comprised of 25–99 eligible professionals to report PQRS quality measures using the GPRO web interface is relatively new as it was finalized in the CY 2013 PRS final rule with comment period (77 FR 69196). As such, we are willing to keep the option for group practices comprised of 25–99 eligible professionals to report PQRS quality measures using the GPRO web interface for the 2014 PQRS incentive to see whether PQRS participation using this reporting criterion will increase. Therefore, we are not finalizing our proposal to eliminate this GPRO reporting option. However, we note that should we continue to see low participation in this reporting criterion, we may propose to eliminate this reporting criterion again in future rulemaking.

In the CY 2013 PFS final rule with comment period, for reporting under the GPRO using the registry-based reporting mechanism, we finalized the following criterion for the satisfactory reporting of PQRS quality measures for group practices composed of 2 or more eligible professionals for the 2014 PQRS incentive: Report at least 3 measures, AND report each measure for at least 80 percent of the group practice's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate will not be counted (77 FR 69196). For the same reasons we proposed to increase the number of measures an individual eligible must report, as well as decrease the percentage threshold for individual eligible professionals reporting via registry for the 2014 PQRS incentive in the CY 2014 PFS proposed rule, we proposed the following modified criteria for the satisfactory reporting of individual quality measures under the GPRO for the registry-based reporting mechanism: Report at least 9 measures covering at least 3 of the NQS domains; AND report each measure for at least 50 percent of the group practice's applicable seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate will not be counted (78 FR 43368). We solicited and received the following public comments on this proposal:

Comment: The majority of commenters supported our proposal to decrease the percentage of patients that must be reported via registry from 80 percent to 50 percent. The commenters supported our proposal specifically because this threshold aligns with the option to report individual measures via the claims-based reporting mechanism.

Response: We appreciate the commenters' feedback and, based on the support received and for the reasons stated previously, we are finalizing this proposal for reducing the reporting threshold. Therefore, for the 2014 PQRS incentive, a group practice reporting individual quality measures via registry will be required to report each measure for at least 50 percent of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Please note, however, that as the program evolves, we anticipate increasing the reporting threshold again both for the registry-based reporting mechanism.

Comment: Several commenters supported our proposal to increase the number of measures to be reported via registry to 9, as requiring a group practice to report on more measures would better capture the quality of care provided by a group practice. However, while several commenters generally supported our proposal to increase the number of measures to be reported via registry, the commenters urged CMS to provide a more gradual approach to increasing the number of measures that must be reported via registry. These commenters suggested requiring the reporting of either 4 measures covering at least 1 NQS domain, 5 measures covering at least 2 NQS domains, or 6 measures covering at least 2 NQS domains.

The majority of commenters opposed our proposal to increase the number of measures to be reported via registry from 3 to 9. Several of these commenters generally opposed any proposal that would increase the number of measures to be reported via registry from 3. Some of these commenters urged CMS not to increase the criteria for satisfactory reporting until participation in PQRS increases, as the commenters feared that increasing the criteria for satisfactory reporting in PQRS would discourage eligible professionals from participating in the PQRS. Still some of these commenters opposing this proposal noted that certain eligible professionals did not have 9 measures for which to report.

Response: We appreciate commenters' positive feedback, as well as suggested alternative reporting criteria. We understand the commenters' concerns opposing this proposal. However, we believe that it is important to collect data that provides a broad picture of the quality of care provided by a group practice, and, as discussed in section K of this final rule with comment period, such information will be used, in part, for the Value-based Payment Modifier to determine upward, downward, and neutral adjustments based on physician performance. So we believe it is important to raise the measure threshold from 3 measures covering 1 NQS domain to 9 measures covering 3 NQS domains. As we noted above and in the proposed rule (78 FR 43368), we believe that we have provided group practices with enough time to familiarize themselves with the reporting options

for satisfactory reporting under the PQRS, particularly for the PQRS incentives.

For the commenters who urge us not to increase the satisfactory reporting criteria for the PQRS until participation in PQRS increases, we understand that, as discussed in this final rule below and in the 2011 PQRS and eRx Reporting Experience, participation in the PQRS has fluctuated around 25 percent among those eligible to participate in the PQRS. Indeed, it is one of our major goals to increase participation in the PQRS. While increasing the satisfactory reporting threshold for the 2014 PQRS incentive may deter or discourage eligible professionals from participating, we believe the increase we proposed for the satisfactory reporting threshold will not significantly deter eligible professionals in group practices from participating in the PQRS. Also, we note that eligible professionals in group practices will be required to report PQRS quality measures data to meet the criteria for satisfactory reporting for the 2016 PQRS payment adjustment, the reporting periods of which run concurrently with the reporting periods for the 2014 PQRS incentive. Since eligible professionals will already be required to meet the criteria for satisfactory reporting for the 2016 PQRS payment adjustment, we believe these eligible professionals will also attempt to report for the 2014 PQRS incentive regardless of whether we increase the measure threshold from 3 measures covering 1 NQS domain to 9 measures covering 3 NQS domains.

But to addres the commenters' concerns about not having at least 9 PQRS measures covering 3 NQS domains for which to report via registry, we are modifying what we are finalizing to allow group practices to report fewer measures so that group practices who do not have at least 9 PQRS measures applicable to their practice. Specifically, if fewer than 9 measures covering less than 3 NQS domains apply to the group practice, a group practice must report 1–8 measures covering 1–3 NQS domains for which there is Medicare patient data. Given this change to the criterion, we will apply a MAV process, which will be triggered when a group practice reports on less than 9 measures. This is consistent with our practice for applying this process to the claims-based reporting option for individuals to report individual measures. For example, if a group practice reports on 8 measures covering 2 NQS domains, the MAV process will be triggered to determine whether a group practice could have reported on an additional measure and/or covering an additional domain.

The 2014 registry MAV process that will determine whether a group practice could have reported on more measures and/covering more NQS domains will be similar to the "clinical relation" test used in the 2013 claims MAV process. To get a better sense of how the 2014 registry MAV process will be implemented by CMS, a description of the "clinical relation" test in the current 2013 claims MAV process is available at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2013_PQRS_MeasureApplicabilityValidation_Docs_030413.zip*. Please note that we will post a guidance document on the 2014 registry MAV process, which will include a list of the measure clusters that are used for the "clinical relation" test, prior to January 1, 2014 (the start of the 2014 reporting periods).

We believe modifying the reporting criterion will address commenters concerns, while still maintaining our general goal of increasing the measures reported to 9 measures covering 3 NQS domains. This also will increase the likelihood that more eligible professionals, including those in group practices, will be able to take advantage of this reporting option.

For the reasons stated above, we are finalizing the following criterion for group practices in the GPRO reporting individual PQRS quality measures via registry for the 2014 PQRS incentive: For the 12-month reporting period for the 2014 PQRS incentive, report at least 9 measures covering at least 3 of the NQS domains, OR, if less than 9 measures covering at least 3 NQS domains apply to the group practice, report 1–8 measures covering 1–3 NQS domains for which there is Medicare patient data, AND report each measure for at least 50 percent of the group practice's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted. For a group practice who reports fewer than 9 measures covering less than 3 NQS domains via the registry-based reporting mechanism, the group practice would be subject to the MAV process, which would allow us to determine whether a group practice should have reported on additional measures and/or measures covering additional NQS domains.

Third, under our authority under section 1848(m)(3)(C)(i) of the Act to select the measures for which a group practice must report, based on our desire to encourage the use of patient surveys to assess beneficiary experience of care and outcomes, we proposed to provide group practices composed of 25 or more eligible professionals with a new satisfactory reporting criterion that would include the option to complete the CG CAHPS survey along with reporting 6 other PQRS measures for purposes of meeting the criteria for satisfactory reporting for the 2014 PQRS incentive and 2016 PQRS payment adjustment (78 FR 43368).

We further proposed that the survey would be administered following the close of the PQRS registration period. We indicated that CMS would provide each group a detailed report about the results of the survey. In addition, we proposed to assign beneficiaries to a group practice using the same assignment methodology that we use for the GPRO web interface (77 FR 69195). This method focuses on assigning beneficiaries to a group based on whether the group provided the plurality of primary care services. Because we proposed to assign beneficiaries to a group based on the provision of primary care services, we noted that this survey is not an appropriate option for groups of physicians (for example, such as a group of surgeons) that do not provide primary care services. In accordance with section 1848(m)(3)(C)(ii) of the Act, which requires the GPRO to provide for the use of a statistical sampling model, we propose that the survey would be administered by certified survey vendor on behalf of the group practice for a sample of group's assigned beneficiaries. As noted earlier, to complete this survey, a group practice must indicate its intent to report the CG CAHPS survey when it registers to participate in the PQRS via the GPRO.

Please note that the CAHPS survey measures only cover 1 NQS domain. To be consistent with other group practice reporting criteria we proposed to require the reporting of measures covering at least 3 NQS domains, we proposed that, unless a group practice is comprised of 100 or more eligible professionals and is participating in the PQRS via the GPRO web interface, if a group practice comprised of 25 of more eligible professionals reports the CAHPS measures via a certified survey vendor, the group practice would be required to report on at least 6 additional measures covering at least 2 NQS domains.

Specifically, we proposed the following criteria for satisfactory reporting for the 2014 PQRS incentive: For the 12-month reporting period for the 2014 PQRS incentive, report all CAHPS survey measures via a certified vendor, AND report at least 6 measures covering at least 2 of the NQS domains

using the qualified registry, direct EHR product, EHR data submission vendor, or GPRO web interface reporting mechanisms (78 FR 43368).

We solicited and received the following public comments on our proposed criterion for the satisfactory reporting of data on these PQRS quality measures under the GPRO for the 2014 PQRS incentive:

Comment: Although one commenter supported the proposal to allow all group practices of 25 or more eligible professionals in the GPRO to report the CG CAHPS survey measures for the 2014 PQRS incentive, since the cost to do the survey will be at the practice's expense, the commenter appreciate CMS' proposal to make this optional for practices.

Response: We appreciate the commenter's response. Unfortunately, except for group practices comprised of 100 or more eligible professionals in the GPRO that are using the GPRO web interface reporting mechanism who must report the CG CAHPS measures (77 FR 69267) to meet the criteria for satisfactory reporting for the 2014 PQRS incentive, we cannot bear the cost of administering the CG CAHPS survey to group practices. However, in the interest of encouraging the administering and reporting of CG CAHPS data, we proposed this alternative reporting criterion for which group practices may use to meet the criteria for satisfactory reporting for the 2014 PQRS incentive. Since CMS cannot bear the cost of administering the CG CAHPS survey for these group practices, the reporting of CG CAHPS measures is optional for the purpose of meeting the criteria for satisfactory reporting for the 2014 PQRS incentive except for group practices comprised of 100+ eligible professionals who are reporting PQRS measures via the GPRO web interface.

Comment: Some commenters opposed our proposal to require the reporting of 6 measures covering at least 2 of the NQS domains using the qualified registry, direct EHR product, EHR data submission vendor, or GPRO web interface reporting mechanisms in addition to the CG CAHPS survey. Commenters felt this proposed criterion was too onerous, especially given the time and expense associated with administering the CG CAHPS survey.

Response: We understand the commenters' concerns with this proposal. However, we believe requiring the reporting of 6 measures covering at least 2 of the NQS domains using the qualified registry, direct EHR product, EHR data submission vendor, or GPRO web interface reporting mechanisms in addition to the CG CAHPS survey is fair. The CG CAHPS survey measure only satisfies the reporting of 1 NQS domain, while other group practice criteria we have established for the registry and EHR-based reporting mechanisms for the 2014 PQRS incentive require the reporting of measures in at least 3 NQS domains to meet the criteria for satisfactory reporting for the 2014 PQRS incentive. In addition, we note that requiring the reporting of 6 measures in addition to the CG CAHPS survey would essentially require a group practice to report on 6 measures and 12 survey questions, for a total of 18 measures and questions. We note that this is the same number of measures (18) that we currently require group practices in the GPRO to report via the GPRO web interface. Based on the comments received and for the reasons stated previously, we are finalizing the following criterion for a group practice comprised of 25 or more eligible professionals who chooses to complete the CG CAHPS survey in conjunction with the qualified registry, direct EHR product, EHR data submission vendor, or GPRO web-interface reporting mechanisms: For the 12-month reporting period for the 2014 PQRS incentive, report all CAHPS survey measures via a certified vendor, AND report at least 6 measures covering at least 2 of the NQS domains using the qualified registry, direct EHR product, EHR data submission vendor, or GPRO web interface reporting mechanisms. We are modifying § 414.90(h) to indicate this reporting criterion.

8. Criteria for Satisfactory Reporting for the 2016 PQRS Payment Adjustment for Group Practices in the GPRO

This section addresses the certain proposals we made regarding criteria for satisfactory reporting for group practices in the GPRO for the 2016 PQRS payment adjustment using the registry, GPRO web interface, and certified survey vendor reporting mechanisms. In the CY 2013 PFS final rule with comment period, we finalized the same criteria for satisfactorily reporting data on quality measures for the 2016 PQRS payment adjustment that apply for the 2014 PQRS incentive for the PQRS GPRO (77 FR 69200). In the CY 2014 PFS proposed rule, we made three of the same proposals for the criteria for satisfactory reporting under the GPRO for the 2016 PQRS payment adjustment that we are proposed for the 2014 PQRS incentive (78 FR 43369).

Specifically, to coincide with our proposals for the 2014 PQRS incentive, we first proposed (78 FR 43369) to eliminate the following criterion for satisfactory reporting of PQRS quality measures via the GPRO web interface for group practices comprised of 25–99 eligible professionals: Report on all measures included in the web interface; AND populate data fields for the first 218 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 218, then report on 100 percent of assigned beneficiaries. We solicited and received the following public comments on this proposal:

Comment: Several commenters opposed our proposal to eliminate the option for group practices comprised of 25–99 eligible professionals to report PQRS quality measures using the GPRO web interface for the 2014 PQRS incentive. The commenters request that, although there has been low participation in this reporting option, we keep this option for at least one more year. The commenters believe that group practices may increasingly use this option, particularly as the PQRS moves from an incentive-based to a program that solely provides payment adjustments.

Response: We appreciate the commenters' feedback and understand the commenters' concerns. Since we are not finalizing our proposal to eliminate this reporting criterion for the 2014 PQRS incentive, to coincide with the criterion established for the 2014 PQRS incentive and for the same reasons we are not finalizing our proposal to remove this reporting criterion for the 2014 PQRS incentive, we are not finalizing our proposal to remove this reporting criterion. As we previously stated, although we proposed to eliminate this reporting criterion due to low participation, we are willing to keep the option for group practices comprised of 25–99 eligible professionals to report PQRS quality measures using the GPRO web interface for the 2014 PQRS incentive to see whether PQRS participation using this reporting criterion will increase. However, we note that should we continue to see low participation in this reporting criterion, we may propose to eliminate this reporting criterion again in future rulemaking. Based on the comments received and for the reasons previously stated, group practices of 25–99 eligible professionals have the option to use the following criterion for satisfactory reporting of PQRS quality measures via the GPRO web interface: Report on all measures included in the web interface; AND populate data fields for the first 218 consecutively ranked and assigned beneficiaries in the order

in which they appear in the group's sample for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 218, then report on 100 percent of assigned beneficiaries.

Second, we proposed to remove the following criterion for satisfactory reporting via registry under the GPRO for the 2016 PQRS payment adjustment: Report at least 3 measures, AND report each measure for at least 80 percent of the group practice's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate will not be counted (78 FR 43369). By eliminating this option as proposed, a group practice reporting via registry would have been required to meet the same criteria for satisfactory reporting for the 2014 PQRS incentive as the 2016 PQRS payment adjustment. This would allow us to maintain consistent criteria for the 2016 PQRS payment adjustment and 2014 PQRS incentive. We solicited and received the following public comments on this proposal:

Comment: While several commenters supported our proposal to increase the number of measures to be reported via registry, these commenters generally did not support eliminating this reporting criterion. Other commenters expressed concern that there are still group practices who do not have 3 measures applicable to their practice. These commenters therefore suggested that this criterion be modified to require the reporting of only 1 measure covering 1 NQS domain for the 2016 PQRS payment adjustment, similar to the criterion that was finalized for the 2015 PQRS payment adjustment (77 FR 69200), as some commenters are concerned that there are still group practices who do not have 3 measures applicable to their practice.

Response: We understand the commenters' concerns regarding eliminating this reporting criterion. Although we still desire to move towards the reporting of more measures, we understand that eligible professionals may need another year to adjust to the reporting of additional measures. We believe it is pertinent to allow time for eligible professionals to adjust to the reporting of additional measures for purposes of the 2016 PQRS payment adjustment as opposed to the 2014 PQRS incentive, where forgoing reporting has no downward payment consequencee. Therefore, based on the concerns expressed by commenters, we are not finalizing our proposal to eliminate this reporting criterion for the 2016 PQRS payment adjustment, but as noted below, are further modifying the criterion in this final rule. We note, however, that it is our intention to move towards the reporting of 9 measures covering at least 3 NQS domains for the 2017 PQRS payment adjustment.

To address commenters concerns and to coincide with the percentage reporting threshold we are finalizing for group practices who report individual measures via registry for the 2014 PQRS incentive, we are lowering the percentage threshold for the reporting of measures via registry for the 2016 PQRS payment adjustment from 80 to 50 percent. We believe this modification reduces reporting burden on group practices since they will be required to report on less patients. This further aligns with some the reporting criteria for the 2014 PQRS incentive criteria.

For the commenters who expressed concern that there are still group practices who do not have 3 measures applicable to their practice, we are finalizing another modification to allow eligible professionals to report 1–2 applicable measures. And consistent with the other final policies we are adopting, we will apply a registry MAV process for the 2016 PQRS payment adjustment. For purposes of this reporting criterion, the registry MAV process will be triggered when a group practice reports on less than 3 measures. For example, if a group practice reports on 1–2 measures, the MAV process will be triggered to determine whether a group practice could have reported on at least 3 measures covering 1 NQS domain. We believe implementing this change to the criterion for the 2016 PQRS payment adjustment will help to alleviate commenters' concerns that certain group practices may not have a sufficient number of measures to report covering a sufficient amount of NQS domains.

This registry MAV process that will determine whether a group practice could have reported on more measures will be similar to the "clinical relation" test used in the 2013 claims MAV process. To get a better sense of how the registry MAV process for the 2016 PQRS payment adjustment will be implemented by CMS, a description of the "clinical relation" test in the current 2013 claims MAV process is available at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2013_PQRS_MeasureApplicabilityValidation_Docs_030413.zip.* Please note that we will post a guidance document on the registry MAV process for the 2016 PQRS payment adjustment, which will include a list of the measure clusters that are used for the "clinical relation" test, prior to January 1, 2014 (the start of the 2014 reporting periods).

In summary, we are finalizing in the following criterion for satisfactory reporting via registry under the GPRO for the 2016 PQRS payment adjustment: For the 12-month reporting period for the 2016 PQRS payment adjustment, report at least 3 measures covering at least 1 of the NQS domains, OR, if less than 3 measures apply to the group practice, report 1–2 measures covering at least 1 NQS domain for which there is Medicare patient data, AND report each measure for at least 50 percent of the group practice's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted. For a group practice who reports fewer than 3 measures via the registry-based reporting mechanism, the group practice would be subject to the MAV process, which would allow us to determine whether a group practice should have reported on additional measures.

Third, to coincide with criterion we are finalizing for the 2014 PQRS incentive, we proposed (78 FR 43369) the following criterion for satisfactory reporting of measures via registry under the GPRO for the 2016 PQRS payment adjustment: Report at least 9 measures covering at least 3 of the National Quality Strategy domains, and report each measure for at least 50 percent of the group practice's applicable patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate will not be counted.

Comment: Several commenters generally supported our proposal to align the satisfactory reporting criteria for the 2014 PQRS incentive with the satisfactory reporting criteria for the 2016 PQRS payment adjustment.

Response: We appreciate the commenters' support. However, given that we are making certain changes to address concerns raised above and with regard to the 2014 incentive about increasing the number of measures to 9 and whether eligible professionals have enough applicable measures to report to take advantage of this reporting criterion, we are finalizing a modification of the criterion that was proposed for the satisfactory reporting of measures via registry under the GPRO for the 2014 PQRS incentive. This will also help to meet our goal of aligment under the program where possible with regard to various reporting criteria.

Specifically, we are finalizing the following criterion for satisfactory reporting via registry under the GPRO for the 2016 PQRS payment adjustment:

Report at least 9 measures covering at least 3 of the NQS domains, OR, if less than 9 measures covering at least 3 NQS domains apply to the group practice, report 1–8 measures covering 1–3 NQS domains for which there is Medicare patient data, AND report each measure for at least 50 percent of the group practice's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted. For a group practice who reports fewer than 9 measures covering less than 3 NQS domains via the registry-based reporting mechanism, the group practice would be subject to the MAV process, which would allow us to determine whether a group practice should have reported on additional measures and/or measures covering additional NQS domains.

Fourth, consistent with the proposal we made to provide group practices comprised of 25 or more eligible professionals with a new satisfactory reporting criterion that would include the option to complete the CG CAHPS survey along with reporting 6 other PQRS measures for purposes of meeting the criteria for satisfactory reporting for the 2014 PQRS incentive, we also proposed the same criterion for purposes of meeting the criteria for satisfactory reporting for the 2016 PQRS payment adjustment. Specifically, we proposed the following criteria for satisfactory reporting for the 2016 PQRS payment adjustment: For the 12-month reporting period for the 2016 PQRS payment adjustment, report all CAHPS survey measures via a certified vendor, AND report at least 6 measures covering at least 2 of the NQS domains using the qualified registry, direct EHR product, EHR data submission vendor, or GPRO web interface reporting mechanisms. As noted earlier, to complete this survey, a group practice must indicate its intent to report the CG CAHPS survey when it registers to participate in the PQRS via the GPRO (78 FR 43369). We solicited and received the following public comments on this proposed criterion:

Comment: Although one commenter supported the proposal to allow all group practices of 25 or more eligible professionals in the GPRO to report the CG CAHPS survey measures, since the cost to do the survey will be at the practice's expense, the commenter appreciates CMS' proposal to make this optional for practices.

