time of tight fiscal restraints, CMS deems ASCs accredited by AAAHC as meeting its Medicare requirements. Thus, CMS continues its focus on assuring the health and safety of services by providers and suppliers already certified for participation in a cost-effective manner.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. This final notice will not have an effect on the governments mentioned nor on the private sector.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. This final notice will not have a substantial effect on State and local governments. In accordance with Executive Order 13132, CMS has determined that this notice will not significantly affect the rights of States, local, or tribal governments.

In accordance with the provisions of Executive Order 12866, this notice was not reviewed by the Office of Management and Budget.

Authority: Section 1865 of the Social Security Act (42 U.S.C. 1395bb).

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program; No. 93.773 Medicare—Hospital Insurance Program; and No. 93.774, Medicare—Supplemental Medical Insurance Program)

Dated: November 2, 2002.

Thomas Scully,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 02–29364 Filed 11–21–02; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1220–N]

RIN 0938–AL97

Medicare Program; Fee Schedule for Payment of Ambulance Services—Update for CY 2003

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

ACTION: Notice.

SUMMARY: This notice updates the Ambulance Inflation Factor (AIF) for ambulance services for calendar year (CY) 2003. The AIF is used in determining the payment limit for ambulance services required by section 1834(l) of the Social Security Act (the Act).

DATES: The AIF for 2003 is effective for ambulance services furnished during the period January 1, 2003, through December 31, 2003.

FOR FURTHER INFORMATION CONTACT: Anne E. Tayloe, (410) 786–4546.

SUPPLEMENTARY INFORMATION:

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I. Background

Requirements of the Statute for Updating the Ambulance Inflation Factor (AIF) for Ambulance Services for CY 2003

On February 27, 2002, we published a final rule entitled ''Medicare Program; Fee Schedule for Payment of Ambulance Services and Revisions to the Physician Certification Requirements for Coverage of Nonemergency Ambulance Services; Final Rule'' (HCFA–1002–FC) in the **Federal Register** (67 FR 9100), that established a fee schedule for ambulance services required by section 1834(l) of the Social Security Act (the Act). This final rule provided that the ambulance fee schedule would be updated by the AIF annually, based on the percentage increase in the consumer price index (CPI) for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year (§ 414.610(f)). It also provided that notice of the AIF would be published in the **Federal Register** without opportunity for prior comment (§ 414.620). We will follow applicable rulemaking procedures in publishing revisions to the fee schedule for ambulance services that result from any factors other than the inflation factor. In this notice, we set forth the ambulance inflation factor for CY 2003.

II. Provisions of the Notice

Section 1834(l)(3)(B) of the Act provides the basis for updating payment amounts for ambulance services. Specifically, this section provides for an update in payments for CY 2003 that is equal to the percentage increase in the CPI for all urban consumers (CPI–U), for the 12-month period ending with June of the previous year (that is, June 2002). For CY 2003 that percentage is 1.1 percent.

During the transition period, the AIF is applied to both the fee schedule portion of the blended payment amount and to the reasonable charge/cost portion of the blended payment amount separately for each ambulance provider/supplier. Then, these two amounts are