Response: We appreciate the commenter's response. However, although this reporting criterion is generally optional for group practices of 25 or more eligible professionals, please note that completion of the CG CAHPS survey it not optional for all group practices participating under the GPRO for the 2016 PQRS payment adjustment. As we stated in the CY 2013 PFS final rule with comment period, all group practices comprised of 100 or more eligible professionals in the GPRO that are using the GPRO web interface reporting mechanism must report the CG CAHPS measures (77 FR 69267) to meet the criteria for satisfactory reporting for the 2014 PQRS incentive. Since, as finalized in the CY 2013 PFS final rule with comment period (77 FR 69200), a group practice may meet the criteria for satisfactory reporting for the 2016 PQRS payment adjustment by meeting the criteria for satisfactory reporting for the 2014 PQRS incentive, all group practices comprised of 100 or more eligible professionals in the GPRO that are using the GPRO web interface reporting mechanism must also report the CG CAHPS measures (77 FR 69267) to meet the criteria for satisfactory reporting for the 2016 PQRS payment adjustment. Because we are requiring these group practices to report the CG CAHPS survey measures, we noted that CMS would bear the cost of administering the survey.

Nonetheless, we are pleased with the commenter's support with making reporting of the CG CAHPS survey measures optional for the 2014 PQRS incentive. We understand that it is a considerable expense to administer the CG CAHPS survey. Since CMS cannot bear the cost of administering the CG CAHPS survey for these group practices, the reporting of CG CAHPS measures is optional for the purpose of meeting the criteria for satisfactory reporting for the 2016 PQRS payment adjustment except for group practices comprised of 100+ eligible professionals who are reporting PQRS measures via the GPRO web interface.

Comment: Some commenters opposed our proposal to require the reporting of 6 measures covering at least 2 of the NQS domains using the qualified registry, direct EHR product, EHR data submission vendor, or GPRO web interface reporting mechanisms in addition to the CG CAHPS survey. Commenters felt this proposed criterion was too onerous, especially given the time and expense associated with administering the CG CAHPS survey.

Response: We understand the commenters' concerns with this proposal. However, we believe requiring the reporting of 6 measures covering at least 2 of the NQS domains using the qualified registry, direct EHR product, EHR data submission vendor, or GPRO web interface reporting mechanisms in addition to the CG CAHPS survey is fair. The CG CAHPS survey measure only satisfies the reporting of 1 NQS domain, while most other group practice criteria we have established for the registry and EHR-based reporting mechanisms require the reporting of measures in at least 3 NQS domains to meet the criteria for satisfactory reporting for the 2016 PQRS payment adjustment. In addition, we note that requiring the reporting of 6 measures in addition to the CG CAHPS survey would essentially require a group practice to report on 6 measures and 12 survey questions, for a total of 18 measures and questions. We note that this is the same number of measures (18) that we currently require group practices in the GPRO to report via the GPRO web interface. Based on the comments received and for the reasons stated previously, we are finalizing the following criterion—which is identical to the criterion finalized for the 2014 PQRS incentive—for a group practice who chooses to complete the CG CAHPS survey in conjunction with the qualified registry, direct EHR product, EHR data submission vendor, or GPRO web-interface reporting mechanisms for the 2016 PQRS payment adjustment: For the 12-month reporting period for the 2014 PQRS incentive, report all CAHPS survey measures via a certified vendor, AND report at least 6 measures covering at least 2 of the NQS domains using the qualified registry, direct EHR product, EHR data submission vendor, or GPRO web interface reporting mechanisms

Tables 49 and 50 provide a summary of our final criteria for the satisfactory reporting of data on PQRS quality measures via the GPRO for the 2014 PQRS incentive and 2016 PQRS payment adjustment. Please note that we are adding paragraph § 414.90(h)(5) to specify the criteria for the satisfactory reporting of data on PQRS quality measures via the GPRO for the 2014 PQRS incentive as described in Table 49, and we are adding paragraph § 414.90(j)(5) to specify the criteria for the satisfactory reporting of data on PQRS quality measures via the GPRO for the 2016 PQRS payment adjustment as described in Table 50.

TABLE 49—SUMMARY OF FINAL REQUIREMENTS FOR THE 2014 PQRS INCENTIVE: CRITERIA FOR SATISFACTORY REPORTING OF DATA ON PQRS QUALITY MEASURES VIA THE GPRO

Reporting period	Reporting mechanism	Group practice size	Proposed reporting criterion
** 12-month (Jan 1–Dec 31).	GPRO Web interface	25–99 eligible professionals.	Report on all measures included in the web interface; AND Populate data fields for the first 218 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 218, then report on 100 percent of assigned beneficiaries.
** 12-month (Jan 1–Dec 31).	GPRO Web interface	100+ eligible professionals.	Report on all measures included in the web interface; AND Populate data fields for the first 411 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 411, then report on 100 percent of assigned beneficiaries. In addition, the group practice must also report all CG CAHPS survey measures via certified survey vendor.
12-month (Jan 1–Dec 31).	Qualified Registry	2+ eligible professionals.	Report at least 9 measures covering at least 3 of the NQS domains, OR, if less than 9 measures covering at least 3 NQS domains apply to the group practice, report 1–8 measures covering 1–3 NQS domains for which there is Medicare patient data, AND report each measure for at least 50 percent of the group practice's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted. For a group practice who reports fewer than 9 measures covering at least 3 NQS domains via the registry-based reporting mechanism, the group practice will be subject to the MAV process, which would allow us to determine whether a group practice should have reported on additional measures and/or measures covering additional NQS domains.
** 12-month (Jan 1–Dec 31).	Direct EHR product that is CEHRT/EHR data submission vendor that is CEHRT.	2+ eligible professionals.	Report 9 measures covering at least 3 of the NQS domains. If a group practice's CEHRT does not contain patient data for at least 9 measures covering at least 3 domains, then the group practice must report the measures for which there is Medicare patient data. A group practice must report on at least 1 measure for which there is Medicare patient data.
12-month (Jan 1–Dec 31.	CMS-certified survey vendor + qualified registry, direct EHR product, EHR data submission vendor, or GPRO web interface.	25+ eligible professionals.	Report all CG CAHPS survey measures via a CMS-certified survey vendor, AND report at least 6 measures covering at least 2 of the NQS domains using a qualified registry, direct EHR product, EHR data submission vendor, or GPRO web interface.

* Subject to the Measure Application Validity (MAV) process.
** Criteria finalized in the CY 2013 PFS final rule (77 FR 69200).

TABLE 50—SUMMARY OF FINAL REQUIREMENTS FOR THE 2016 PQRS PAYMENT ADJUSTMENT: CRITERIA FOR SATISFACTORY REPORTING OF DATA ON PQRS QUALITY MEASURES VIA THE GPRO

Reporting period	Reporting mechanism	Group practice size	Proposed reporting criterion
** 12-month (Jan 1–Dec 31).	GPRO Web interface	25–99 eligible professionals.	Report on all measures included in the web interface; AND Populate data fields for the first 218 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 218, then report on 100 percent of assigned beneficiaries.
** 12-month (Jan 1–Dec 31).	GPRO Web interface	100+ eligible professionals.	Report on all measures included in the web interface; AND Populate data fields for the first 411 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 411, then report on 100 percent of assigned beneficiaries. In addition, the group practice must report all CG CAHPS survey measures via certified survey vendor.

TABLE 50—SUMMARY OF FINAL REQUIREMENTS FOR THE 2016 PQRS PAYMENT ADJUSTMENT: CRITERIA FOR SATISFACTORY REPORTING OF DATA ON PQRS QUALITY MEASURES VIA THE GPRO—Continued

Reporting period	Reporting mechanism	Group practice size	Proposed reporting criterion
12-month (Jan 1–Dec 31).	Qualified Registry	2+ eligible professionals.	Report at least 9 measures covering at least 3 of the NQS domains, OR, if less than 9 measures covering at least 3 NQS domains apply to the group practice, report 1–8 measures covering 1–3 NQS domains for which there is Medicare patient data, AND report each measure for at least 50 percent of the group practice's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted. For a group practice who reports fewer than 9 measures via the registry-based reporting mechanism, the group practice would be subject to the MAV process, which would allow us to determine whether a group practice should have reported on additional measures and/or measures covering additional NQS domains.
12-month (Jan 1–Dec 31).	Qualified Registry	2+ eligible professionals.	Report at least 3 measures covering at least 1 of the NQS domains, OR, if less than 3 measures covering 1 NQS domain apply to the group practice, report 1–2 measures covering 1 NQS domain for which there is Medicare patient data, AND report each measure for at least 50 percent of the group practice's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted. For a group practice who reports fewer than 3 measures covering 1 NQS domain via the registry-based reporting mechanism, the group practice would be subject to the MAV process, which would allow us to determine whether a group practice should have reported on additional measures.
** 12-month (Jan 1–Dec 31).	Direct EHR product that is CEHRT/EHR data submission vendor that is CEHRT.	2+ eligible professionals.	Report 9 measures covering at least 3 of the NQS domains. If a group practice's CEHRT does not contain patient data for at least 9 measures covering at least 3 domains, then the group practice must report the measures for which there is Medicare patient data. A group practice must report on at least 1 measure for which there is Medicare patient data.
12-month (Jan 1–Dec 31.	CMS-certified survey vendor + qualified registry, direct EHR product, EHR data submission vendor, or GPRO web interface.	25+ eligible professionals.	Report all CG CAHPS survey measures via a CMS-certified survey vendor, AND report at least 6 measures covering at least 2 of the NQS domains using a qualified registry, direct EHR product, EHR data submission vendor, or GPRO web interface.

* Subject to the Measure Application Validity (MAV) process.
** Criteria finalized in the CY 2013 PFS final rule (77 FR 69200).

9. Statutory Requirements and Other Considerations for the Selection of PQRS Quality Measures for Meeting the Criteria for Satisfactory Reporting for 2014 and Beyond for Individual Eligible Professionals and Group Practices

CMS underwent an annual Call for Measures that solicited new measures from the public for possible inclusion in the PQRS for 2014 and beyond. During the Call for Measures, we requested measures for inclusion in PQRS that meet the following statutory and non-statutory criteria.

Sections 1848(k)(2)(C) and 1848(m)(3)(C)(i) of the Act, respectively, govern the quality measures reported by individual eligible professionals and group practices reporting under the PQRS. Under section 1848(k)(2)(C)(i) of the Act, the PQRS quality measures shall be such measures selected by the Secretary from measures that have been endorsed by the entity with a contract with the Secretary under section 1890(a) of the Act (currently, that is the National Quality Forum, or NQF). However, in the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the NQF, section 1848(k)(2)(C)(ii) of the Act authorizes the Secretary to specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary, such as the AQA alliance. In light of these statutory requirements, we believe that, except in the circumstances specified in the statute, each PQRS quality measure must be endorsed by the NQF. Additionally, section 1848(k)(2)(D) of the Act requires that for each PQRS quality measure, "the Secretary shall ensure that eligible professionals have the opportunity to provide input during the development, endorsement, or selection of measures applicable to services they furnish."

The statutory requirements under section 1848(k)(2)(C) of the Act, subject to the exception noted previously, require only that the measures be selected from measures that have been endorsed by the entity with a contract with the Secretary under section 1890(a) of the Act (that is, the NQF) and are silent for how the measures that are submitted to the NQF for endorsement were developed. The basic steps for developing measures applicable to physicians and other eligible professionals prior to submission of the measures for endorsement may be carried out by a variety of different organizations. We do not believe there needs to be any special restrictions on the type or make-up of the organizations carrying out this basic process of development of physician measures, such as restricting the initial development to physician-controlled

organizations. Any such restriction would unduly limit the basic development of quality measures and the scope and utility of measures that may be considered for endorsement as voluntary consensus standards for purposes of the PQRS.

In addition to section 1848(k)(2)(C) of the Act, section 1890A of the Act, which was added by section 3014(b) of the Affordable Care Act, requires that the entity with a contract with the Secretary under section 1890(a) of the Act (currently, that is the NQF) convene multi-stakeholder groups to provide input to the Secretary on the selection of certain categories of quality and efficiency measures. These categories are described in section 1890(b)(7)(B) of the Act, and include such measures as the quality measures selected for reporting under the PQRS. Under section 3014 of the Affordable Care Act, the NQF convened multi-stakeholder groups by creating the Measure Applications Partnership (MAP). Section 1890(A)(a) of the Act requires that the Secretary establish a pre-rulemaking process in which the Secretary must make publicly available by December 1st of each year a list of the quality and efficiency measures that the Secretary is considering for selection through rulemaking for use in the Medicare program. The NQF must provide CMS with the MAP's input on selecting measures by February 1st of each year. The list of measures under consideration for 2013 is available at *http://www.qualityforum.org/map/*.

As we noted above, section 1848(k)(2)(C)(ii) of the Act provides an exception to the requirement that the Secretary select measures that have been endorsed by the entity with a contract under section 1890(a) of the Act (that is, the NQF). We may select measures under this exception if there is a specified area or medical topic for which a feasible and practical measure has not been endorsed by the entity, as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary. We requested that stakeholders apply the following considerations when submitting measures for possible inclusion in the PQRS measure set:

- High impact on healthcare.
- Measures that are high impact and support CMS and HHS priorities for improved quality and efficiency of care for Medicare beneficiaries.
- Measures that address gaps in the quality of care delivered to Medicare beneficiaries.
- Address Gaps in the PQRS measure set.
- Measures impacting chronic conditions (chronic kidney disease, diabetes mellitus, heart failure, hypertension and musculoskeletal).
- Measures applicable across care settings (such as, outpatient, nursing facilities, domiciliary, etc.).
- Broadly applicable measures that could be used to create a core measure set required of all participating eligible professionals.
- Measures groups that reflect the services furnished to beneficiaries by a particular specialty.

10. PQRS Quality Measures

Taking into consideration the statutory and non-statutory criteria we described previously, this section contains our proposals for the inclusion or removal of measures in PQRS for 2014 and beyond. We are classifying all measures against six domains based on the NQS's six priorities, as follows:

(1) *Person and Caregiver-Centered Experience and Outcomes.* These are measures that reflect the potential to improve patient-centered care and the quality of care delivered to patients. They emphasize the importance of collecting patient-reported data and the ability to impact care at the individual patient level, as well as the population level through greater involvement of patients and families in decision making, self-care, activation, and understanding of their health condition and its effective management.

(2) *Patient Safety.* These are measures that reflect the safe delivery of clinical services in both hospital and ambulatory settings and include processes that would reduce harm to patients and reduce burden of illness. These measures should enable longitudinal assessment of condition-specific, patient-focused episodes of care.

(3) *Communication and Care Coordination.* These are measures that demonstrate appropriate and timely sharing of information and coordination of clinical and preventive services among health professionals in the care team and with patients, caregivers, and families to improve appropriate and timely patient and care team communication.

(4) *Community/Population Health.* These are measures that reflect the use of clinical and preventive services and achieve improvements in the health of the population served. These are outcome-focused and have the ability to achieve longitudinal measurement that will demonstrate improvement or lack of improvement in the health of the US population.

(5) *Efficiency and Cost Reduction.* These are measures that reflect efforts to significantly improve outcomes and reduce errors. These measures also impact and benefit a large number of patients and emphasize the use of evidence to best manage high priority conditions and determine appropriate use of healthcare resources.

(6) *Effective Clinical Care.* These are measures that reflect clinical care processes closely linked to outcomes based on evidence and practice guidelines.

Please note that the PQRS quality measure specifications for any given PQRS quality measure may differ from specifications for the same quality measure used in prior years. For example, for the PQRS quality measures that were selected for reporting in 2013 and beyond, please note that detailed measure specifications, including the measure's title, for the individual PQRS quality measures for 2013 and beyond may have been updated or modified during the NQF endorsement process or for other reasons. In addition, due to our desire to align measure titles with the measure titles that are finalized for 2013, 2014, 2015, and potentially subsequent years of the EHR Incentive Program, we note that the measure titles for measures available for reporting via EHRs may change from year to year. We note that the EHR Incentive Program has updated its measure titles to include version numbers, and these version numbers are referenced in the tables containing the final PQRS measures set below. Please note that any changes reflected below are not substantive. We will continue to work toward complete alignment, where possible, of measure specifications across programs, and do so in both rulemaking and subregulatory communication, as applicable, including through guidance such as in the detailed quality measure specifications PQRS publishes each year at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html*.

Through NQF's measure maintenance process, NQF endorsed measures are sometimes updated to incorporate changes that we believe do not substantively change the nature of the measure. Examples of such changes could be updated diagnosis or procedure codes or changes to exclusions to the patient population or definitions. We believe these types of maintenance changes are distinct from more substantive changes to measures that result in what are considered new or different measures, and that they do not trigger the same agency obligations under the Administrative Procedure

Act. In the CY 2013 PFS final rule with comment period, we finalized our proposal providing that if the NQF updates an endorsed measure that we have adopted for the PQRS in a manner that we consider to not substantively change the nature of the measure, we would use a subregulatory process to incorporate those updates to the measure specifications that apply to the program (77 FR 69207). We believe this adequately balances our need to incorporate non-substantive NQF updates to NQF-endorsed measures in the most expeditious manner possible, while preserving the public's ability to comment on updates that so fundamentally change an endorsed measure that it is no longer the same measure that we originally adopted. We also noted that the NQF process incorporates an opportunity for public comment and engagement in the measure maintenance process. We will revise the Specifications Manual and post notices to clearly identify the updates and provide links to where additional information on the updates can be found. Updates will also be available on the CMS PQRS Web site at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html.*

Additionally, eligible professionals and registry vendors should be aware that the 2014 *Physician Quality Reporting System (PQRS) Claims/Registry Measure Specifications Manual* and other supporting documentation may be published with placeholder quality-data codes (represented as GXXXX) in a sub-set of measures' numerator options. PQRS participants should note that these placeholder codes should not be submitted and will not count toward satisfactory reporting. In the event the specifications are published with the placeholder codes, we will revise the measure specifications and post notices to clearly identify the updates and provide links to where additional information on the updates can be found. Updates will also be available on the CMS PQRS Web site at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html.*

For the PQRS EHR measures that are also reportable under the EHR Incentive Program (that is, electronically specified clinical quality measures), please note that the updates to these measures will be provided on the EHR Incentive Program Web site. We understand that the EHR Incentive Program may accept versions of electronically specified clinical quality measures that may be outdated. We proposed that for purposes of the PQRS, eligible professionals must report the most recent, updated version of a clinical quality measure (78 FR 43371). We solicited and received no public comment on this proposal. However, we are not finalizing this proposal. To avoid confusion on which measure version to report for the PQRS, rather than redirecting eligible professionals to the EHR Incentive Program Web site, although actual measure specifications will be provided on the EHR Incentive Program Web site, the electronic measure version that must be reported under the PQRS for a specific year will be found in the Measure Specifications List updated for that year. For example, for purposes of reporting clinical quality measures that are electronically specified during the PQRS reporting periods that occur in 2014, we would only accept the version of clinical quality measures that will be found in the 2014 Measure Specifications List, which will be made available at the PQRS Web site at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html.* However, please note that the 2014 PQRS Measures List will to the EHR Incentive Program's Web site for the measure specifications for the 2014 EHR measures.

We also understand, for purposes of the EHR Incentive Program, that once direct EHR products and EHR data submission vendors are issued a 2014 Edition certification for clinical quality measures, they will not necessarily be required to have such technology retested and recertified against the most recent, updated version of a clinical quality measure when such versions are made available. We proposed that for purposes of PQRS, however, that the eligible professional's direct EHR product or EHR data submission vendor must be tested and certified to the most updated, recent versions of electronically specified clinical quality measures for that year (78 FR 43371–43372). We solicited but received no public comment on this proposal to require eligible professionals to use a direct EHR product or EHR data submission vendor that has been tested and certified to the most recent, updated version of the clinical quality measure's electronic specifications for PQRS purposes. However, we are not finalizing this proposal. Instead, for purposes of PQRS, the eligible professional's direct EHR product or EHR data submission vendor must be tested and certified to the versions of electronically specified clinical quality measures listed in the Measure Specifications List for the particular program year. For example, for purposes of reporting clinical quality measures that are electronically specified during the PQRS reporting periods that occur in 2014, we would only accept the reporting of clinical quality measures from direct EHR products or EHR data submission vendors that have been tested and certified to versions of the electronic specifications that will be found in the 2014 PQRS Measure Specifications List that will be released following the display of this final rule with comment period. Since the PQRS Measure Specifications List is not typically released until late November/December of the year prior to the January 1 start of the reporting periods for a particularly year, we understand that vendors may be concerned with having enough time to update their systems with the most recent measure specifications in time prior to the start of the year. Please note that, unless there are errors discovered in updated electronic measure specifications, the PQRS intends to use the most recent, updated versions of electronically specified clinical quality measures for that year. For example, for 2014, the PQRS will accept the June 2013 versions of electronically specified clinical quality measures under the EHR Incentive Program, except for the following measure—CMS140v2, Breast Cancer Hormonal Therapy for Stage IC–IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer (NQF 0387). As a substantive error which would result in a, erroneous zero percent performance rate when reported this measure was discovered in the June 2013 version of this electronically specified clinical quality measure, the PQRS will require the use of the prior, December 2012 version of this measure, which is CMS140v1.

a. Individual PQRS Measures and Measures Within Measures Groups Available for Reporting for 2014 and Beyond

(1) PQRS Core Measures Available for Reporting for 2014 and Beyond

In the CY 2013 PFS final rule with comment period, we finalized the HHS Million Hearts Measures as a recommended set of core measures for which we encourage eligible professionals to report in PQRS (77 FR 69209). In addition to the HHS Million Hearts Measures we previously finalized, we proposed to include the measures specified in the EHR Incentive Program as additional recommended core measures for 2014 and beyond (78 FR 43372–43378, Table 28). These additional proposed recommended core

measures were also finalized as recommended core measures in the EHR Incentive Program for 2014. Therefore, due to our desire to align with the recommended measures available under the EHR Incentive Program, we proposed the additional recommended measures specified in Table 51 for 2014 and beyond. We solicited and received the following public comment on this proposal:

Comment: Several commenters generally supported our proposal to align, when possible, the clinical quality measures found under the PQRS and the clinical quality measures found under the EHR Incentive Program.

Response: We appreciate the commenters' general support in aligning measures under the PQRS and the EHR Incentive Program. In response to the comment and for the reasons we discussed above, we are finalizing our proposal to add these measures as recommended core measures under the PQRS for 2014 and beyond. Table 51 shows the final measures classified as the PQRS recommended core measures for 2014 and beyond.

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TABLE 51: Physician Quality Reporting System Recommended Core Measures for 2014 and Beyond

NQF/ PQRS	CMS E-Measure ID	NQS Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
0002/ 66 **	146v2	Efficiency and Cost Reduction	**Appropriate Testing for Children with Pharyngitis:** Percentage of children 2-18 years of age who were diagnosed with pharyngitis, ordered an antibiotic and received a group A streptococcus (strep) test for the episode	NCQA		X	X			MU2
0018/ 236 *	165v2	Effective Clinical Care	**Controlling High Blood Pressure:** Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mmHg) during the measurement period.	NCQA	X	X	X	X	X	MU2 ACO Million Hearts
0022/ 238 *	156v2	Patient Safety	**Use of High-Risk Medications in the Elderly:** Percentage of patients 66 years of age and older who were ordered high-risk medications. Two rates are reported. a. Percentage of patients who were ordered at least one high-risk medication. b. Percentage of patients who were ordered at least two different high-risk medications.	NCQA			X			MU2

NQF/ PQRS	CMS E-Measure ID	NQS Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
0024/ 239 **	155v2	Community/Population Health	**Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents:** Percentage of patients 3-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or Obstetrician/Gynecologist (OB/GYN) and who had evidence of the following during the measurement period. Three rates are reported. - Percentage of patients with height, weight, and body mass index (BMI) percentile documentation - Percentage of patients with counseling for nutrition - Percentage of patients with counseling for physical activity	NCQA			X			MU2
0028/ 226 *	138v2	Community/Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** Percentage of patients 18 years and older who were screened for tobacco use one or more times within 24 months **AND** who received cessation counseling intervention if identified as a tobacco user	AMA-PCPI	X	X	X	X	X	MU2 ACO Million Hearts
0033/ 310 **	153v2	Community/ Population Health	**Chlamydia Screening for Women:** Percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement period	NCQA			X			MU2
0036/ 311 **	126v2	Effective Clinical Care	**Use of Appropriate Medications for Asthma:** Percentage of patients 5-64 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement period	NCQA			X			MU2

NQF/ PQRS	CMS E-Measure ID	NQS Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
0038/ 240 **	117v2	Community/Population Health	**Childhood Immunization Status:** Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday	NCQA			X			MU2
0052/ 312 *	166v3	Efficiency and Cost Reduction	**Use of Imaging Studies for Low Back Pain:** Percentage of patients 18-50 years of age with a diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.	NCQA			X			MU2
0069/ 65 **	154v2	Efficiency and Cost Reduction	**Appropriate Treatment for Children with Upper Respiratory Infection (URI):** Percentage of children 3 months-18 years of age who were diagnosed with upper respiratory infection (URI) and were not dispensed an antibiotic prescription on or three days after the episode	NCQA		X	X			MU2

NQF/ PQRS	CMS E-Measure ID	NQS Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
0108/ N/A **	136v3	Effective Clinical Care	**ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication:** Percentage of children 6-12 years of age and newly dispensed a medication for attention-deficit/hyperactivity disorder (ADHD) who had appropriate follow-up care. Two rates are reported. a. Percentage of children who had one follow-up visit with a practitioner with prescribing authority during the 30-Day Initiation Phase. b. Percentage of children who remained on ADHD medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two additional follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.	NCQA			X			MU2
0418/ 134 * **	2v3	Community/Population Health	**Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan:** Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.	CMS	X	X	X	X		MU2 ACO

NQF/ PQRS	CMS E-Measure ID	NQS Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
0419/ 130 *	68v3	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list ***must*** include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND ***must*** contain the medications' name, dosage, frequency and route of administration.	CMS	X	X	X		X	MU2
0421/ 128 *	69v2	Community/Population Health	**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up:** Percentage of patients aged 18 years and older with a documented BMI during the current encounter or during the previous 6 months AND when the BMI is **outside of normal parameters**, a follow-up plan is documented during the encounter or during the previous 6 months of the encounter **Normal Parameters:** Age 65 years and older BMI ≥ 23 and < 30; Age 18 – 64 ycars BMI ≥ 18.5 and < 25	CMS	X	X	X	X	X	MU2 ACO
N/A/ N/A **	75v2	Effective Clinical Care	**Children Who Have Dental Decay or Cavities:** Percentage of children, age 0-20 years, who have had tooth decay or cavities during the measurement period	CMS			X			MU2
N/A/ N/A *	50v2	Communication and Care Coordination	**Closing the referral loop: receipt of specialist report:** Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred	CMS			X			MU2

NQF/ PQRS	CMS E-Measure ID	NQS Domain	Measure Title and Description¥	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
N/A/ N/A *	90v3	Person and Caregiver-Centered Experience and Outcomes	**Functional Status Assessment for Complex Chronic Conditions:** Percentage of patients aged 65 years and older with heart failure who completed initial and follow-up patient-reported functional status assessments	CMS			X			MU2

* Recommended Adult Core CQMs for eligible professionals

** Recommended Pediatric Core CQMs for eligible professionals

¥ Titles and descriptions in this table are aligned with the 2014 Physician Quality Reporting System Claims and Qualified Registry measure titles and descriptions, and may differ based on reporting mechanism within PQRS. Additionally, there may be tittle and description variations for the same measure across other quality reporting programs. Please reference the National Quality Forum (NQF) and Physician Quality Reporting System numbers for clarification.

(2) Individual PQRS Measures Available for Reporting for 2014 and Beyond

In the CY 2014 PFS proposed rule, we proposed to include additional measures in the PQRS measure set for 2014 and beyond (*see* Table 52, 78 FR 43379). We solicited and received public comment on these proposed measures.

Table 52 provides the individual quality measures and measures included in the PQRS measures groups we are finalizing for 2014 and beyond. The comments received and our responses to these comments are also contained in Table 52. Please note that Table 52 also provides certain measures we previously finalized for 2013 or 2014 and beyond in the CY 2013 PFS final rule with comment period (*see* Table 95, 77 FR 69215). Please also note that, in the CY 2014 proposed rule, in an effort to move away from claims-based process measures, we proposed to change the reporting mechanisms for which certain measures were previously reportable (78 FR 43474). Please note that the comments we received on these proposed reporting mechanism changes, as well as our responses are also specified in Table 52.

Furthermore, CMS recognizes that updated clinical guidelines for cholesterol screening were recently released. The measures related to cholesterol screening contained in Table 52 do not reflect these recently updated guidelines. CMS will work to address any potential changes related to these new guidelines in future rulemaking

TABLE 52: Final Individual Quality Measures and Those Included in Measures Groups for the Physician Quality Reporting System to be Available for Satisfactory Reporting via Claims, Registry, or EHR Beginning in 2014

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
0059/ 1	122v2	Effective Clinical Care	**Diabetes: Hemoglobin A1c Poor Control:** Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period. This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	NCQA	X	X	X	X	X	MU2 ACO
0064/ 2	163v2	Effective Clinical Care	**Diabetes: Low Density Lipoprotein (LDL) Management:** Percentage of patients 18–75 years of age with diabetes whose LDL-C was adequately controlled (<100 mg/dL) during the measurement period. This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	NCQA	X	X	X		X	MU2 Million Hearts
0081/ 5	135v2	Effective Clinical Care	**Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD):**	AMA-PCPI/ACCF/AHA		X	X		X	MU2

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description¥	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB therapy either within a 12 month period when seen in the outpatient setting OR at **each** hospital discharge This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
0067/ 6		Effective Clinical Care	**Coronary Artery Disease (CAD): Antiplatelet Therapy:** Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who were prescribed aspirin or clopidogrel *The EHR-based reporting mechanism is no longer available for reporting this measure for 2014 and beyond.* We solicited but received no public comment on this proposed measure. In an effort to align with the EHR	AMA-PCPI/ACCF/AHA	X	X			X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			Incentive Program, this measure will no longer be reportable via EHR beginning in 2014. The alignment of measures contained within multiple CMS reporting programs eases the burden of reporting and encourages eligible professionals to submit quality clinical data on care provided for Medicare beneficiaries. Alignment also promotes a robust data source and consistency in analysis, which supports other quality programs within CMS. For the reasons previously stated, we are finalizing the removal of the EHR-based option beginning in 2014.							
0070/ 7	145v2	Effective Clinical Care	**Coronary Artery Disease (CAD): Beta-Blocker Therapy – Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF < 40%):** Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have prior MI OR a current or LVEF < 40% who were prescribed beta-blocker therapy	AMA- PCPI/ ACCF/AHA		X	X			MU2

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
0083/ 8	144v2	Effective Clinical Care	**Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD):** Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed beta-blocker therapy either within a 12 month period when seen in the outpatient setting OR at **each** hospital discharge This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AMA- PCPI/ ACCF/AHA		X	X	X	X	MU2 ACO

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description¥	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
0105/ 9	128v2	Effective Clinical Care	**Anti-depressant Medication Management:** Percentage of patients 18 years of age and older who were diagnosed with major depression and treated with antidepressant medication, and who remained on antidepressant medication treatment. Two rates are reported a. Percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks). b. Percentage of patients who remained on an antidepressant medication for at least 180 days (6 months). *The claims-based reporting option is no longer available for reporting this measure for 2014 and beyond, additionally, the EHR-based reporting option is available for reporting this measure beginning in 2014.* Several commenters were concerned with CMS' proposal to eliminate the claims-based reporting option for this measure, stating eligible professionals who may have reported this measure will no longer be able to participate in PQRS. CMS appreciates the commenters' concerns but notes that this measure will still be available for registry-based reporting, along with	NCQA		X	X			MU2

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			additional clinically-related measures. Eligible professionals who report this measure will still have an opportunity to participate in PQRS using the registry-based reporting option. As stated in the proposed rule, 2012 claims data indicates a low threshold of eligible professionals reporting this measure via claims. CMS intends to streamline the reporting options available under the PQRS and to eliminate reporting options that are not widely used. Additionally, in an effort to align with the EHR Incentive Program, this measure will be reportable via EHR beginning in 2014. The alignment of measures contained within multiple CMS reporting programs eases the burden of reporting and encourages eligible professionals to submit quality clinical data on care provided for Medicare beneficiaries. Alignment also promotes a robust data source and consistency in analysis, which supports other quality programs within CMS. For the reasons previously stated, we are finalizing the removal of the claims-based option and the addition of the EHR-based reporting option for this measure beginning in 2014.							

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[v]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
0086/ 12	143v2	Effective Clinical Care	**Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation:** Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma (POAG) who have an optic nerve head evaluation during one or more office visits within 12 months This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AMA- PCPI/ NCQA	X	X	X			MU2
0087/ 14		Effective Clinical Care	**Age-Related Macular Degeneration (AMD): Dilated Macular Examination:** Percentage of patients aged 50 years and older with a diagnosis of age-related macular degeneration (AMD) who had a dilated macular examination performed which included documentation of the presence or absence of macular thickening or hemorrhage AND the level of macular degeneration severity during one or more office visits within 12 months	AMA- PCPI/ NCQA	X	X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description¥	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
0088/ 18	167v2	Effective Clinical Care	**Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy:** Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy and the presence or absence of macular edema during one or more office visits within 12 months This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AMA- PCPI/ NCQA	X	X	X			MU2
0089/ 19	142v2	Effective Clinical Care	**Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care:** Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular	AMA- PCPI/ NCQA	X	X	X			MU2

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215). However, please note that we are updating the domain for this measure from the Communication Care Coordination domain. We are making this change to align with the domains indicated in the EHR Incentive Program final rule for 2014. It is necessary for the domains for EHR measures within the EHR Incentive Program and the PQRS to create consistency for the EHR systems used to report these measures have one set of logic.							
0270/ 20		Patient Safety	**Perioperative Care: Timing of Prophylactic Parenteral Antibiotic – Ordering Physician:** Percentage of	AMA- PCPI/ NCQA	X	X			X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description¥	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic parenteral antibiotics, who have an order for prophylactic parenteral antibiotic to be given within one hour (if fluoroquinolone or vancomycin, two hours), prior to the surgical incision (or start of procedure when no incision is required) This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
0268/ 21		Patient Safety	**Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin:** Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for a first OR second generation cephalosporin prophylactic antibiotic, who had an order for a first OR second generation cephalosporin for antimicrobial prophylaxis	AMA- PCPI/ NCQA	X	X			X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
0271/ 22		Patient Safety	**Perioperative Care: Discontinuation of Prophylactic Parenteral Antibiotics (Non-Cardiac Procedures):** Percentage of non-cardiac surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic parenteral antibiotics AND who received a prophylactic parenteral antibiotic, who have an order for discontinuation of prophylactic parenteral antibiotics within 24 hours of surgical end time This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AMA- PCPI/ NCQA	X	X			X	
0239/ 23		Patient Safety	**Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients):** Percentage of surgical patients aged 18 years and older undergoing procedures for which VTE	AMA- PCPI/ NCQA	X	X			X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			prophylaxis is indicated in all patients, who had an order for Low Molecular Weight Heparin (LMWH), Low-Dose Unfractionated Heparin (LDUH), adjusted-dose warfarin, fondaparinux or mechanical prophylaxis to be given within 24 hours prior to incision time or within 24 hours after surgery end time This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
0045/ 24		Communication and Care Coordination	**Osteoporosis: Communication with the Physician Managing On-going Care Post-Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older:** Percentage of patients aged 50 years and older treated for a hip, spine or distal radial fracture with documentation of communication with the physician managing the patient's on-going care that a fracture occurred and that the patient was or should be tested or treated for osteoporosis	AMA- PCPI/ NCQA	X	X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[v]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
0092/ 28		Effective Clinical Care	**Aspirin at Arrival for Acute Myocardial Infarction (AMI):** Percentage of patients, regardless of age, with an emergency department discharge diagnosis of acute myocardial infarction (AMI) who had documentation of receiving aspirin within 24 hours before emergency department arrival or during emergency department stay This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AMA- PCPI/ NCQA	X	X				
0269/ 30		Patient Safety	**Perioperative Care: Timing of Prophylactic Antiobiotic—Administering Physician:** Percentage of surgical patients aged 18 years and older who receive an anesthetic when undergoing procedures with the indications for prophylactic parenteral antibiotics for whom administration of a prophylactic parenteral antibiotic	AMA- PCPI/ NCQA	X	X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			ordered has been initiated within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required) This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
0240/ 31		Effective Clinical Care	**Stroke and Stroke Rehabilitation: Venous Thromboembolism (VTE) Prophylaxis for Ischemic Stroke or Intracranial Hemorrhage:** Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or intracranial hemorrhage who were administered venous thromboembolism (VTE) prophylaxis the day of or the day after hospital admission This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AMA- PCPI/ NCQA	X	X				
0325/ 32		Effective Clinical Care	**Stroke and Stroke Rehabilitation: Discharged on Antithrombotic Therapy:** Percentage of patients aged	AMA- PCPI/ NCQA	X	X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[V]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			18 years and older with a diagnosis of ischemic stroke or transient ischemic attack (TIA) who were prescribed antithrombotic therapy at discharge This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
0241/ 33		Effective Clinical Care	**Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation (AF) at Discharge:** Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or transient ischemic attack (TIA) with documented permanent, persistent, or paroxysmal atrial fibrillation who were prescribed an anticoagulant at discharge This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AMA- PCPI/ NCQA		X				
0243/ 35		Effective Clinical Care	**Stroke and Stroke Rehabilitation: Screening for Dysphagia:** Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or	AMA- PCPI/ NCQA	X	X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			intracranial hemorrhage who receive any food, fluids or medication by mouth (PO) for whom a dysphagia screening was performed prior to PO intake in accordance with a dysphagia screening tool approved by the institution in which the patient is receiving care This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
0244/ 36		Effective Clinical Care	**Stroke and Stroke Rehabilitation: Rehabilitation Services Ordered:** Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or intracranial hemorrhage for whom occupational, physical, or speech rehabilitation services were ordered at or prior to inpatient discharge OR documentation that no rehabilitation services are indicated at or prior to inpatient discharge	AMA- PCPI/ NCQA	X	X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[v]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
0046/ 39		Effective Clinical Care	**Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older:** Percentage of female patients aged 65 years and older who have a central dual-energy X- ray absorptiometry (DXA) measurement ordered or performed at least once since age 60 or pharmacologic therapy prescribed within 12 months *The EHR-based reporting mechanism is no longer available for reporting this measure for 2014 and beyond.* In an effort to align with the EHR Incentive Program, this measure will no longer be reportable via EHR beginning in 2014. The alignment of measures contained within multiple CMS reporting programs eases the burden of reporting and encourages eligible professionals to submit quality clinical data on care provided for Medicare beneficiaries. Alignment also promotes	AMA- PCPI/ NCQA	X	X			X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			a robust data source and consistency in analysis, which supports other quality programs within CMS. For the reasons previously stated, we are finalizing the removal of the EHR-based option beginning in 2014.							
0048/ 40		Effective Clinical Care	**Osteoporosis: Management Following Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older:** Percentage of patients **aged 50 years and older** with fracture of the hip, spine, or distal radius who had a central dual-energy X-ray absorptiometry (DXA) measurement ordered or performed or pharmacologic therapy prescribed This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AMA- PCPI/ NCQA	X	X				
0049/ 41		Effective Clinical Care	**Osteoporosis: Pharmacologic Therapy for Men and Women Aged 50 Years and Older:** Percentage of patients **aged 50 years and older** with a diagnosis of osteoporosis who were prescribed pharmacologic therapy within 12 months	AMA- PCPI/ NCQA	X	X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
0134/ 43		Effective Clinical Care	**Coronary Artery Bypass Graft (CABG): Use of Internal Mammary Artery (IMA) in Patients with Isolated CABG Surgery:** Percentage of patients aged 18 years and older undergoing isolated CABG surgery who received an IMA graft This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	STS	X	X			X	
0236/ 44		Effective Clinical Care	**Coronary Artery Bypass Graft (CABG): Preoperative Beta-Blocker in Patients with Isolated CABG Surgery:** Percentage of isolated Coronary Artery Bypass Graft (CABG) surgeries for patients aged 18 years and older who received a beta-blocker within 24 hours prior to surgical incision	CMS	X	X			X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
0637/ 45		Patient Safety	**Perioperative Care: Discontinuation of Prophylactic Parenteral Antibiotics (Cardiac Procedures):** Percentage of cardiac surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic parenteral antibiotics AND who received a prophylactic parenteral antibiotic, who have an order for discontinuation of prophylactic parenteral antibiotics within 48 hours of surgical end time This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AMA- PCPI/ NCQA	X	X				
0097/ 46		Patient Safety	**Medication Reconciliation:** Percentage of patients aged 65 years and older **discharged from any inpatient facility** (e.g., hospital, skilled nursing facility, or rehabilitation facility) and **seen within 30 days following**	AMA- PCPI/ NCQA	X	X		X		ACO

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care who had a reconciliation of the discharge medications with the current medication list in the outpatient medical record documented This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
0326/ 47		Communication and Care Coordination	**Advance Care Plan:** Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan *The EHR-based reporting mechanism is no longer available for reporting this measure for 2014 and beyond.*	AMA- PCPI/ NCQA	X	X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			We solicited but received no public comment on this measure. In an effort to align with the EHR Incentive Program, this measure will no longer be reportable via EHR beginning in 2014. The alignment of measures contained within multiple CMS reporting programs eases the burden of reporting and encourages eligible professionals to submit quality clinical data on care provided for Medicare beneficiaries. Alignment also promotes a robust data source and consistency in analysis, which supports other quality programs within CMS. For the reasons previously stated, we are finalizing the removal of the EHR-based option beginning in 2014.							
0098/ 48		Effective Clinical Care	**Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older:** Percentage of female patients aged 65 years and older who were assessed for the presence or absence of urinary incontinence within 12 months	AMA- PCPI/ NCQA	X	X			X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			The EHR-based reporting mechanism is no longer available for reporting this measure for 2014 and beyond. In an effort to align with the EHR Incentive Program, this measure will no longer be reportable via EHR beginning in 2014. The alignment of measures contained within multiple CMS reporting programs eases the burden of reporting and encourages eligible professionals to submit quality clinical data on care provided for Medicare beneficiaries. Alignment also promotes a robust data source and consistency in analysis, which supports other quality programs within CMS. For the reasons previously stated, we are finalizing the removal of the EHR-based option beginning in 2014.							
0099/ 49		Effective Clinical Care	**Urinary Incontinence: Characterization of Urinary Incontinence in Women Aged 65 Years and Older:** Percentage of female patients aged 65 years and older with a diagnosis of urinary incontinence whose urinary incontinence was	AMA- PCPI/ NCQA	X	X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			characterized at least once within 12 months This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
0100/ 50		Person and Caregiver-Centered Experience and Outcomes	**Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older:** Percentage of female patients aged 65 years and older with a diagnosis of urinary incontinence with a documented plan of care for urinary incontinence at least once within 12 months This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AMA- PCPI/ NCQA	X	X				
0091/ 51		Effective Clinical Care	**Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation:** Percentage of patients aged 18 years and older with a diagnosis of COPD who had spirometry evaluation results documented	AMA-PCPI	X	X			X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
0102/ 52		Effective Clinical Care	**Chronic Obstructive Pulmonary Disease (COPD): Inhaled Bronchodilator Therapy:** Percentage of patients aged 18 years and older with a diagnosis of COPD and who have an FEV_1/FVC less than 60% and have symptoms who were prescribed an inhaled bronchodilator This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AMA-PCPI	X	X			X	
0047/ 53		Effective Clinical Care	**Asthma: Pharmacologic Therapy for Persistent Asthma - Ambulatory Care Setting:** Percentage of patients aged 5 through 64 years with a diagnosis of persistent asthma who were prescribed long-term control medication *The claims-based reporting option is no longer available for reporting this measure for 2014 and beyond.*	AMA- PCPI/ NCQA		X			X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description¥	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			We solicited but received no public comment on removing the claims-based reporting mechanism as an option to report this measure. 2012 claims data indicates a low threshold of eligible professionals reporting this measure via claims. CMS intends to streamline the reporting options available under the PQRS and to eliminate reporting options that are not widely used. For these reasons, we are finalizing the removal of the claims-based option for this measure beginning in 2014.							
0090/ 54		Effective Clinical Care	**Emergency Medicine: 12-Lead Electrocardiogram (ECG) Performed for Non-Traumatic Chest Pain:** Percentage of patients aged 40 years and older with an emergency department discharge diagnosis of non-traumatic chest pain who had a 12-lead electrocardiogram (ECG) performed This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AMA- PCPI/ NCQA	X	X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
0093/ 55		Effective Clinical Care	**Emergency Medicine: 12-Lead Electrocardiogram (ECG) Performed for Syncope:** Percentage of patients aged 60 years and older with an emergency department discharge diagnosis of syncope who had a 12-lead electrocardiogram (ECG) performed This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AMA- PCPI/ NCQA	X	X				
0232/ 56		Effective Clinical Care	**Emergency Medicine: Community-Acquired Bacterial Pneumonia (CAP): Vital Signs:** Percentage of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia (CAP) with vital signs documented and reviewed This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AMA- PCPI/ NCQA	X	X				
0096/ 59		Effective Clinical Care	**Emergency Medicine: Community-Acquired Bacterial Pneumonia (CAP): Empiric Antibiotic:** Percentage of patients aged 18 years	AMA- PCPI/ NCQA	X	X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			and older with a diagnosis of community-acquired bacterial pneumonia (CAP) with an appropriate empiric antibiotic prescribed This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
0001/ 64		Effective Clinical Care	**Asthma: Assessment of Asthma Control – Ambulatory Care Setting:** Percentage of patients aged 5 through 64 years with a diagnosis of asthma who were evaluated at least once during the measurement period for asthma control (comprising asthma impairment and asthma risk) *The claims-based and EHR-based reporting options are no longer available for reporting this measure for 2014 and beyond* We solicited but received no public comment on this measure, including not having this measure reportable via the claims and EHR-based reporting mechanisms beginning ni 2014. 2012	AMA- PCPI/ NCQA		X			X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			claims data indicates a low threshold of eligible professionals reporting this measure via claims. CMS intends to streamline the reporting options available under the PQRS and to eliminate reporting options that are not widely used. Additionally, in an effort to align with the EHR Incentive Program, this measure will no longer be reportable via EHR beginning in 2014. The alignment of measures contained within multiple CMS reporting programs eases the burden of reporting and encourages eligible professionals to submit quality clinical data on care provided for Medicare beneficiaries. Alignment also promotes a robust data source and consistency in analysis, which supports other quality programs within CMS. For these reasons, we are finalizing the removal of this measure from the claims-based and EHR-based reporting options beginning in 2014.							
0069/ 65	154v2	Efficiency and Cost Reduction	**Appropriate Treatment for Children with Upper Respiratory Infection (URI):** Percentage of children 3 months-18 years of age who were diagnosed with upper respiratory	NCQA		X	X			MU2

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			infection (URI) and were not dispensed an antibiotic prescription on or three days after the episode. *The claims-based reporting option is no longer available for reporting this measure for 2014 and beyond, additionally, the EHR-based reporting option is available for reporting this measure beginning in 2014.* We solicited but received no public comment on this measure. 2012 claims data indicates a low threshold of eligible professionals reporting this measure via claims. CMS intends to streamline the reporting options available under the PQRS and to eliminate reporting options that are not widely used. Additionally, in an effort to align with the EHR Incentive Program, this measure will be reportable via EHR beginning in 2014. The alignment of measures contained within multiple CMS reporting programs eases the burden of reporting and encourages eligible professionals to submit quality clinical data on care							

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			provided for Medicare beneficiaries. Alignment also promotes a robust data source and consistency in analysis, which supports other quality programs within CMS. For the reasons previously stated, we are finalizing the removal of the claims-based option and the addition of the EHR-based reporting option for this measure beginning in 2014.							
0002/ 66	146v2	Efficiency and Cost Reduction	**Appropriate Testing for Children with Pharyngitis:** Percentage of children 2-18 years of age who were diagnosed with pharyngitis, ordered an antibiotic and received a group A streptococcus (strep) test for the episode. *The claims-based reporting option is no longer available for reporting this measure for 2014 and beyond.* We solicited but received no public comment on this measure. 2012 claims data indicates a low threshold of eligible professionals reporting this measure via claims. CMS intends to streamline the reporting options	NCQA		X	X			MU2

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			available under the PQRS and to eliminate reporting options that are not widely used. For these reasons, we are finalizing the removal of the claims-based option for this measure beginning in 2014.							
0377/ 67		Effective Clinical Care	**Hematology: Myelodysplastic Syndrome (MDS) and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow:** Percentage of patients aged 18 years and older with a diagnosis of myelodysplastic syndrome (MDS) or an acute leukemia who had baseline cytogenetic testing performed on bone marrow This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AMA- PCPI/ ASH	X	X				
0378/ 68		Effective Clinical Care	**Hematology: Myelodysplastic Syndrome (MDS): Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy:** Percentage of patients aged 18 years and older with a diagnosis of myelodysplastic syndrome (MDS) who are receiving	AMA- PCPI/ ASH	X	X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			erythropoietin therapy with documentation of iron stores within 60 days prior to initiating erythropoietin therapy This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
0380/ 69		Effective Clinical Care	**Hematology: Multiple Myeloma: Treatment with Bisphosphonates:** Percentage of patients aged 18 years and older with a diagnosis of multiple myeloma, not in remission, who were prescribed or received intravenous bisphosphonate therapy within the 12-month reporting period This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AMA- PCPI/ ASH	X	X				
0379/ 70		Effective Clinical Care	**Hematology: Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry:** Percentage of patients aged 18 years and older seen within a 12 month reporting period with a diagnosis of chronic lymphocytic leukemia (CLL) made at any time during or prior to the reporting period	AMA- PCPI/ ASH	X	X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[v]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			who had baseline flow cytometry studies performed and documented in the chart This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
0387/ 71	140v1	Effective Clinical Care	**Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer:** Percentage of female patients aged 18 years and older with Stage IC through IIIC, ER or PR positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AMA-PCPI/ ASCO/ NCCN	X	X	X		X	MU2
0385/ 72	141v3	Effective Clinical Care	**Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patients:** Percentage of patients aged 18 through 80 years with AJCC Stage III colon cancer who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or have previously received adjuvant	AMA-PCPI/ ASCO/NCCN	X	X	X		X	MU2

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			chemotherapy within the 12-month reporting period. This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
0464/ 76		Patient Safety	**Prevention of Catheter-Related Bloodstream Infections (CRBSI): Central Venous Catheter (CVC) Insertion Protocol:** Percentage of patients, regardless of age, who undergo CVC insertion for whom CVC was inserted with all elements of maximal sterile barrier technique [cap AND mask AND sterile gown AND sterile gloves AND a large sterile sheet AND hand hygiene AND 2% chlorhexidine for cutaneous antisepsis (or acceptable alternative antiseptics per current guideline)] followed This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AMA-PCPI	X	X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
0323/ 81		Communication and Care Coordination	**Adult Kidney Disease: Hemodialysis Adequacy: Solute:** Percentage of calendar months within a 12-month period during which patients aged 18 years and older with a diagnosis of End Stage Renal Disease (ESRD) receiving hemodialysis three times a week for ≥ 90 days who have a spKt/V ≥ 1.2 This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AMA-PCPI		X				
0321/ 82		Communication and Care Coordination	**Adult Kidney Disease: Peritoneal Dialysis Adequacy: Solute:** Percentage of patients aged 18 years and older with a diagnosis of End Stage Renal Disease (ESRD) receiving peritoneal dialysis who have a total Kt/V ≥ 1.7 per week measured once every 4 months This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AMA-PCPI		X				
0393/ 83		Effective Clinical Care	**Hepatitis C: Confirmation of Hepatitis C Viremia:** Percentage of patients aged 18 years and older who	AMA-PCPI		X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[v]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			are hepatitis C antibody positive seen for an initial evaluation for whom hepatitis C virus (HCV) RNA testing was ordered or previously performed This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
0395/ 84		Effective Clinical Care	**Hepatitis C: Ribonucleic Acid (RNA) Testing Before Initiating Treatment:** Percentage of patients aged 18 years and older with a diagnosis of chronic hepatitis C who started antiviral treatment within the 12 month reporting period for whom hepatitis C virus (HCV) genotype testing was performed within 12 months prior to initiation of antiviral treatment *The claims-based reporting option is no longer available for reporting this measure for 2014 and beyond.* We solicited but received no public comment on this measure. CMS would like to note that although this measure	AMA-PCPI		X			X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			was not listed in our proposal as having a reporting option change, we are finalizing it as registry-only beginning in 2014. CMS believes it necessary to maintain consistency of clinically-related measures available within a particular reporting option; therefore, we are eliminating this measure from the claims-based reporting option. 2012 claims data indicates a low threshold of eligible professionals reporting this measure via claims. CMS intends to streamline the reporting options available under the PQRS and to eliminate reporting options that are not widely used. Eligible professionals who report this measure will still have an opportunity to participate in PQRS using the registry-based reporting option. For these reasons, we are finalizing the removal of the claims-based option for this measure beginning in 2014.							
0396/ 85		Effective Clinical Care	**Hepatitis C: HCV Genotype Testing Prior to Treatment:** Percentage of patients aged 18 years and older with a diagnosis of chronic hepatitis C who	AMA-PCPI		X			X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			started antiviral treatment within the 12 month reporting period for whom quantitative hepatitis C virus (HCV) RNA testing was performed within 12 months prior to initiation of antiviral treatment *The claims-based reporting option is no longer available for reporting this measure for 2014 and beyond.* We solicited but received no public comment on this measure. CMS would like to note that although this measure was not listed in our proposal as having a reporting option change, we are finalizing it as registry-only beginning in 2014. CMS believes it necessary to maintain consistency of clinically-related measures available within a particular reporting option; therefore, we are eliminating this measure from the claims-based reporting option. 2012 claims data indicates a low threshold of eligible professionals reporting this measure via claims. CMS intends to streamline the reporting options available under the PQRS and to							

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[v]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			eliminate reporting options that are not widely used. Eligible professionals who report this measure will still have an opportunity to participate in PQRS using the registry-based reporting option. For these reasons, we are finalizing the removal of the claims-based option for this measure beginning in 2014.							
0398/ 87		Effective Clinical Care	**Hepatitis C: Hepatitis C Virus (HCV) Ribonucleic Acid (RNA) Testing Between 4-12 Weeks After Initiation of Treatment:** Percentage of patients aged 18 years and older with a diagnosis of chronic hepatitis C who are receiving antiviral treatment for whom quantitative hepatitis C virus (HCV) RNA testing was performed between 4-12 weeks after the initiation of antiviral treatment *The claims-based reporting option is no longer available for reporting this measure for 2014 and beyond.* We solicited but received no public comment on this measure. 2012 claims	AMA-PCPI		X			X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			data indicates a low threshold of eligible professionals reporting this measure via claims. CMS intends to streamline the reporting options available under the PQRS and to eliminate reporting options that are not widely used. For these reasons, we are finalizing the removal of the claims-based option for this measure beginning in 2014.							
0653/ 91		Effective Clinical Care	**Acute Otitis Externa (AOE): Topical Therapy:** Percentage of patients aged 2 years and older with a diagnosis of AOE who were prescribed topical preparations This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AMA-PCPI	X	X				
0654/ 93		Communication and Care Coordination	**Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use:** Percentage of patients aged 2 years and older with a diagnosis of AOE who were **not prescribed** systemic antimicrobial therapy	AMA-PCPI	X	X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
0391/ 99		Effective Clinical Care	**Breast Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade:** Percentage of breast cancer resection pathology reports that include the pT category (primary tumor), the pN category (regional lymph nodes), and the histologic grade This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AMA- PCPI/ CAP	X	X				
0392/ 100		Effective Clinical Care	**Colorectal Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade:** Percentage of colon and rectum cancer resection pathology reports that include the pT category (primary tumor), the pN category (regional lymph nodes) and the	AMA- PCPI/ CAP	X	X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[v]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			histologic grade This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
0389/ 102	129v3	Efficiency and Cost Reduction	**Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients:** Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did **not** have a bone scan performed at any time since diagnosis of prostate cancer This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AMA-PCPI	X	X	X			MU2
0390/ 104		Effective Clinical Care	**Prostate Cancer: Adjuvant Hormonal Therapy for High Risk Prostate Cancer Patients:** Percentage of patients, regardless of age, with a diagnosis of prostate cancer at high risk	AMA-PCPI	X	X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			of recurrence receiving external beam radiotherapy to the prostate who were prescribed adjuvant hormonal therapy (GnRH agonist or antagonist) This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
0103/ 106		Effective Clinical Care	**Adult Major Depressive Disorder (MDD): Comprehensive Depression Evaluation: Diagnosis and Severity:** Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of major depressive disorder (MDD) with evidence that they met the Diagnostic and Statistical Manual of Mental Disorders (DSM)-IV-TR criteria for MDD AND for whom there is an assessment of depression severity during the visit in which a new diagnosis or recurrent episode was identified This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AMA-PCPI	X	X				
0104/ 107	161v2	Effective Clinical Care	**Adult Major Depressive Disorder (MDD): Suicide Risk Assessment:** Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with a	AMA-PCPI	X	X	X			MU2

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified *The EHR-based reporting option is available for reporting this measure beginning in 2014.* In an effort to align with the EHR Incentive Program, this measure will be reportable via EHR beginning in 2014. The alignment of measures contained within multiple CMS reporting programs eases the burden of reporting and encourages eligible professionals to submit quality clinical data on care provided for Medicare beneficiaries. Alignment also promotes a robust data source and consistency in analysis, which supports other quality programs within CMS. For these reasons, we are finalizing the removal of the claims-based option and the addition of the EHR-based reporting option for this measure beginning in 2014.							

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
0054/ 108		Effective Clinical Care	**Rheumatoid Arthritis (RA): Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy:** Percentage of patients aged 18 years and older who were diagnosed with RA and were prescribed, dispensed, or administered at least one ambulatory prescription for a DMARD This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	NCQA	X	X			X	
0050/ 109		Person and Caregiver-Centered Experience and Outcomes	**Osteoarthritis (OA): Function and Pain Assessment:** Percentage of patient visits for patients aged 21 years and older with a diagnosis of osteoarthritis (OA) with assessment for function and pain This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AMA-PCPI	X	X				
0041/ 110	147v2	Community/ Population Health	**Preventive Care and Screening: Influenza Immunization:** Percentage of patients aged 6 months and older seen for a visit between October 1 and	AMA-PCPI	X	X	X	X	X	MU2 ACO

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[v]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
0043/ 111	127v2	Effective Clinical Care	**Pneumonia Vaccination Status for Older Adults:** Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine. This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	NCQA	X	X	X	X	X	MU2 ACO
N/A/ 112	125v2	Effective Clinical Care	**Breast Cancer Screening:** Percentage of women 50 through 74 years of age who had a mammogram to screen for breast cancer within 27 months This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	NCQA	X	X	X	X	X	MU2 ACO

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description¥	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
0034/ 113	130v2	Effective Clinical Care	**Colorectal Cancer Screening:** Percentage of patients 50-75 years of age who had appropriate screening for colorectal cancer. This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	NCQA	X	X	X	X	X	MU2 ACO
0058/ 116		Efficiency and Cost Reduction	**Antibiotic Treatment for Adults with Acute Bronchitis: Avoidance of Inappropriate Use:** Percentage of adults 18 through 64 years of age with a diagnosis of acute bronchitis who were **not prescribed or dispensed** an antibiotic prescription on or 3 days after the episode *The claims-based reporting option is no longer available for reporting this measure for 2014 and beyond.* 2012 claims data indicates a low threshold of eligible professionals reporting this measure via claims. CMS intends to streamline the reporting options available under the PQRS and to eliminate reporting options that are not widely used. For these reasons, we	NCQA		X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			are finalizing the removal of the claims-based reporting option beginning in 2014.							
0055/ 117	131v2	Effective Clinical Care	**Diabetes: Eye Exam:** Percentage of patients 18-75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal eye exam (no evidence of retinopathy) in the 12 months prior to the measurement period This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	NCQA	X	X	X		X	MU2
0066/ 118		Effective Clinical Care	**Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy - Diabetes or Left Ventricular Systolic Dysfunction (LVEF < 40%):** Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have diabetes OR a current or prior Left Ventricular Ejection Fraction (LVEF) < 40% who	AMA- PCPI/ ACCF/AHA		X		X		ACO

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			were prescribed ACE inhibitor or ARB therapy This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
0062/ 119	134v2	Effective Clinical Care	**Diabetes: Urine Protein Screening:** The percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period. This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	NCQA	X	X	X		X	MU2
1668/ 121		Effective Clinical Care	**Adult Kidney Disease: Laboratory Testing (Lipid Profile):** Percentage of patients aged 18 years and older with a diagnosis of chronic kidney disease (CKD) (stage 3, 4, or 5, not receiving Renal Replacement Therapy [RRT]) who had a fasting lipid profile performed at least once within a 12-month period	AMA-PCPI	X	X			X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
AQA adopted/ 122		Effective Clinical Care	**Adult Kidney Disease: Blood Pressure Management:** Percentage of patient visits for those patients aged 18 years and older with a diagnosis of chronic kidney disease (CKD) (stage 3, 4, or 5, not receiving Renal Replacement Therapy [RRT]) and proteinuria with a blood pressure < 130/80 mmHg OR ≥ 130/80 mmHg with a documented plan of care This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AMA-PCPI	X	X			X	
1666/ 123		Effective Clinical Care	**Adult Kidney Disease: Patients On Erythropoiesis-Stimulating Agent (ESA) - Hemoglobin Level > 12.0 g/dL:** Percentage of calendar months within a 12-month period during which a hemoglobin level is measured for patients aged 18 years and older with a diagnosis of advanced chronic kidney disease (CKD) (stage 4 or 5, not	AMA-PCPI	X	X			X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description¥	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			receiving Renal Replacement Therapy [RRT]) or End Stage Renal Disease (ESRD) (who are on hemodialysis or peritoneal dialysis) who are also receiving erythropoiesis-stimulating agent (ESA) therapy have a hemoglobin level > 12.0 g/dL This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
0417/ 126		Effective Clinical Care	**Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation:** Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who had a neurological examination of their lower extremities within 12 months *The claims-based reporting option is no longer available for reporting this measure for 2014 and beyond.* 2012 claims data indicates a low threshold of eligible professionals reporting this measure via claims. CMS intends to streamline the reporting	APMA		X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[V]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			options available under the PQRS and to eliminate reporting options that are not widely used. For these reasons, we are finalizing the removal of the claims-based reporting option beginning in 2014.							
0416/ 127		Effective Clinical Care	**Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention – Evaluation of Footwear:** Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who were evaluated for proper footwear and sizing *The claims-based reporting option is no longer available for reporting this measure for 2014 and beyond.* 2012 claims data indicates a low threshold of eligible professionals reporting this measure via claims. CMS intends to streamline the reporting options available under the PQRS and to eliminate reporting options that are not widely used. For these reasons, we are finalizing the removal of the claims-based reporting option beginning in 2014.	APMA		X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
0421/ 128	69v2	Community/ Population Health	**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up:** Percentage of patients aged 18 years and older with a documented BMI during the current encounter or during the previous 6 months, AND when the BMI is **outside of normal parameters**, a follow-up plan is documented during the encounter or during the previous 6 months of the encounter **Normal Parameters:** Age 65 years and older BMI ≥ 23 and < 30; Age 18 – 64 years BMI ≥ 18.5 and < 25 This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	CMS	X	X	X	X	X	MU2 ACO
0419/ 130	68v3	Patient Safety	**Documentation of Current Medications in the Medical Record:** Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list ***must*** include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND ***must*** contain the	CMS	X	X	X		X	MU2

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[V]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			medications' name, dosage, frequency and route of administration. *The EHR-based reporting option is available for reporting this measure beginning in 2014.* In an effort to align with the EHR Incentive Program, this measure will be reportable via EHR beginning in 2014. The alignment of measures contained within multiple CMS reporting programs eases the burden of reporting and encourages eligible professionals to submit quality clinical data on care provided for Medicare beneficiaries. Alignment also promotes a robust data source and consistency in analysis, which supports other quality programs within CMS. For the reasons previously stated, we are finalizing the addition of the EHR-based option beginning in 2014.							
0420/ 131		Community/ Population Health	**Pain Assessment and Follow-Up:** Percentage of visits for patients aged 18 years and older with documentation of a pain assessment using a standardized tool(s) on each visit AND	CMS	X	X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			documentation of a follow-up plan when pain is present This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
0418/ 134	2v3	Community/ Population Health	**Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan:** Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen. *The EHR-based reporting option is available for reporting this measure beginning in 2014.* In an effort to align with the EHR Incentive Program, this measure will be reportable via EHR beginning in 2014. The alignment of measures contained within multiple CMS reporting programs eases the burden of reporting and encourages eligible professionals to submit quality clinical data on care provided for Medicare beneficiaries. Alignment also promotes a robust data source and consistency in analysis, which supports other quality programs within CMS. For the reasons	CMS	X	X	X	X		MU2 ACO

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims[ʃ]	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			previously stated, we are finalizing the addition of the EHR-based option beginning in 2014.							
0650/ 137		Effective Clinical Care	**Melanoma: Continuity of Care – Recall System:** Percentage of patients, regardless of age, with a current diagnosis of melanoma or a history of melanoma whose information was entered, at least once within a 12 month period, into a recall system that includes: • A target date for the next complete physical skin exam, AND • A process to follow up with patients who either did not make an appointment within the specified timeframe or who missed a scheduled appointment This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AMA-PCPI/NCQA		X				
N/A/ 138		Communication and Care Coordination	**Melanoma: Coordination of Care:** Percentage of patient visits, regardless of age, with a new occurrence of melanoma who have a treatment plan documented in the chart that was	AMA-PCPI/NCQA		X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			communicated to the physician(s) providing continuing care within 1 month of diagnosis This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
0566/ 140		Effective Clinical Care	**Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement:** Percentage of patients aged 50 years and older with a diagnosis of age-related macular degeneration (AMD) or their caregiver(s) who were counseled within 12 months on the benefits and/or risks of the Age-Related Eye Disease Study (AREDS) formulation for preventing progression of AMD This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AMA- PCPI/ NCQA	X	X				
0563/ 141		Communication and Care Coordination	**Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care:**	AMA- PCPI/ NCQA	X	X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma (POAG) whose glaucoma treatment has not failed (the most recent IOP was reduced by at least 15% from the pre- intervention level) OR if the most recent IOP was not reduced by at least 15% from the pre-intervention level, a plan of care was documented within 12 months This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
0051/ 142		Effective Clinical Care	**Osteoarthritis (OA): Assessment for Use of Anti-Inflammatory or Analgesic Over-the-Counter (OTC) Medications:** Percentage of patient visits for patients aged 21 years and older with a diagnosis of osteoarthritis (OA) with an assessment for use of anti-inflammatory or analgesic over-the-counter (OTC) medications This measure was finalized for inclusion in 2014 PQRS in the CY 2013	AMA-PCPI	X	X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			PFS Final Rule (see Table 95 at 77 FR 69215).							
0384/ 143	157v2	Person and Caregiver-Centered Experience and Outcomes	**Oncology: Medical and Radiation – Pain Intensity Quantified:** Percentage of patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified *The EHR-based reporting option is available for reporting this measure beginning in 2014.* In an effort to align with the EHR Incentive Program, this measure will be reportable via EHR beginning in 2014. The alignment of measures contained within multiple CMS reporting programs eases the burden of reporting and encourages eligible professionals to submit quality clinical data on care provided for Medicare beneficiaries. Alignment also promotes a robust data source and consistency in analysis, which supports other quality programs within CMS. For the reasons previously stated, we are finalizing the addition of	AMA-PCPI		X	X		X	MU2

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[v]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			the EHR-based option beginning in 2014.							
0383/ 144		Person and Caregiver-Centered Experience and Outcomes	**Oncology: Medical and Radiation – Plan of Care for Pain:** Percentage of visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain with a documented plan of care to address pain This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AMA-PCPI		X			X	
0510/ 145		Patient Safety	**Radiology: Exposure Time Reported for Procedures Using Fluoroscopy:** Percentage of final reports for procedures using fluoroscopy that include documentation of radiation exposure or exposure time This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AMA- PCPI/ NCQA	X	X				
0508/ 146		Efficiency and Cost Reduction	**Radiology: Inappropriate Use of "Probably Benign" Assessment Category in Mammography**	AMA- PCPI/ NCQA	X	X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			Screening: Percentage of final reports for screening mammograms that are classified as "probably benign" This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
N/A/ 147		Communication and Care Coordination	**Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy:** Percentage of final reports for all patients, regardless of age, undergoing bone scintigraphy that include physician documentation of correlation with existing relevant imaging studies (e.g., x-ray, MRI, CT, etc.) that were performed This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AMA-PCPI	X	X				
0322/ 148		Efficiency and Cost Reduction	**Back Pain: Initial Visit:** The percentage of patients aged 18 through 79 years with a diagnosis of back pain or undergoing back surgery who had back pain and function assessed during	NCQA					X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			the initial visit to the clinician for the episode of back pain This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
0319/ 149		Effective Clinical Care	**Back Pain: Physical Exam:** Percentage of patients aged 18 through 79 years with a diagnosis of back pain or undergoing back surgery who received a physical examination at the initial visit to the clinician for the episode of back pain This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	NCQA					X	
0314/ 150		Effective Clinical Care	**Back Pain: Advice for Normal Activities:** The percentage of patients aged 18 through 79 years with a diagnosis of back pain or undergoing back surgery who received advice for normal activities at the initial visit to the clinician for the episode of back pain	NCQA					X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
0313/ 151		Effective Clinical Care	**Back Pain: Advice Against Bed Rest:** The percentage of patients aged 18 through 79 years with a diagnosis of back pain or undergoing back surgery who received advice against bed rest lasting four days or longer at the initial visit to the clinician for the episode of back pain This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	NCQA					X	
0101/ 154		Patient Safety	**Falls: Risk Assessment:** Percentage of patients aged 65 years and older with a history of falls who had a risk assessment for falls completed within 12 months This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AMA- PCPI/ NCQA	X	X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[v]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
0101/ 155		Communication and Care Coordination	**Falls: Plan of Care:** Percentage of patients aged 65 years and older with a history of falls who had a plan of care for falls documented within 12 months This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AMA- PCPI/ NCQA	X	X				
0382/ 156		Patient Safety	**Oncology: Radiation Dose Limits to Normal Tissues:** Percentage of patients, regardless of age, with a diagnosis of pancreatic or lung cancer receiving 3D conformal radiation therapy, with documentation in medical record that radiation dose limits to normal tissues were established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissues This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AMA-PCPI	X	X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
0455/ 157		Patient Safety	**Thoracic Surgery: Recording of Clinical Stage Prior to Lung Cancer or Esophageal Cancer Resection:** Percentage of surgical patients aged 18 years and older undergoing resection for lung or esophageal cancer who had clinical staging provided prior to surgery This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	STS	X	X				
0404/ 159		Effective Clinical Care	**HIV/AIDS: CD4+ Cell Count or CD4+ Percentage Performed:** Percentage of patients aged 6 months and older with a diagnosis of HIV/AIDS for whom a CD4+ cell count or CD4+ cell percentage was performed at least once every 6 months This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AMA- PCPI/ NCQA		X			X	
0405/ 160	52v2	Effective Clinical Care	**HIV/AIDS: Pneumocystis jiroveci pneumonia (PCP) prophylaxis:** Percentage of patients aged 6 weeks	NCQA		X	X		X	MU2

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			and older with a diagnosis of HIV/AIDS who were prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis *The EHR-based reporting option is available for reporting this measure beginning in 2014.* In an effort to align with the EHR Incentive Program, this measure will be reportable via EHR beginning in 2014. The alignment of measures contained within multiple CMS reporting programs eases the burden of reporting and encourages eligible professionals to submit quality clinical data on care provided for Medicare beneficiaries. Alignment also promotes a robust data source and consistency in analysis, which supports other quality programs within CMS. For the reasons previously stated, we are finalizing the addition of the EHR-based option beginning in 2014.							
0056/ 163	123v2	Effective Clinical Care	**Diabetes: Foot Exam:** Percentage of patients aged 18-75 years of age with	NCQA	X	X	X		X	MU2

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			diabetes who had a foot exam during the measurement period. This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
0129/ 164		Effective Clinical Care	**Coronary Artery Bypass Graft (CABG): Prolonged Intubation:** Percentage of patients aged 18 years and older undergoing isolated CABG surgery who require postoperative intubation > 24 hours This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	STS		X			X	
0130/ 165		Effective Clinical Care	**Coronary Artery Bypass Graft (CABG): Deep Sternal Wound Infection Rate:** Percentage of patients aged 18 years and older undergoing isolated CABG surgery who, within 30 days postoperatively, develop deep sternal wound infection involving muscle, bone, and/or mediastinum requiring operative intervention	STS		X			X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[v]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
0131/ 166		Effective Clinical Care	**Coronary Artery Bypass Graft (CABG): Stroke:** Percentage of patients aged 18 years and older undergoing isolated CABG surgery who have a **postoperative** stroke (i.e., any confirmed neurological deficit of abrupt onset caused by a disturbance in blood supply to the brain) that did not resolve within 24 hours This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	STS		X			X	
0114/ 167		Effective Clinical Care	**Coronary Artery Bypass Graft (CABG): Postoperative Renal Failure:** Percentage of patients aged 18 years and older undergoing isolated CABG surgery (without pre-existing renal failure) who develop postoperative renal failure or require dialysis	STS		X			X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
0115/ 168		Effective Clinical Care	**Coronary Artery Bypass Graft (CABG): Surgical Re-Exploration:** Percentage of patients aged 18 years and older undergoing isolated CABG surgery who require a return to the operating room (OR) during the current hospitalization for mediastinal bleeding with or without tamponade, graft occlusion, valve dysfunction, or other cardiac reason This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	STS		X			X	
0116/ 169		Effective Clinical Care	**Coronary Artery Bypass Graft (CABG): Antiplatelet Medications at Discharge:** Percentage of patients aged 18 years and older undergoing isolated CABG surgery who were discharged on antiplatelet medication	STS		X			X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
0117/ 170		Effective Clinical Care	**Coronary Artery Bypass Graft (CABG): Beta-Blockers Administered at Discharge:** Percentage of patients aged 18 years and older undergoing isolated CABG surgery who were discharged on beta-blockers This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	STS		X			X	
0118/ 171		Effective Clinical Care	**Coronary Artery Bypass Graft (CABG): Anti-Lipid Treatment at Discharge:** Percentage of patients aged 18 years and older undergoing isolated CABG surgery who were discharged on a statin or other lipid-lowering regimen This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	STS		X			X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
0259/ 172		Effective Clinical Care	**Hemodialysis Vascular Access Decision-Making by Surgeon to Maximize Placement of Autogenous Arterial Venous (AV) Fistula:** Percentage of patients aged 18 years and older with a diagnosis of advanced Chronic Kidney Disease (CKD) (stage 3, 4 or 5) or End Stage Renal Disease (ESRD) requiring hemodialysis vascular access documented by surgeon to have received autogenous AV fistula This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	SVS	X	X				
AQA adopted/ 173		Community/ Population Health	**Preventive Care and Screening: Unhealthy Alcohol Use – Screening:** Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method within 24 months *The claims-based and EHR-based reporting options have been removed from this measure for 2014 PQRS.*	AMA-PCPI		X			X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
AQA adopted/ 176		Effective Clinical Care	**Rheumatoid Arthritis (RA): Tuberculosis Screening:** Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) who have documentation of a tuberculosis (TB) screening performed and results interpreted within 6 months prior to receiving a first course of therapy using a biologic disease-modifying anti-rheumatic drug (DMARD) *The claims-based reporting option is no longer available for reporting this measure for 2014 and beyond.* 2012 claims data indicates a low threshold of eligible professionals reporting this measure via claims. CMS intends to streamline the reporting options available under the PQRS and to eliminate reporting options that are not widely used. For these reasons, we	AMA- PCPI		X			X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			are finalizing the removal of the claims-based option for 2014 and beyond.							
AQA adopted/ 177		Effective Clinical Care	**Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity:** Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) who have an assessment and classification of disease activity within 12 months *The claims-based reporting option is no longer available for reporting this measure for 2014 and beyond.* 2012 claims data indicates a low threshold of eligible professionals reporting this measure via claims. CMS intends to streamline the reporting options available under the PQRS and to eliminate reporting options that are not widely used. For these reasons, we are finalizing the removal of the claims-based option for 2014 and beyond.	AMA- PCPI		X			X	
AQA adopted/ 178		Effective Clinical Care	**Rheumatoid Arthritis (RA): Functional Status Assessment:** Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) for whom a	AMA- PCPI		X			X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			functional status assessment was performed at least once within 12 months *The claims-based reporting option is no longer available for reporting this measure for 2014 and beyond.* 2012 claims data indicates a low threshold of eligible professionals reporting this measure via claims. CMS intends to streamline the reporting options available under the PQRS and to eliminate reporting options that are not widely used. For these reasons, we are finalizing the removal of the claims-based option for 2014 and beyond.							
AQA adopted/ 179		Effective Clinical Care	**Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis:** Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) who have an assessment and classification of disease prognosis at least once within 12 months	AMA- PCPI		X			X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			The claims-based reporting option is no longer available for reporting this measure for 2014 and beyond. 2012 claims data indicates a low threshold of eligible professionals reporting this measure via claims. CMS intends to streamline the reporting options available under the PQRS and to eliminate reporting options that are not widely used. For these reasons, we are finalizing the removal of the claims-based option for 2014 and beyond.							
AQA adopted/ 180		Communication and Care Coordination	**Rheumatoid Arthritis (RA): Glucocorticoid Management:** Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) who have been assessed for glucocorticoid use and, for those on prolonged doses of prednisone ≥ 10 mg daily (or equivalent) with improvement or no change in disease activity, documentation of glucocorticoid management plan within 12 months	AMA- PCPI		X			X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[1]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			The claims-based reporting option is no longer available for reporting this measure for 2014 and beyond. CMS would like to note that although this measure was not listed in our proposal as having a reporting option change, we are finalizing it as registry-only beginning in 2014. CMS believes it necessary to maintain consistency of clinically-related measures available within a particular reporting option; therefore, we are eliminating this measure from the claims-based reporting option. 2012 claims data indicates a low threshold of eligible professionals reporting this measure via claims. CMS intends to streamline the reporting options available under the PQRS and to eliminate reporting options that are not widely used. Eligible professionals who report this measure will still have an opportunity to participate in PQRS using the registry-based reporting option. For these reasons, we are finalizing the							

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			removal of the claims-based option for this measure beginning in 2014.							
AQA adopted/ 181		Patient Safety	**Elder Maltreatment Screen and Follow-Up Plan:** Percentage of patients aged 65 years and older with a documented elder maltreatment screen using an Elder Maltreatment Screening Tool on the date of encounter AND a documented follow-up plan on the date of the positive screen This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	CMS	X	X				
AQA adopted/ 182		Communication and Care Coordination	**Functional Outcome Assessment:** Percentage of visits for patients aged 18 years and older with documentation of a current functional outcome assessment using a standardized functional outcome assessment tool on the date of encounter AND documentation of a care plan based on identified functional outcome deficiencies on the date of the identified deficiencies This measure was finalized for inclusion in 2014 PQRS in the CY 2013	CMS	X	X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[v]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			PFS Final Rule (see Table 95 at 77 FR 69215).							
0399/ 183		Community/Population Health	**Hepatitis C: Hepatitis A Vaccination in Patients with Hepatitis C Virus (HCV):** Percentage of patients aged 18 years and older with a diagnosis of chronic hepatitis C who have received at least one injection of hepatitis A vaccine, or who have documented immunity to hepatitis A *The claims-based reporting option is no longer available for reporting this measure for 2014 and beyond.* CMS would like to note that although this measure was not listed in our proposal as having a reporting option change, we are finalizing it as registry-only beginning in 2014. CMS believes it necessary to maintain consistency of clinically-related measures available within a particular reporting option; therefore, we are eliminating this measure from the claims-based reporting option. 2012 claims data indicates a low threshold of eligible professionals reporting this measure via	AMA-PCPI		X			X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description¥	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			claims. CMS intends to streamline the reporting options available under the PQRS and to eliminate reporting options that are not widely used. Eligible professionals who report this measure will still have an opportunity to participate in PQRS using the registry-based reporting option. For these reasons, we are finalizing the removal of the claims-based option for this measure beginning in 2014.							
0659/ 185		Communication and Care Coordination	**Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use:** Percentage of patients aged 18 years and older receiving a surveillance colonoscopy, with a history of a prior adenomatous polyp(s) in previous colonoscopy findings, who had an interval of 3 or more years since their last colonoscopy This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AMA- PCPI/ NCQA	X	X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
N/A/ 187		Effective Clinical Care	**Stroke and Stroke Rehabilitation: Thrombolytic Therapy:** Percentage of patients aged 18 years and older with a diagnosis of acute ischemic stroke who arrive at the hospital within two hours of time last known well and for whom IV t-PA was initiated within three hours of time last known well This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AHA/ ASA/ TJC		X				
0565/ 191	133v2	Effective Clinical Care	**Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery:** Percentage of patients aged 18 years and older with a diagnosis of uncomplicated cataract who had cataract surgery and no significant ocular conditions impacting the visual outcome of surgery and had best-corrected visual acuity of 20/40 or better (distance or near) achieved within 90 days following the cataract surgery	AMA- PCPI/ NCQA		X	X		X	MU2

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description¥	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			The EHR-based reporting option is available for reporting this measure beginning in 2014. In an effort to align with the EHR Incentive Program, this measure will be reportable via EHR beginning in 2014. The alignment of measures contained within multiple CMS reporting programs eases the burden of reporting and encourages eligible professionals to submit quality clinical data on care provided for Medicare beneficiaries. Alignment also promotes a robust data source and consistency in analysis, which supports other quality programs within CMS. For these reasons, we are finalizing the addition of the EHR-based reporting option for this measure beginning in 2014.							
0564/ 192	132v2	Patient Safety	**Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures:** Percentage of patients aged 18 years and older with a diagnosis of uncomplicated cataract who had cataract surgery and had any of a specified list of surgical procedures	AMA- PCPI/ NCQA		X	X		X	MU2

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[v]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			in the 30 days following cataract surgery which would indicate the occurrence of any of the following major complications: retained nuclear fragments, endophthalmitis, dislocated or wrong power IOL, retinal detachment, or wound dehiscence *The EHR-based reporting option is available for reporting this measure beginning in 2014.* In an effort to align with the EHR Incentive Program, this measure will be reportable via EHR beginning in 2014. The alignment of measures contained within multiple CMS reporting programs eases the burden of reporting and encourages eligible professionals to submit quality clinical data on care provided for Medicare beneficiaries. Alignment also promotes a robust data source and consistency in analysis, which supports other quality programs within CMS. For these reasons, we are finalizing the addition of the EHR-based reporting option for this measure beginning in 2014.							

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description¥	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
0454/ 193		Patient Safety	**Perioperative Temperature Management:** Percentage of patients, regardless of age, undergoing surgical or therapeutic procedures under general or neuraxial anesthesia of 60 minutes duration or longer, except patients undergoing cardiopulmonary bypass, for whom *either* active warming was used intraoperatively for the purpose of maintaining normothermia, OR at least one body temperature equal to or greater than 36 degrees Centigrade (or 96.8 degrees Fahrenheit) was recorded within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AMA-PCPI	X	X				
0386/ 194		Effective Clinical Care	**Oncology: Cancer Stage Documented:** Percentage of patients, regardless of age, with a diagnosis of cancer who are seen in the ambulatory setting who have a baseline American Joint Committee on Cancer (AJCC) cancer stage or documentation that the	AMA- PCPI/ ASCO	X	X			X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			cancer is metastatic in the medical record at least once during the 12 month reporting period This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
0507/ 195		Effective Clinical Care	**Radiology: Stenosis Measurement in Carotid Imaging Reports:** Percentage of final reports for carotid imaging studies (neck magnetic resonance angiography [MRA], neck computed tomography angiography [CTA], neck duplex ultrasound, carotid angiogram) performed that include direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AMA- PCPI/ NCQA	X	X				
0074/ 197		Effective Clinical Care	**Coronary Artery Disease (CAD): Lipid Control:** Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease	AMA- PCPI/ ACCF/AHA		X		X	X	ACO

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			seen within a 12 month period who have a LDL-C result < 100 mg/dL OR patients who have a LDL-C result ≥ 100 mg/dL and have a documented plan of care to achieve LDL-C < 100 mg/dL, including at a minimum the prescription of a statin *The EHR-based reporting mechanism is no longer available for reporting this measure for 2014 and beyond.* In an effort to align with the EHR Incentive Program, this measure will no longer be reportable via EHR beginning in 2014. The alignment of measures contained within multiple CMS reporting programs eases the burden of reporting and encourages eligible professionals to submit quality clinical data on care provided for Medicare beneficiaries. Alignment also promotes a robust data source and consistency in analysis, which supports other quality programs within CMS. For the reasons previously stated, we are finalizing the removal of the EHR-based option beginning in 2014.							

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
0079/ 198		Effective Clinical Care	**Heart Failure: Left Ventricular Ejection Fraction (LVEF) Assessment:** Percentage of patients aged 18 years and older with a diagnosis of heart failure for whom the quantitative or qualitative results of a recent or prior [any time in the past] LVEF assessment is documented within a 12 month period This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AMA- PCPI/ ACCF/AHA		X			X	
0068/ 204	164v2	Effective Clinical Care	**Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic:** Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period, and who had documentation of use of aspirin or another antithrombotic during	NCQA	X	X	X	X	X	MU2 ACO Million Hearts

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description¥	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			the measurement period. This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
0409/205		Effective Clinical Care	**HIV/AIDS: Sexually Transmitted Disease Screening for Chlamydia, Gonorrhea, and Syphilis:** Percentage of patients aged 13 years and older with a diagnosis of HIV/AIDS for whom chlamydia, gonorrhea and syphilis screenings were performed at least once since the diagnosis of HIV infection This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AMA-PCPI/ NCQA		X			X	
0422/217		Communication and Care Coordination	**Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Knee Impairments:** Percentage of patients aged 18 or older that receive treatment for a functional deficit secondary to a diagnosis that affects the knee in which the change in their Risk-Adjusted Functional Status is	FOTO		X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[v]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			measured This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
0423/ 218		Communication and Care Coordination	**Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Hip Impairments:** Percentage of patients aged 18 or older that receive treatment for a functional deficit secondary to a diagnosis that affects the hip in which the change in their Risk-Adjusted Functional Status is measured This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	FOTO		X				
0424/ 219		Communication and Care Coordination	**Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Lower Leg, Foot or Ankle Impairments:** Percentage of patients aged 18 or older that receive treatment for a functional deficit secondary to a diagnosis that affects the lower leg, foot or ankle in which the	FOTO		X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description¥	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			change in their Risk-Adjusted Functional Status is measured This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
0425/ 220		Communication and Care Coordination	**Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Lumbar Spine Impairments:** Percentage of patients aged 18 or older that receive treatment for a functional deficit secondary to a diagnosis that affects the lumbar spine in which the change in their Risk-Adjusted Functional Status is measured This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	FOTO		X				
0426/ 221		Communication and Care Coordination	**Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Shoulder Impairments:** Percentage of patients aged 18 or older that receive treatment for a functional deficit secondary to a diagnosis that affects the shoulder in which the change	FOTO		X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			in their Risk-Adjusted Functional Status is measured This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
0427/ 222		Communication and Care Coordination	**Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Elbow, Wrist or Hand Impairments:** Percentage of patients aged 18 or older that receive treatment for a functional deficit secondary to a diagnosis that affects the elbow, wrist or hand in which the change in their Risk-Adjusted Functional Status is measured This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	FOTO		X				
0428/ 223		Communication and Care Coordination	**Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Neck, Cranium, Mandible, Thoracic Spine, Ribs, or Other General Orthopedic Impairments:** Percentage of patients	FOTO		X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			aged 18 or older that receive treatment for a functional deficit secondary to a diagnosis that affects the neck, cranium, mandible, thoracic spine, ribs, or other general orthopedic impairment in which the change in their Risk-Adjusted Functional Status is measured This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
0562/ 224		Efficiency and Cost Reduction	**Melanoma: Overutilization of Imaging Studies in Melanoma:** Percentage of patients, regardless of age, with a current diagnosis of stage 0 through IIC melanoma or a history of melanoma of any stage, without signs or symptoms suggesting systemic spread, seen for an office visit during the one-year measurement period, for whom no diagnostic imaging studies were ordered This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AMA- PCPI/ NCQA		X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
0509/ 225		Communication and Care Coordination	**Radiology: Reminder System for Mammograms:** Percentage of patients aged 40 years and older undergoing a screening mammogram whose information is entered into a reminder system with a target due date for the next mammogram This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AMA- PCPI/ NCQA	X	X				
0028/ 226	138v2	Community/ Population Health	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AMA-PCPI	X	X	X	X	X	MU2 ACO Million Hearts

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description¥	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
N/A/ 228		Effective Clinical Care	**Heart Failure (HF): Left Ventricular Function (LVF) Testing:** Percentage of patients 18 years and older with Left Ventricular Function (LVF) testing documented as being performed within the previous 12 months or LVF testing performed prior to discharge for patients who are hospitalized with a principal diagnosis of Heart Failure (HF) during the reporting period This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	CMS		X				
N/A/ 231		Effective Clinical Care	**Asthma: Tobacco Use: Screening - Ambulatory Care Setting:** Percentage of patients aged 5 through 64 years with a diagnosis of asthma (or their primary caregiver) who were queried about tobacco use and exposure to second hand smoke within their home environment at least once during the one-year measurement period This measure was finalized for inclusion in 2014 PQRS in the CY 2013	AMA- PCPI/ NCQA	X	X			X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			PFS Final Rule (see Table 95 at 77 FR 69215).							
N/A/ 232		Effective Clinical Care	**Asthma: Tobacco Use: Intervention - Ambulatory Care Setting:** Percentage of patients aged 5 through 64 years with a diagnosis of asthma who were identified as tobacco users (or their primary caregiver) who received tobacco cessation intervention at least once during the one-year measurement period This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AMA-PCPI/NCQA	X	X			X	
0457/ 233		Effective Clinical Care	**Thoracic Surgery: Recording of Performance Status Prior to Lung or Esophageal Cancer Resection:** Percentage of patients aged 18 years and older undergoing resection for lung or esophageal cancer for whom performance status was documented and reviewed within 2 weeks prior to surgery	STS		X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
0458/ 234		Patient Safety	**Thoracic Surgery: Pulmonary Function Tests Before Major Anatomic Lung Resection (Pneumonectomy, Lobectomy, or Formal Segmentectomy):** Percentage of thoracic surgical patients aged 18 years and older undergoing at least one pulmonary function test within 12 months prior to a major lung resection (pneumonectomy, lobectomy, or formal segmentectomy) This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	STS		X				
0018/ 236	165v2	Effective Clinical Care	**Controlling High Blood Pressure:** Percentage of patients 18-85 years of age who had a diagnosis of hypertension whose blood pressure was adequately controlled (<140/90 mmHg) during the measurement period.	NCQA	X	X	X	X	X	MU2 ACO Million Hearts

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
0022/ 238	156v2	Patient Safety	**Use of High-Risk Medications in the Elderly:** Percentage of patients 66 years of age and older who were ordered high-risk medications. Two rates are reported. a. Percentage of patients who were ordered at least one high-risk medication. b. Percentage of patients who were ordered at least two different high-risk medications. This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	NCQA			X			MU2
0024/ 239	155v2	Community/Population Health	**Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents:** Percentage of patients 3-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or Obstetrician/Gynecologist (OB/GYN) and who had evidence of the following during the measurement period. Three rates are reported. - Percentage of patients with height, weight, and body mass index (BMI)	NCQA			X			MU2

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			percentile documentation - Percentage of patients with counseling for nutrition - Percentage of patients with counseling for physical activity This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
0038/ 240	117v2	Community/Population Health	**Childhood Immunization Status:** Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	NCQA			X			MU2

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
0075/ 241	182v3	Effective Clinical Care	**Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control:** Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period, and who had a complete lipid profile performed during the measurement period and whose LDL-C was adequately controlled (< 100 mg/dL). This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	NCQA	X	X	X	X	X	MU2 ACO Million Hearts
N/A/ 242		Effective Clinical Care	**Coronary Artery Disease (CAD): Symptom Management:** Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period with results of an evaluation of level of activity and an assessment of whether	AMA- PCPI/ ACCF/AHA		X			X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			anginal symptoms are present or absent with appropriate management of anginal symptoms within a 12 month period This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
0643/ 243		Effective Clinical Care	**Cardiac Rehabilitation Patient Referral from an Outpatient Setting:** Percentage of patients evaluated in an outpatient setting who within the previous 12 months have experienced an acute myocardial infarction (MI), coronary artery bypass graft (CABG) surgery, a percutaneous coronary intervention (PCI), cardiac valve surgery, or cardiac transplantation, or who have chronic stable angina (CSA) and have not already participated in an early outpatient cardiac rehabilitation/secondary prevention (CR) program for the qualifying event/diagnosis who were referred to a CR program	ACCF-AHA		X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[v]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
AQA adopted/ 245		Effective Clinical Care	**Chronic Wound Care: Use of Wound Surface Culture Technique in Patients with Chronic Skin Ulcers (Overuse Measure):** Percentage of patient visits for those patients aged 18 years and older with a diagnosis of chronic skin ulcer **without** the use of a wound surface culture technique This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AMA- PCPI/ NCQA	X	X				
AQA adopted/ 246		Effective Clinical Care	**Chronic Wound Care: Use of Wet to Dry Dressings in Patients with Chronic Skin Ulcers (Overuse Measure):** Percentage of patient visits for those patients aged 18 years and older with a diagnosis of chronic skin ulcer **without** a prescription or recommendation to use wet to dry dressings	AMA- PCPI/ NCQA	X	X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
AQA adopted/ 247		Effective Clinical Care	**Substance Use Disorders: Counseling Regarding Psychosocial and Pharmacologic Treatment Options for Alcohol Dependence:** Percentage of patients aged 18 years and older with a diagnosis of current alcohol dependence who were counseled regarding psychosocial AND pharmacologic treatment options for alcohol dependence within the 12-month reporting period This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AMA- PCPI/ NCQA	X	X				
AQA adopted/ 248		Effective Clinical Care	**Substance Use Disorders: Screening for Depression Among Patients with Substance Abuse or Dependence:** Percentage of patients aged 18 years and older with a diagnosis of current substance abuse or dependence who were screened for depression within the 12-month reporting period	AMA- PCPI/ NCQA	X	X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
N/A/ 249		Effective Clinical Care	**Barrett's Esophagus:** Percentage of esophageal biopsy reports that document the presence of Barrett's mucosa that also include a statement about dysplasia This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	CAP	X	X				
N/A/ 250		Effective Clinical Care	**Radical Prostatectomy Pathology Reporting:** Percentage of radical prostatectomy pathology reports that include the pT category, the pN category, the Gleason score and a statement about margin status This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	CAP	X	X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
N/A/ 251		Effective Clinical Care	**Immunohistochemical (IHC) Evaluation of Human Epidermal Growth Factor Receptor 2 Testing (HER2) for Breast Cancer Patients:** This is a measure based on whether quantitative evaluation of Human Epidermal Growth Factor Receptor 2 Testing (HER2) by immunohistochemistry (IHC) uses the system recommended in the ASCO/CAP Guidelines for Human Epidermal Growth Factor Receptor 2 Testing in breast cancer This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	CAP	X	X				
0651/ 254		Effective Clinical Care	**Ultrasound Determination of Pregnancy Location for Pregnant Patients with Abdominal Pain:** Percentage of pregnant female patients aged 14 to 50 who present to the emergency department (ED) with a chief complaint of abdominal pain or vaginal bleeding who receive a trans-abdominal or trans-	ACEP	X	X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			vaginal ultrasound to determine pregnancy location This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
0652/ 255		Effective Clinical Care	**Rh Immunoglobulin (Rhogam) for Rh-Negative Pregnant Women at Risk of Fetal Blood Exposure:** Percentage of Rh-negative pregnant women aged 14-50 years at risk of fetal blood exposure who receive Rh-Immunoglobulin (Rhogam) in the emergency department (ED) This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	ACEP	X	X				
N/A/ 257		Effective Clinical Care	**Statin Therapy at Discharge after Lower Extremity Bypass (LEB):** Percentage of patients aged 18 years and older undergoing infra-inguinal lower extremity bypass who are prescribed a statin medication at discharge	SVS		X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
N/A/ 258		Communication and Care Coordination	**Rate of Open Repair of Small or Moderate Non-Ruptured Abdominal Aortic Aneurysms (AAA) without Major Complications (Discharged to Home by Post-Operative Day #7):** Percent of patients undergoing open repair of small or moderate sized non-ruptured abdominal aortic aneurysms who do not experience a major complication (discharge to home no later than post-operative day #7) This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	SVS		X				
N/A/ 259		Communication and Care Coordination	**Rate of Endovascular Aneurysm Repair (EVAR) of Small or Moderate Non-Ruptured Abdominal Aortic Aneurysms (AAA) without Major Complications (Discharged to Home by Post-Operative Day #2):** Percent of patients undergoing endovascular repair of small or moderate non-ruptured	SVS		X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			abdominal aortic aneurysms (AAA) that do not experience a major complication (discharged to home no later than post-operative day #2) This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
N/A/ 260		Communication and Care Coordination	**Rate of Carotid Endarterectomy (CEA) for Asymptomatic Patients, without Major Complications (Discharged to Home by Post-Operative Day #2):** Percent of asymptomatic patients undergoing CEA who are discharged to home no later than post-operative day #2 This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	SVS		X				
N/A/ 261		Communication and Care Coordination	**Referral for Otologic Evaluation for Patients with Acute or Chronic Dizziness:** Percentage of patients aged birth and older referred to a physician (preferably a physician specially trained in disorders of the ear) for an otologic	AQC	X	X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			evaluation subsequent to an audiologic evaluation after presenting with acute or chronic dizziness This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
N/A/ 262		Patient Safety	**Image Confirmation of Successful Excision of Image–Localized Breast Lesion:** Image confirmation of lesion(s) targeted for image guided excisional biopsy or image guided partial mastectomy in patients with nonpalpable, image-detected breast lesion(s). Lesions may include: microcalcifications, mammographic or sonographic mass or architectural distortion, focal suspicious abnormalities on magnetic resonance imaging (MRI) or other breast imaging amenable to localization such as positron emission tomography (PET) mammography, or a biopsy marker demarcating site of confirmed pathology as established by previous core biopsy.	ASBS	X	X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[v]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
N/A/ 263		Effective Clinical Care	**Preoperative Diagnosis of Breast Cancer:** The percent of patients undergoing breast cancer operations who obtained the diagnosis of breast cancer preoperatively by a minimally invasive biopsy method This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	ASBS	X	X				
N/A/ 264		Effective Clinical Care	**Sentinel Lymph Node Biopsy for Invasive Breast Cancer:** The percentage of clinically node negative (clinical stage T1N0M0 or T2N0M0) breast cancer patients who undergo a sentinel lymph node (SLN) procedure This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	ASBS		X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
0645/ 265		Communication and Care Coordination	**Biopsy Follow-Up:** Percentage of new patients whose biopsy results have been reviewed and communicated to the primary care/referring physician and patient by the performing physician This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AAD		X				
N/A/ 266		Effective Clinical Care	**Epilepsy: Seizure Type(s) and Current Seizure Frequency(ies):** Percentage of patient visits with a diagnosis of epilepsy who had the type(s) of seizure(s) and current seizure frequency(ies) for each seizure type documented in the medical record This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AAN	X	X				
N/A/ 267		Effective Clinical Care	**Epilepsy: Documentation of Etiology of Epilepsy or Epilepsy Syndrome:** All visits for patients with a diagnosis of epilepsy who had their etiology of epilepsy or with epilepsy syndrome(s) reviewed and documented if known, or	AAN	X	X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[V]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			documented as unknown or cryptogenic This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
N/A/ 268		Effective Clinical Care	**Epilepsy: Counseling for Women of Childbearing Potential with Epilepsy:** All female patients of childbearing potential (12-44 years old) diagnosed with epilepsy who were counseled about epilepsy and how its treatment may affect contraception and pregnancy at least once a year This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AAN	X	X				
N/A/ 269		Effective Clinical Care	**Inflammatory Bowel Disease (IBD): Type, Anatomic Location and Activity All Documented:** Percentage of patients aged 18 years and older with a diagnosis of inflammatory bowel disease who have documented the disease type, anatomic location and activity, at least once during the reporting period	AGA					X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
N/A/ 270		Effective Clinical Care	**Inflammatory Bowel Disease (IBD): Preventive Care: Corticosteroid Sparing Therapy:** Percentage of patients aged 18 years and older with a diagnosis of inflammatory bowel disease who have been managed by corticosteroids greater than or equal to 10 mg/day for 60 or greater consecutive days that have been prescribed corticosteroid sparing therapy in the last reporting year This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AGA					X	
N/A/ 271		Effective Clinical Care	**Inflammatory Bowel Disease (IBD): Preventive Care: Corticosteroid Related Iatrogenic Injury – Bone Loss Assessment:** Percentage of patients aged 18 years and older with a diagnosis of inflammatory bowel	AGA					X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			disease who have received dose of corticosteroids greater than or equal to 10 mg/day for 60 or greater consecutive days and were assessed for risk of bone loss once per the reporting year This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
N/A/ 272		Effective Clinical Care	**Inflammatory Bowel Disease (IBD): Preventive Care: Influenza Immunization:** Percentage of patients aged 18 years and older with a diagnosis of inflammatory bowel disease for whom influenza immunization was recommended, administered or previously received during the reporting year This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AGA					X	
N/A/ 273		Effective Clinical Care	**Inflammatory Bowel Disease (IBD): Preventive Care: Pneumococcal Immunization:** Percentage of patients aged 18 years and older with a	AGA					X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			diagnosis of inflammatory bowel disease that had pneumococcal vaccination administered or previously received This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
N/A/ 274		Effective Clinical Care	**Inflammatory Bowel Disease (IBD): Testing for Latent Tuberculosis (TB) Before Initiating Anti-TNF (Tumor Necrosis Factor) Therapy:** Percentage of patients aged 18 years and older with a diagnosis of inflammatory bowel disease for whom a tuberculosis (TB) screening was performed and results interpreted within 6 months prior to receiving a first course of anti-TNF (tumor necrosis factor) therapy This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AGA					X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
N/A/ 275		Effective Clinical Care	**Inflammatory Bowel Disease (IBD): Assessment of Hepatitis B Virus (HBV) Status Before Initiating Anti-TNF (Tumor Necrosis Factor) Therapy:** Percentage of patients aged 18 years and older with a diagnosis of inflammatory bowel disease who had Hepatitis B Virus (HBV) status assessed and results interpreted within 1 year prior to receiving a first course of anti-TNF (tumor necrosis factor) therapy This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AGA					X	
N/A/ 276		Effective Clinical Care	**Sleep Apnea: Assessment of Sleep Symptoms:** Percentage of visits for patients aged 18 years and older with a diagnosis of obstructive sleep apnea that includes documentation of an assessment of sleep symptoms, including presence or absence of snoring and daytime sleepiness This measure was finalized for inclusion in 2014 PQRS in the CY 2013	AMA- PCPI/ NCQA					X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			PFS Final Rule (see Table 95 at 77 FR 69215).							
N/A/ 277		Effective Clinical Care	**Sleep Apnea: Severity Assessment at Initial Diagnosis:** Percentage of patients aged 18 years and older with a diagnosis of obstructive sleep apnea who had an apnea hypopnea index (AHI) or a respiratory disturbance index (RDI) measured at the time of initial diagnosis This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AMA- PCPI/ NCQA					X	
N/A/ 278		Effective Clinical Care	**Sleep Apnea: Positive Airway Pressure Therapy Prescribed:** Percentage of patients aged 18 years and older with a diagnosis of moderate or severe obstructive sleep apnea who were prescribed positive airway pressure therapy This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AMA- PCPI/ NCQA					X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
N/A/ 279		Effective Clinical Care	**Sleep Apnea: Assessment of Adherence to Positive Airway Pressure Therapy:** Percentage of visits for patients aged 18 years and older with a diagnosis of obstructive sleep apnea who were prescribed positive airway pressure therapy who had documentation that adherence to positive airway pressure therapy was objectively measured This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AMA- PCPI/ NCQA					X	
N/A/ 280		Communication and Care Coordination	**Dementia: Staging of Dementia:** Percentage of patients, regardless of age, with a diagnosis of dementia whose severity of dementia was classified as mild, moderate or severe at least once within a 12 month period This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AMA-PCPI					X	
N/A/ 281	149v2	Effective Clinical Care	**Dementia: Cognitive Assessment:** Percentage of patients, regardless of	AMA-PCPI			X		X	MU2

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description¥	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least once within a 12 month period *The EHR-based reporting option is available for reporting this measure beginning in 2014.* In an effort to align with the EHR Incentive Program, this measure will be reportable via EHR beginning in 2014. The alignment of measures contained within multiple CMS reporting programs eases the burden of reporting and encourages eligible professionals to submit quality clinical data on care provided for Medicare beneficiaries. Alignment also promotes a robust data source and consistency in analysis, which supports other quality programs within CMS. For these reasons, we are finalizing the addition of the EHR-based reporting option for this measure beginning in 2014.							
N/A/ 282		Effective Clinical Care	**Dementia: Functional Status Assessment:** Percentage of patients, regardless of age, with a diagnosis of	AMA-PCPI					X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			dementia for whom an assessment of patient's functional status is performed and the results reviewed at least once within a 12 month period This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
N/A/ 283		Effective Clinical Care	**Dementia: Neuropsychiatric Symptom Assessment:** Percentage of patients, regardless of age, with a diagnosis of dementia and for whom an assessment of patient's neuropsychiatric symptoms is performed and results reviewed at least once in a 12 month period This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AMA-PCPI					X	
N/A/ 284		Effective Clinical Care	**Dementia: Management of Neuropsychiatric Symptoms:** Percentage of patients, regardless of age, with a diagnosis of dementia who have one or more neuropsychiatric symptoms who received or were	AMA-PCPI					X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			recommended to receive an intervention for neuropsychiatric symptoms within a 12 month period This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
N/A/ 285		Effective Clinical Care	**Dementia: Screening for Depressive Symptoms:** Percentage of patients, regardless of age, with a diagnosis of dementia who were screened for depressive symptoms within a 12 month period This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AMA-PCPI					X	
N/A/ 286		Patient Safety	**Dementia: Counseling Regarding Safety Concerns:** Percentage of patients, regardless of age, with a diagnosis of dementia or their caregiver(s) who were counseled or referred for counseling regarding safety concerns within a 12 month period	AMA-PCPI					X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
N/A/ 287		Effective Clinical Care	**Dementia: Counseling Regarding Risks of Driving:** Percentage of patients, regardless of age, with a diagnosis of dementia or their caregiver(s) who were counseled regarding the risks of driving and the alternatives to driving at least once within a 12 month period This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AMA-PCPI					X	
N/A/ 288		Effective Clinical Care	**Dementia: Caregiver Education and Support:** Percentage of patients, regardless of age, with a diagnosis of dementia whose caregiver(s) were provided with education on dementia disease management and health behavior AND referred to additional sources for support within a 12 month period	AMA-PCPI					X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
N/A/ 289		Effective Clinical Care	**Parkinson's Disease: Annual Parkinson's Disease Diagnosis Review:** All patients with a diagnosis of Parkinson's disease who had an annual assessment including a review of current medications (e.g., medications than can produce Parkinson-like signs or symptoms) and a review for the presence of atypical features (e.g., falls at presentation and early in the disease course, poor response to levodopa, symmetry at onset, rapid progression [to Hoehn and Yahr stage 3 in 3 years], lack of tremor or dysautonomia) at least annually This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AAN					X	
N/A/ 290		Effective Clinical Care	**Parkinson's Disease: Psychiatric Disorders or Disturbances Assessment:** All patients with a diagnosis of Parkinson's disease who	AAN					X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[v]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)[x]	Measures Groups	Other Quality Reporting Programs
			were assessed for psychiatric disorders or disturbances (e.g., psychosis, depression, anxiety disorder, apathy, or impulse control disorder) at least annually This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
N/A/ 291		Effective Clinical Care	**Parkinson's Disease: Cognitive Impairment or Dysfunction Assessment:** All patients with a diagnosis of Parkinson's disease who were assessed for cognitive impairment or dysfunction at least annually This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AAN					X	
N/A/ 292		Effective Clinical Care	**Parkinson's Disease: Querying about Sleep Disturbances:** All patients with a diagnosis of Parkinson's disease (or caregivers, as appropriate) who were queried about sleep disturbances at least annually	AAN					X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
N/A/ 293		Effective Clinical Care	**Parkinson's Disease: Rehabilitative Therapy Options:** All patients with a diagnosis of Parkinson's disease (or caregiver(s), as appropriate) who had rehabilitative therapy options (e.g., physical, occupational, or speech therapy) discussed at least annually This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AAN					X	
N/A/ 294		Effective Clinical Care	**Parkinson's Disease: Parkinson's Disease Medical and Surgical Treatment Options Reviewed:** All patients with a diagnosis of Parkinson's disease (or caregiver(s), as appropriate who had the Parkinson's disease treatment options (e.g., non-pharmacological treatment, pharmacological treatment, or surgical treatment) reviewed at least once annually	AAN					X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
N/A/ 295		Effective Clinical Care	**Hypertension: Use of Aspirin or Other Antithrombotic Therapy:** Percentage of patients aged 30 through 90 years old with a diagnosis of hypertension and are eligible for aspirin or other antithrombotic therapy who were prescribed aspirin or other antithrombotic therapy This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	ABIM					X	
N/A/ 296		Effective Clinical Care	**Hypertension: Complete Lipid Profile:** Percentage of patients aged 18 through 90 years old with a diagnosis of hypertension who received a complete lipid profile within **60 months** This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	ABIM					X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description¥	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
N/A/ 297		Effective Clinical Care	**Hypertension: Urine Protein Test:** Percentage of patients aged 18 through 90 years old with a diagnosis of hypertension who either have chronic kidney disease diagnosis documented or had a urine protein test done within **36 months** This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	ABIM					X	
N/A/ 298		Effective Clinical Care	**Hypertension: Annual Serum Creatinine Test:** Percentage of patients aged 18 through 90 years old with a diagnosis of hypertension who had a serum creatinine test done within **12 months** This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	ABIM					X	
N/A/ 299		Effective Clinical Care	**Hypertension: Diabetes Mellitus Screening Test:** Percentage of patients aged 18 through 90 years old with a diagnosis of hypertension who had a	ABIM					X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[v]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			diabetes screening test within **36 months** This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
N/A/ 300		Effective Clinical Care	**Hypertension: Blood Pressure Control:** Percentage of patients aged 18 through 90 years old with a diagnosis of hypertension whose most recent blood pressure was under control (< 140/90 mmHg) This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	ABIM					X	
N/A/ 301		Effective Clinical Care	**Hypertension: Low Density Lipoprotein (LDL-C) Control:** Percentage of patients aged 18 through 90 years old with a diagnosis of hypertension whose most recent LDL cholesterol level was under control (at goal) This measure was finalized for inclusion in 2014 PQRS in the CY 2013	ABIM					X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			PFS Final Rule (see Table 95 at 77 FR 69215).							
N/A/ 302		Effective Clinical Care	**Hypertension: Dietary and Physical Activity Modifications Appropriately Prescribed:** Percentage of patients aged 18 through 90 years old with a diagnosis of hypertension who received dietary and physical activity counseling at least once within **12 months** This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	ABIM					X	
N/A/ 303		Effective Clinical Care	**Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery:** Percentage of patients aged 18 years and older in sample who had cataract surgery and had improvement in visual function achieved within 90 days following the cataract surgery, based on completing a pre-operative and post-operative visual function survey This measure was finalized for inclusion in 2014 PQRS in the CY 2013	AAO		X			X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			PFS Final Rule (see Table 95 at 77 FR 69215).							
N/A/ 304		Person and Caregiver-Centered Experience and Outcomes	**Cataracts: Patient Satisfaction within 90 Days Following Cataract Surgery:** Percentage of patients aged 18 years and older in sample who had cataract surgery and were satisfied with their care within 90 days following the cataract surgery, based on completion of the Consumer Assessment of Healthcare Providers and Systems Surgical Care Survey This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AAO		X			X	
0004/ 305	137v2	Effective Clinical Care	**Initiation and Engagement of Alcohol and Other Drug Dependence Treatment:** Percentage of patients 13 years of age and older with a new episode of alcohol and other drug (AOD) dependence who received the following. Two rates are reported a. Percentage of patients who initiated treatment within 14 days of the diagnosis.	NCQA			X			MU2

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			b. Percentage of patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit. This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
0032/ 309	124v2	Effective Clinical Care	**Cervical Cancer Screening:** Percentage of women 21-64 years of age, who received one or more Pap tests to screen for cervical cancer. This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	NCQA			X			MU2
0033/ 310	153v2	Community/ Population Health	**Chlamydia Screening for Women:** Percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement period This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	NCQA			X			MU2

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
0036/ 311	126v2	Effective Clinical Care	**Use of Appropriate Medications for Asthma:** Percentage of patients 5-64 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement period This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	NCQA			X			MU2
0052/ 312	166v3	Efficiency and Cost Reduction	**Use of Imaging Studies for Low Back Pain:** Percentage of patients 18-50 years of age with a diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis. This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	NCQA			X			MU2
N/A/ 316	61v3 and 64v3	Effective Clinical Care	**Preventive Care and Screening: Cholesterol – Fasting Low Density Lipoprotein (LDL-C) Test Performed AND Risk-Stratified Fasting LDL-C:** Percentage of patients aged 20 through 79 years whose risk factors* have been assessed and a fasting LDL test has	CMS			X			MU2 Million Hearts

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			been performed AND percentage of patients aged 20 through 79 years who had a fasting LDL-C test performed and whose risk-stratified fasting LDL-C is at or below the recommended LDL-C goal. *There are three criteria for this measure based on the patient's risk category. 1. Highest Level of Risk: Coronary Heart Disease (CHD) or CHD Risk Equivalent OR 10-Year Framingham Risk >20% 2. Moderate Level of Risk: Multiple (2+) Risk Factors OR 10-Year Framingham Risk 10-20% 3. Lowest Level of Risk: 0 or 1 Risk Factor OR 10-Year Framingham Risk <10% This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
N/A/ 317	22v2	Community/ Population Health	**Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented:** Percentage of patients aged 18 years	CMS	X	X	X	X	X	MU2 ACO Million Hearts

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
0101/ 318	139v2	Patient Safety	**Falls: Screening for Future Fall Risk:** Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period. *The EHR-based reporting option is available for reporting this measure beginning in 2014.* In an effort to align with the EHR Incentive Program, this measure will be reportable via EHR beginning in 2014. The alignment of measures contained within multiple CMS reporting programs eases the burden of reporting and encourages eligible professionals to submit quality clinical data on care	NCQA			X	X		MU2 ACO

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description¥	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			provided for Medicare beneficiaries. Alignment also promotes a robust data source and consistency in analysis, which supports other quality programs within CMS. For these reasons, we are finalizing the addition of the EHR-based reporting option for this measure beginning in 2014.							
0729/319		Effective Clinical Care	**Diabetes Composite: Optimal Diabetes Care:** Patients ages 18 through 75 with a diagnosis of diabetes, who meet all the numerator targets of this composite measure: • A1c < 8.0%, • LDL < 100 mg/dL, • blood pressure < 140/90 mmHg, • tobacco non-user and • for patients with a diagnosis of ischemic vascular disease daily aspirin use unless contraindicated This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	MNCM				X		ACO
0658/320		Communication and Care Coordination	**Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients:** Percentage of patients aged	AMA-PCPI	X	X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			50 years and older receiving a screening colonoscopy without biopsy or polypectomy who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
0005& 0006/ 321		Communication and Care Coordination	**CG-CAHPS Clinician/Group Survey** • Getting timely care, appointments,and information; • How well providers Communicate; • Patient's Rating of Provider; • Access to Specialists; • Health Promotion & Education; • Shared Decision Making; • Health Status/Functional Status; • Courteous and Helpful Office Staff; • Care Coordination; • Between Visit Communication; • Helping Your to Take Medication as Directed; and • Stewardship of Patient Resources	ASPE				X		ACO

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
0670/ 322		Efficiency and Cost Reduction	**Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Preoperative Evaluation in Low-Risk Surgery Patients:** Percentage of stress single-photon emission computed tomography (SPECT) myocardial perfusion imaging (MPI), stress echocardiogram (ECHO), cardiac computed tomography angiography (CCTA), or cardiac magnetic resonance (CMR) performed in low risk surgery patients 18 years or older for preoperative evaluation during the 12-month reporting period This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	ACC		X				
0671/ 323		Efficiency and Cost Reduction	**Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Routine Testing After Percutaneous Coronary Intervention (PCI):** Percentage of all stress single-photon emission computed	ACC		X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[v]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			tomography (SPECT) myocardial perfusion imaging (MPI), stress echocardiogram (ECHO), cardiac computed tomography angiography (CCTA), and cardiovascular magnetic resonance (CMR) performed in patients aged 18 years and older routinely after percutaneous coronary intervention (PCI), with reference to timing of test after PCI and symptom status This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
0672/ 324		Efficiency and Cost Reduction	**Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Testing in Asymptomatic, Low-Risk Patients:** Percentage of all stress single-photon emission computed tomography (SPECT) myocardial perfusion imaging (MPI), stress echocardiogram (ECHO), cardiac computed tomography angiography (CCTA), and cardiovascular magnetic resonance (CMR) performed in asymptomatic, low coronary heart disease (CHD) risk patients 18 years and older for initial detection and risk assessment This measure was finalized for inclusion in 2014 PQRS in the CY 2013	ACC		X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			PFS Final Rule (see Table 95 at 77 FR 69215).							
N/A/ 325		Effective Clinical Care	**Adult Major Depressive Disorder (MDD): Coordination of Care of Patients with Specific Comorbid Conditions:** Percentage of medical records of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) and a specific diagnosed comorbid condition (diabetes, coronary artery disease, ischemic stroke, intracranial hemorrhage, chronic kidney disease [stages 4 or 5], End Stage Renal Disease [ESRD] or congestive heart failure) being treated by another clinician with communication to the clinician treating the comorbid condition This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AMA-PCPI		X				
1525/ 326		Patient Safety	**Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy:** Percentage of patients aged 18 years and older with a diagnosis of	AMA-PCPI/ ACCF/AHA	X	X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[v]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			nonvalvular atrial fibrillation (AF) or atrial flutter whose assessment of the specified thromboembolic risk factors indicate one or more high-risk factors or more than one moderate risk factor, as determined by CHADS2 risk stratification, who are prescribed warfarin OR another oral anticoagulant drug that is FDA approved for the prevention of thromboembolism This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).							
N/A/ 327		Effective Clinical Care	**Pediatric Kidney Disease: Adequacy of Volume Management:** Percentage of calendar months within a 12-month period during which patients aged 17 years and younger with a diagnosis of End Stage Renal Disease (ESRD) undergoing maintenance hemodialysis in an outpatient dialysis facility have an assessment of the adequacy of volume management from a nephrologist This measure was finalized for inclusion in 2014 PQRS in the CY 2013	AMA	X	X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description¥	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			PFS Final Rule (see Table 95 at 77 FR 69215).							
1667/ 328		Effective Clinical Care	**Pediatric Kidney Disease: ESRD Patients Receiving Dialysis: Hemoglobin Level < 10 g/dL:** Percentage of calendar months within a 12-month period during which patients aged 17 years and younger with a diagnosis of End Stage Renal Disease (ESRD) receiving hemodialysis or peritoneal dialysis have a hemoglobin level < 10 g/dL This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule (see Table 95 at 77 FR 69215).	AMA-PCPI	X	X				
N/A/N/ A‡		Effective Clinical Care	**Adult Kidney Disease: Catheter Use at Initiation of Hemodialysis:** Percentage of patients aged 18 years and older with a diagnosis of End Stage Renal Disease (ESRD) who initiate maintenance hemodialysis during the measurement period, whose mode of vascular access is a catheter at the time maintenance hemodialysis is initiated	AMA-PCPI		X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[v]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			Several commenters supported the inclusion of this measure, stating catheter use is the primary contributing factor to bloodstream infections in hemodialysis patients. We appreciate the commenters' feedback and believe this measure will help deter the use of catheters for hemodialysis patients. Additionally, this measure expands upon the care that is represented in adult kidney disease patient population. It allows eligible professionals providing care for these patients a greater variety of measures to report. For the reasons previously stated, we finalizing this individual measure for reporting beginning in 2014.							
N/A/N/ A‡		Effective Clinical Care	**Adult Kidney Disease: Catheter Use for Greater Than or Equal to 90 Days:** Percentage of patients aged 18 years and older with a diagnosis of End Stage Renal Disease (ESRD) receiving maintenance hemodialysis for greater than or equal to 90 days whose mode of vascular access is a catheter Several commenters supported the inclusion of this measure, stating	AMA-PCPI		X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description¥	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			physician referrals for appropriate vascular access placement in patients who will soon need dialysis and who are already on dialysis, are important to reducing the use of catheters in hemodialysis patients. We agree with the commenters' feedback this measure expands upon the care that is represented in adult kidney disease patient population. Additionally, it allows eligible professionals providing care for these patients a greater variety of measures to report. For the reasons previously stated, we finalizing this individual measure for reporting beginning in 2014.							
N/A/N/ A‡		Effective Clinical Care	**Adult Sinusitis: Antibiotic Prescribed for Acute Sinusitis (Appropriate Use):** Percentage of patients, aged 18 years and older, with a diagnosis of acute sinusitis who were prescribed an antibiotic within 7 days of diagnosis or within 10 days after onset of symptoms Several commenters supported the inclusion of this measure. One commenter requested clarification as to why this measure has been included for	AMA-PCPI		X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[Y]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			registry-only reporting, despite requests that it also be included for EHR-based reporting. In an effort to streamline the reporting options available under the PQRS and to eliminate reporting options that are not widely used, all new measures incorporated in PQRS are available via registry-only. Additionally, for CY 2014, CMS was unable to determine the feasibility of incorporation of this measure for other reporting options; however, CMS intends to continue working toward complete alignment of measure specifications across programs whenever possible and incorporation of this measure for EHR-based reporting may be considered in the future.							
			This measure represents a new medical concept and fills a gap in care not previously addressed by the PQRS. The measure is reportable by Ear, Nose and Throat (ENT) and other eligible professionals within this specific scope of practice that previously had a limited number of measures available for							

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			reporting within PQRS. For these reasons, we are finalizing this measure for registry-based reporting beginning in 2014.							
N/A/N/A‡		Effective Clinical Care	**Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin Prescribed for Patients with Acute Bacterial Sinusitis:** Percentage of patients aged 18 years and older with a diagnosis of acute bacterial sinusitis that were prescribed amoxicillin, without clavulante, as a first line antibiotic at the time of diagnosis Several commenters expressed general support for the inclusion of this measure. One commenter requested clarification as to why this measure has been included for registry-only reporting, despite requests that it also be included for EHR-based reporting. In an effort to streamline the reporting options available under the PQRS and to eliminate reporting options that are not widely used, all new measures incorporated in PQRS are available via registry-only. Additionally, for CY 2014, CMS was unable to determine the	AMA-PCPI		X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			feasibility of incorporation of this measure for other reporting options; however, CMS intends to continue working toward complete alignment of measure specifications across programs whenever possible and incorporation of this measure for EHR-based reporting may be considered in the future. This measure represents a new medical concept and fills a gap in care not previously addressed by the PQRS. The measure is reportable by Ear, Nose and Throat (ENT) and other eligible professionals within this specific scope of practice that previously had a limited number of measures available for reporting within PQRS. For these reasons, we are finalizing this measure for registry-based reporting beginning in 2014.							
N/A/N/ A‡		Efficiency and Cost Reduction	**Adult Sinusitis: Computerized Tomography for Acute Sinusitis (Overuse):** Percentage of patients aged 18 years and older with a diagnosis of acute sinusitis who had a computerized tomography (CT) scan of the paranasal sinuses ordered at the time of diagnosis	AMA-PCPI		X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			or received within 28 days after date of diagnosis Several commenters supported the inclusion of this measure. One commenter requested clarification as to why this measure has been included for registry-only reporting, despite requests that it also be included for EHR-based reporting. In an effort to streamline the reporting options available under the PQRS and to eliminate reporting options that are not widely used, all new measures incorporated in PQRS are available via registry-only. Additionally, for CY 2014, CMS was unable to determine the feasibility of incorporation of this measure for other reporting options; however, CMS intends to continue working toward complete alignment of measure specifications across programs whenever possible and incorporation of this measure for EHR-based reporting may be considered in the future.							

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			This measure represents a new medical concept and fills a gap in care not previously addressed by the PQRS. The measure is reportable by Ear, Nose and Throat (ENT) and other eligible professionals within this specific scope of practice that previously had a limited number of measures available for reporting within PQRS. For these reasons, we are finalizing this measure for registry-based reporting beginning in 2014.							
N/A/N/ A‡		Efficiency and Cost Reduction	**Adult Sinusitis: More than One Computerized Tomography (CT) Scan Within 90 Days for Chronic Sinusitis (Overuse):** Percentage of patients aged 18 years and older with a diagnosis of chronic sinusitis who had more than one CT scan of the paranasal sinuses ordered or received within 90 days after the date of diagnosis Several commenters expressed general support for the inclusion of this measure. One commenter requested clarification as to why this measure has been included for registry-only reporting, despite requests that it also	AMA-PCPI		X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			be included for EHR-based reporting. In an effort to streamline the reporting options available under the PQRS and to eliminate reporting options that are not widely used, all new measures incorporated in PQRS are available via registry-only. Additionally, for CY 2014, CMS was unable to determine the feasibility of incorporation of this measure for other reporting options; however, CMS intends to continue working toward complete alignment of measure specifications across programs whenever possible and incorporation of this measure for EHR-based reporting may be considered in the future. This measure represents a new medical concept and fills a gap in care not previously addressed by the PQRS. The measure is reportable by Ear, Nose and Throat (ENT) and other eligible professionals within this specific scope of practice that previously had a limited number of measures available for reporting within PQRS. For these						

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			reasons, we are finalizing this measure for registry-based reporting beginning in 2014.							
N/A/N/A‡		Patient Safety	**Maternity Care: Elective Delivery or Early Induction Without Medical Indication at ≥ 37 and < 39 Weeks:** Percentage of patients, regardless of age, who gave birth during a 12-month period who delivered a live singleton at ≥ 37 and < 39 weeks of gestation completed who had elective deliveries or early inductions without medical indication One commenter expressed general support for the inclusion of this measure and proposed it be adopted for EHR reporting in the future. We appreciate the commenter's support of this measure. For CY 2014, CMS was unable to determine the feasibility of incorporation of this measure for other reporting options; however, CMS intends to continue working toward complete alignment of measure specifications across programs whenever possible and incorporation of	AMA-PCPI		X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description¥	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			this measure for EHR-based reporting may be considered in the future. This measure represents a new medical concept within PQRS, reportable by Obstetrics/Gynecologist and other eligible professionals within this specific scope of practice who previously had a limited number of measures available for reporting. For these reasons, we are finalizing this measure for registry-based reporting beginning in 2014.							
N/A/N/ A‡		Communication and Care Coordination	**Maternity Care: Post-Partum Follow-Up and Care Coordination:** Percentage of patients, regardless of age, who gave birth during a 12-month period who were seen for post-partum care within 8 weeks of giving birth who received a breast feeding evaluation and education, post-partum depression screening, post-partum glucose screening for gestational diabetes patients, and family and contraceptive planning One commenter expressed general support for the inclusion of this	AMA-PCPI		X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			measure and proposed it be adopted for EHR reporting in the future. We appreciate the commenter's support of this measure. For CY 2014, CMS was unable to determine the feasibility of incorporation of this measure for other reporting options; however, CMS intends to continue working toward complete alignment of measure specifications across programs whenever possible and incorporation of this measure for EHR-based reporting may be considered in the future. This measure represents a new medical concept within PQRS, reportable by Obstetrics/Gynecologist and other eligible professionals within this specific scope of practice who previously had a limited number of measures available for reporting. For these reasons, we are finalizing this measure for registry-based reporting beginning in 2014.							
N/A/N/ A‡		Effective Clinical Care	**Tuberculosis Prevention for Psoriasis and Psoriatic Arthritis Patients on a Biological Immune Response Modifier:** Percentage of patients whose	AAD		X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[Y]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			providers are ensuring active tuberculosis prevention either through yearly negative standard tuberculosis screening tests or are reviewing the patient's history to determine if they have had appropriate management for a recent or prior positive test One commenter expressed general support for the inclusion of this measure. We appreciate the commenters' feedback. Psoriasis is a new medical concept for reporting within PQRS and fills a gap in care not previously addressed by the PQRS. This measure would provide Dermatology and other related eligible professionals an additional measure to report within PQRS. This measure could also be reported by other professionals that treat joint care, such as Family Practice and Rheumatologists. For these reasons, we are finalizing this measure for reporting beginning in 2014.							

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description¥	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
2082/N/A‡		Effective Clinical Care	**HIV Viral Load Suppression:** The percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule.	HRSA		X			X	
2083/N/A‡		Effective Clinical Care	**Prescription of HIV Antiretroviral Therapy:** Percentage of patients, regardless of age, with a diagnosis of HIV prescribed antiretroviral therapy for the treatment of HIV infection during the measurement year This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule.	HRSA		X			X	
N/A/2079‡		Efficiency and Cost Reduction	**HIV Medical Visit Frequency:** Percentage of patients, regardless of age with a diagnosis of HIV who had at least one medical visit in each 6 month period of the 24 month measurement period, with a minimum of 60 days between medical visits	HRSA					X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description¥	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule.							
N/A/ 2080‡		Efficiency and Cost Reduction	**Gap in HIV Medical Visits:** Percentage of patients, regardless of age, with a diagnosis of HIV who did not have a medical visit in the last 6 months This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule.	HRSA					X	
0209/N/ A‡		Person and Caregiver-Centered Experience and Outcomes	**Pain Brought Under Control Within 48 Hours:** Patients aged 18 and older who report being uncomfortable because of pain at the initial assessment (after admission to palliative care services) who report pain was brought to a comfortable level within 48 hours One commenter expressed general support for the inclusion of this measure. We appreciate the commenter's support. Previously, there were no measures within the PQRS that addressed care for patients being managed by palliative	NHPCO		X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description¥	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			care or eligible professionals that would provide these services to patients. Pain management for patients receiving palliative care will provide beneficial data for this medical concept. For these reasons, we are finalizing this measure for inclusion in PQRS beginning in 2014.							
N/A/N/ A‡		Effective Clinical Care	**Screening Colonoscopy Adenoma Detection Rate Measure:** The percentage of patients age 50 years or older with at least one adenoma or other colorectal cancer precursor or colorectal cancer detected during screening colonoscopy One commenter agreed with CMS that this measure, along with other existing PQRS colonoscopy measures, is vital to improving patient outcomes. Another commenter supported the inclusion of this measure but was concerned that it was proposed for registry-only reporting. In an effort to streamline the reporting options available under the PQRS and to eliminate reporting options that are	ACG/ ASGE		X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description¥	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			not widely used, all new measures incorporated in PQRS are available via registry-only. Additionally, for CY 2014, CMS was unable to determine the feasibility of incorporation of this measure for other reporting options; however, CMS intends to continue working toward complete alignment of measure specifications across programs whenever possible and incorporation of this measure in other PQRS reporting options may considered in the future. This measure addresses a broad patient population for screening and detection of colorectal cancer and is medically significant in the measurement of utilizing preventive healthcare services.. For this reason, we are finalizing this individual measure for registry reporting beginning in 2014.							
N/A/N/ A‡		Effective Clinical Care	**Rate of Carotid Artery Stenting (CAS) for Asymptomatic Patients, Without Major Complications (Discharged to Home by Post-Operative Day #2):** Percent of	SVS		X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[Y]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			asymptomatic patients undergoing CAS who are discharged to home no later than post-operative day #2 Several commenters expressed general support for the inclusion of this measure in PQRS beginning in 2014. We appreciate the commenters' support Additionally, this measure provides opportunity for Vascular Surgical eligible professionals to report a greater number of measures. CMS' goal is to provide ample reporting opportunities to eligible professionals, especially those who are unable to report other broadly applicable measures. For this reason, we are finalizing this measure for inclusion in PQRS beginning in 2014.							
N/A/N/A‡		Effective Clinical Care	**Rate of Postoperative Stroke or Death in Asymptomatic Patients Undergoing Carotid Artery Stenting (CAS):** Percent of asymptomatic patients undergoing CAS who experience stroke or death following surgery while in the hospital	SVS		X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			Several commenters expressed general support for the inclusion of this measure in 2014 PQRS. One commenter supported the inclusion of this measure but was concerned that it was proposed for registry-only reporting. In an effort to streamline the reporting options available under the PQRS and to eliminate reporting options that are not widely used, all new measures incorporated in PQRS are available via registry-only. Additionally, for CY 2014, CMS was unable to determine the feasibility of incorporation of this measure for other reporting options; however, CMS intends to continue working toward complete alignment of measure specifications across programs whenever possible and incorporation of this measure in other PQRS reporting options may considered in the future. This measure provides opportunity for Vascular Surgical eligible professionals to report a greater number of measures. CMS' goal is to provide ample							

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description¥	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			reporting opportunities to eligible professionals, especially those who are unable to report other broadly applicable measures. For this reason, we are finalizing this measure for inclusion in PQRS beginning in 2014.							
N/A/N/ A‡		Effective Clinical Care	**Rate of Postoperative Stroke or Death in Asymptomatic Patients undergoing Carotid Endarterectomy (CEA):** Percent of asymptomatic patients undergoing CEA who experience stroke or death following surgery while in the hospital Several commenters expressed general support for the inclusion of this measure in 2014 PQRS. One commenter supported the inclusion of this measure but was concerned that it was proposed for registry-only reporting. In an effort to streamline the reporting options available under the PQRS and to eliminate reporting options that are not widely used, all new measures incorporated in PQRS are available via registry-only.	SVS		X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			Additionally, for CY 2014, CMS was unable to determine the feasibility of incorporation of this measure for other reporting options; however, CMS intends to continue working toward complete alignment of measure specifications across programs whenever possible and incorporation of this measure in other PQRS reporting options may considered in the future. This measure provides opportunity for Vascular Surgical eligible professionals to report a greater number of measures. CMS' goal is to provide ample reporting opportunities to eligible professionals, especially those who are unable to report other broadly applicable measures. For this reason, we are finalizing this measure for inclusion in PQRS beginning in 2014.							
N/A/N/ A‡		Effective Clinical Care	**Rate of Endovascular Aneurysm Repair (EVAR) of Small or Moderate Non-Ruptured Abdominal Aortic Aneurysms (AAA) Who Die While in Hospital;** Percent of patients undergoing endovascular repair of small or moderate abdominal aortic	SVS		X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[v]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			aneurysms (AAA) who die while in the hospital Several commenters expressed general support for the inclusion of this measure. We appreciate the commenters' feedback. This measure provides opportunity for Vascular Surgical eligible professionals to report a greater number of measures. CMS' goal is to provide ample reporting opportunities to eligible professionals, especially those who are unable to report other broadly applicable measures. For this reason, we are finalizing this measure for inclusion in PQRS beginning in 2014.							
N/A/N/ A‡		Effective Clinical Care	**HRS-3: Implantable Cardioverter-Defibrillator (ICD) Complications Rate:** Patients with physician-specific risk-standardized rates of procedural complications following the first time implantation of an ICD Several commenters supported the inclusion of this measure in 2014 PQRS as it has the potential to significantly	HRS		X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			improve the quality of care delivered to patients with advanced heart disease. One commenter also expressed support for including this measure for registry-based reporting, stating the risk adjustment in this measure includes a number of data elements that could not be found in claims data. We appreciate the commenters' support. This measure provides opportunity for Electrophysiologists and other eligible professionals within this scope of practice to report a greater number of measures. CMS' goal is to provide ample reporting opportunities to eligible professionals, especially those who may be unable to report other broadly applicable measures. For this reason, we are finalizing this measure for inclusion in PQRS beginning in 2014.							
N/A/N/A‡		Effective Clinical Care	**Optimal Vascular Composite:** Percent of patients aged 18 to 75 with ischemic vascular disease (IVD) who have optimally managed modifiable risk factors demonstrated by meeting all of the numerator targets of this patient	MNCM		X				

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[1]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			level all-or-none composite measure: LDL less than 100, blood pressure less than 140/90, tobacco-free status, and daily aspirin use One commenter provided general support for this measure but opposed its use due to its target population and emphasis on numerical value targets as numerical targets as they believe numerical targets provide an incentive to treat tests rather than symptoms. We respectfully disagree, as this composite encompasses measurements that address risk factors for the specific patient population diagnosed with vascular disease. Addressing risk factors with treatment such as antiplatelet therapy and assessing blood pressure, lipid control and smoking within this patient population are common annual assessments and treatment for patients diagnosed with vascular disease. Management of blood pressure and lipids and encouraging patients to avoid smoking and maintain an antiplatelet treatment is beneficial for this patient population.							

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			Additionally, it is reportable by a variety of eligible professionals. Therefore, we are finalizing this measure for inclusion in PQRS beginning in 2014.							
N/A/ N/A‡		Communication and Care Coordination	**Total Knee Replacement: Shared Decision-Making: Trial of Conservative (Non-surgical) Therapy:** Percentage of patients undergoing a total knee replacement with documented shared decision-making with discussion of conservative (non-surgical) therapy prior to the procedure This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule.	AAHKS					X	
N/A/ N/A‡		Patient Safety	**Total Knee Replacement: Venous Thromboembolic and Cardiovascular Risk Evaluation:** Percentage of patients regardless of age or gender undergoing a total knee replacement who are evaluated for the presence or absence of venous thromboembolic and cardiovascular risk factors within 30 days prior to the procedure including history of Deep Vein Thrombosis,	AAHKS					X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			Pulmonary Embolism, Myocardial Infarction, Arrhythmia and Stroke One commenter expressed general support for the inclusion of this measure. We appreciate the commenter's feedback and are finalizing it for inclusion in 2014 PQRS							
N/A/ N/A‡		Patient Safety	**Total Knee Replacement: Preoperative Antibiotic Infusion with Proximal Tourniquet:** Percentage of patients regardless of age undergoing a total knee replacement who had the prophylactic antibiotic completely infused prior to the inflation of the proximal tourniquet This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule.	AAHKS					X	
N/A/ N/A‡		Patient Safety	**Total Knee Replacement: Identification of Implanted Prosthesis in Operative Report:** Percentage of patients regardless of age or gender undergoing total knee replacement whose operative report identifies the prosthetic implant specifications including the prosthetic	AAHKS					X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			implant manufacturer, the brand name of prosthetic implant and the size of prosthetic implant This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule.							
N/A/N/ A‡		Effective Clinical Care	**Anastomotic Leak Intervention:** Percentage of patients aged 18 years and older who required an anastomotic leak intervention following gastric bypass or colectomy surgery This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule.	ACS					X	
N/A/N/ A‡		Effective Clinical Care	**Unplanned Reoperation within the 30 Day Postoperative Period:** Percentage of patients aged 18 years and older who had any unplanned reoperation within the 30 day postoperative period This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule.	ACS					X	
N/A/N/ A‡		Effective Clinical Care	**Unplanned Hospital Readmission within 30 Days of Principal Procedure:** Percentage of patients aged	ACS					X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[v]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			18 years and older who had an unplanned hospital readmission within 30 days of principal procedure This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule.							
N/A/N/ A‡		Effective Clinical Care	**Surgical Site Infection (SSI):** Percentage of patients aged 18 years and older who had a surgical site infection (SSI) This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule.	ACS					X	
N/A/N/ A‡		Person and Caregiver-Centered Experience and Outcomes	**Patient-Centered Surgical Risk Assessment and Communication:** Percentage of patients who underwent a non-emergency surgery who had their personalized risks of postoperative complications assessed by their surgical team prior to surgery using a clinical data-based, patient-specific risk calculator and who received personal discussion of those risks with the surgeon	ACS		X			X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			One commenter requested clarification regarding the target patient population and the patient-specific risk calculator. The commenter encouraged CMS to provide clarification to providers regarding measure applicability and guidance on which measures CMS believes are best suited for an eligible professional or group practice to report. Please note that these questions are not typically addressed in rulemaking. We urge the commenters to review the 2014 PQRS program documentation and contact the QualityNet Help Desk for assistance with reporting applicable measures.							
N/A/ N/A‡		Communication and Care Coordination	**Optimizing Patient Exposure to Ionizing Radiation: Utilization of a Standardized Nomenclature for Computed Tomography (CT) Imaging Description:** Percentage of computed tomography (CT) imaging reports for all patients, regardless of age, with the imaging study named according to a standardized nomenclature and the standardized nomenclature is used in institution's computer systems	AMA-PCPI					X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule.							
N/A/ N/A‡		Patient Safety	**Optimizing Patient Exposure to Ionizing Radiation: Count of Potential High Dose Radiation Imaging Studies: Computed Tomography (CT) and Cardiac Nuclear Medicine Studies:** Percentage of computed tomography (CT) and cardiac nuclear medicine (myocardial perfusion studies) imaging reports for all patients, regardless of age, that document a count of known previous CT (any type of CT) and cardiac nuclear medicine (myocardial perfusion) studies that the patient has received in the 12-month period prior to the current study This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule.	AMA-PCPI					X	
N/A/ N/A‡		Patient Safety	**Optimizing Patient Exposure to Ionizing Radiation: Reporting to a Radiation Dose Index Registry:** Percentage of total computed	AMA-PCPI					X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			tomography (CT) studies performed for all patients, regardless of age, that are reported to a radiation dose index registry AND that include at a minimum selected data elements This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule.							
N/A/ N/A‡		Communication and Care Coordination	**Optimizing Patient Exposure to Ionizing Radiation: Computed Tomography (CT) Images Available for Patient Follow-up and Comparison Purposes:** Percentage of final reports for computed tomography (CT) studies performed for all patients, regardless of age, which document that Digital Imaging and Communications in Medicine (DICOM) format image data are available to non-affiliated external entities on a secure, media free, reciprocally searchable basis with patient authorization for at least a 12-month period after the study This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule.	AMA-PCPI					X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
N/A/ N/A‡		Communication and Care Coordination	**Optimizing Patient Exposure to Ionizing Radiation: Search for Prior Computed Tomography (CT) Imaging Studies Through a Secure, Authorized, Media-Free, Shared Archive:** Percentage of final reports of computed tomography (CT) studies performed for all patients, regardless of age, which document that a search for Digital Imaging and Communications in Medicine (DICOM) format images was conducted for prior patient CT imaging studies completed at non-affiliated external entities within the past 12-months and are available through a secure, authorized, media free, shared archive prior to an imaging study being performed This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule.	AMA-PCPI					X	
N/A/ N/A‡		Communication and Care Coordination	**Optimizing Patient Exposure to Ionizing Radiation: Appropriateness: Follow-up CT Imaging for Incidentally Detected Pulmonary Nodules According to Recommended Guidelines:** Percentage of final reports	AMA-PCPI					X	

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description¥	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			for CT imaging studies of the thorax for patients aged 18 years and older with documented follow-up recommendations for incidentally detected pulmonary nodules (eg, follow-up CT imaging studies needed or that no follow-up is needed) based at a minimum on nodule size AND patient risk factors This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule.							
0060/ N/A‡	148v2	Effective Clinical Care	**Hemoglobin A1c Test for Pediatric Patients:** Percentage of patients 5-17 years of age with diabetes with a HbA1c test during the measurement period This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule.	NCQA			X			MU2
0108/ N/A‡	136v3	Effective Clinical Care	**ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication:** Percentage of children 6-12 years of age and newly dispensed a medication for attention-deficit/hyperactivity disorder (ADHD)	NCQA			X			MU2

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[v]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			who had appropriate follow-up care. Two rates are reported. a. Percentage of children who had one follow-up visit with a practitioner with prescribing authority during the 30-Day Initiation Phase. b. Percentage of children who remained on ADHD medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two additional follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended. This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule.							
0110/ N/A‡	169v2	Effective Clinical Care	**Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use:** Percentage of patients with depression or bipolar disorder with evidence of an initial assessment that includes an appraisal for alcohol or chemical substance use. This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule.	CQAIMH			X			MU2

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
0403/ N/A‡	62v2	Effective Clinical Care	**HIV/AIDS: Medical Visit:** Percentage of patients, regardless of age, with a diagnosis of HIV/AIDS with at least two medical visits during the measurement year with a minimum of 90 days between each visit This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule.	NCQA			X			MU2
0608/ N/A‡	158v2	Effective Clinical Care	**Pregnant women that had HBsAg testing:** This measure identifies pregnant women who had a HBsAg (hepatitis B) test during their pregnancy. This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule.	OptumInsight			X			MU2
0710/N/ A‡	159v2	Effective Clinical Care	**Depression Remission at Twelve Months:** Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current	MNCM			X			MU2

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			PHQ-9 score indicates a need for treatment One commenter was concerned that this measure was only proposed for inclusion using the EHR-based reporting option. In an effort to completely align programs, all measures in the EHR Incentive Program have been adopted for 2014 PQRS EHR-based reporting option. For CY 2014, CMS was unable to determine the feasibility of incorporation of this measure for other reporting options; however, CMS intends to continue working toward complete alignment of measure specifications across programs whenever possible and incorporation of this measure in other PQRS reporting options may considered in the future. This measure identifies specific gaps in care and encourages more provider reporting to assess quality care while allowing specialty professionals to participate in the program. For these reasons, we are finalizing this measure							

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description¥	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			as proposed for PQRS beginning in 2014.							
0712/ N/A‡	160v2	Effective Clinical Care	**Depression Utilization of the PHQ-9 Tool:** Adult patients age 18 and older with the diagnosis of major depression or dysthymia who have a PHQ-9 tool administered at least once during a 4 month period in which there was a qualifying visit. One commenter was concerned that this measure was only proposed for inclusion using the EHR-based reporting option. In an effort to completely align programs, all measures in the EHR Incentive Program have been adopted for 2014 PQRS EHR-based reporting option. For CY 2014, CMS was unable to determine the feasibility of incorporation of this measure for other reporting options; however, CMS intends to continue working toward complete alignment of measure specifications across programs whenever possible and incorporation of this measure in other PQRS reporting options may considered in the future.	MNCM			X			MU2

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[v]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			This measure identifies specific gaps in care and encourages more provider reporting to assess quality care while allowing specialty professionals to participate in the program. For these reasons, we are finalizing this measure as proposed for PQRS beginning in 2014.							
1401/ N/A‡	82v1	Community/ Population Health	**Maternal Depression Screening:** The percentage of children who turned 6 months of age during the measurement year, who had a face-to-face visit between the clinician and the child during child's first 6 months, and who had a maternal depression screening for the mother at least once between 0 and 6 months of life. One commenter was concerned that this measure was only proposed for inclusion using the EHR-based reporting option. In an effort to completely align programs, all measures in the EHR Incentive Program have been adopted for 2014 PQRS EHR-based reporting option. For CY 2014, CMS was unable to	NCQA			X			MU2

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description¥	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			determine the feasibility of incorporation of this measure for other reporting options; however, CMS intends to continue working toward complete alignment of measure specifications across programs whenever possible and incorporation of this measure in other PQRS reporting options may considered in the future. This measure identifies specific gaps in care and encourages more provider reporting to assess quality care while allowing specialty professionals to participate in the program. For these reasons, we are finalizing this measure as proposed for PQRS beginning in 2014.							
N/A/ N/A‡	65v3	Effective Clinical Care	**Hypertension: Improvement in Blood Pressure:** Percentage of patients aged 18-85 years of age with a diagnosis of hypertension whose blood pressure improved during the measurement period. One commenter expressed concern with attaching numerical targets to blood pressure measures, stating this measure	CMS♦			X			MU2

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[v]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			still encourages a focus on management of numbers over management of patients. CMS appreciates the commenters' feedback and acknowledges that the focus of medicine should be with the management of the patients. Analytically, this measure excludes patients that may have clinical conditions such as end-stage renal disease, pregnancy and/or renal transplant, hemodialysis or peritoneal dialysis. Exclusion of these populations is an attempt to allow the blood pressure measurement as guide lined by JNC-7 to apply to a more generalized population of patient diagnosed with hypertension. In an effort to completely align programs, all measures in the EHR Incentive Program have been adopted for the PQRS EHR-based reporting option beginning in 2014. Alignment of measures contained within multiple CMS reporting programs eases the burden of reporting and encourages eligible professionals to submit quality clinical data on care provided for Medicare beneficiaries.							

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description¥	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			For these reasons, we are finalizing this measure as proposed.							
N/A/ N/A‡	50v2	Communication and Care Coordination	**Closing the referral loop: receipt of specialist report:** Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred. This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule.	CMS			X			MU2
N/A/N/ A‡	66v2	Person and Caregiver-Centered Experience and Outcomes	**Functional Status Assessment for Knee Replacement:** Percentage of patients aged 18 years and older with primary total knee arthroplasty (TKA) who completed baseline and follow-up (patient-reported) functional status assessments. This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule.	CMS			X			MU2
N/A/ N/A‡	56v2	Person and Caregiver-Centered Experience and Outcomes	**Functional Status Assessment for Hip Replacement:** Percentage of patients aged 18 years and older with primary total hip arthroplasty (THA) who completed baseline and follow-up	CMS			X			MU2

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[v]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			(patient-reported) functional status assessments This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule.							
N/A/ N/A‡	90v3	Person and Caregiver-Centered Experience and Outcomes	**Functional Status Assessment for Complex Chronic Conditions:** Percentage of patients aged 65 years and older with heart failure who completed initial and follow-up patient-reported functional status assessments One commenter appreciates the value of assessing functional status in heart failure patients, however, is concerned the measure requires a questionnaire and the potential of associated cost. CMS would like to note that many of the assessment tools are readily available to the public and generally do not have an associated cost. We are finalizing this measure as for inclusion in the EHR-based reporting option for PQRS beginning in 2014.	CMS			X			MU2
N/A/N/ A‡	75v2	Effective Clinical Care	**Children Who Have Dental Decay or Cavities:** Percentage of children, age 0-	CMS			X			MU2

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			20 years, who have had tooth decay or cavities during the measurement period. This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule.							
N/A/N/ A‡	74v3	Effective Clinical Care	**Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists:** Percentage of children, age 0-20 years, who received a fluoride varnish application during the measurement period. This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule.	CMS			X			MU2
N/A/N/ A‡	179v2	Patient Safety	**ADE Prevention and Monitoring: Warfarin Time in Therapeutic Range:** Average percentage of time in which patients aged 18 and older with atrial fibrillation who are on chronic warfarin therapy have International Normalized Ratio (INR) test results within the therapeutic range (i.e., TTR) during the measurement period.	CMS			X			MU2

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description[¥]	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups*	Other Quality Reporting Programs
			One commenter supported the inclusion of this measure but cautioned against the use of a single measure and methodology for tracking the appropriateness of anticoagulant therapy. CMS appreciates the commenters support and feedback. This measure is analytically challenging for reporting in a claims-based or registry-based mechanisms, therefore is currently implemented as an EHR measure. Patients with atrial fibrillation are at an increased risk for stroke, therefore CMS agrees that this measure is a valuable measurement within PQRS and the EHR Incentive Program. In an effort to completely align programs, all measures in the EHR Incentive Program have been adopted for 2014 PQRS EHR-based reporting option. CMS appreciates the suggestion and encourages societies and measure developers to develop measures they believe address possible gaps in quality reporting. We are finalizing this measure for inclusion, as proposed, beginning in 2014.						

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description*	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
N/A/N/A‡	77v2	Effective Clinical Care	**HIV/AIDS: RNA Control for Patients with HIV:** Percentage of patients aged 13 years and older with a diagnosis of HIV/AIDS, with at least two visits during the measurement year, with at least 90 days between each visit, whose most recent HIV RNA level is <200 copies/mL. This measure was finalized for inclusion in 2014 PQRS in the CY 2013 PFS Final Rule.	CMS			X			MU2
1365/ N/A‡	177v2	Patient Safety	**Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment:** Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk One commenter supported the addition of this measure and it's alignment with the EHR Incentive Program. We appreciate the support of this measure and our actions to align quality reporting programs. Another commenter was concerned that this measure was only proposed for	AMA-PCPI			X			MU2

NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Measure Title and Description¥	Measure Steward	Claims	Registry	EHR	GPRO (Web Interface)*	Measures Groups	Other Quality Reporting Programs
			inclusion using the EHR-based reporting option. For CY 2014, CMS was unable to determine the feasibility of incorporation of this measure for other reporting options; however, CMS intends to continue working toward complete alignment of measure specifications across programs whenever possible and incorporation of this measure in other PQRS reporting options may considered in the future. This measure identifies specific gaps in care and encourages more provider reporting to assess quality care while allowing specialty professionals to participate in the program. For these reasons, we are finalizing this measure as proposed for PQRS beginning in 2014.							

‡ This measure is new to the Physician Quality Reporting System and has been adopted for reporting beginning in CY 2014.

¥ Titles and descriptions in this table are aligned with the 2014 Physician Quality Reporting System Claims and Qualified Registry measure titles and descriptions, and may differ based on reporting mechanism within PQRS. Additionally, there may be tittle and description variations for the same measure across other quality reporting programs. Please reference the National Quality Forum (NQF) and Physician Quality Reporting System numbers for clarification. This column also contains summary of public comments and CMS's responses, if applicable.

Table 53 includes the measures we proposed to include in the PQRS measure set for 2014 and beyond but, for the reasons specified in Table 53, we are not finalizing for 2014 and beyond.

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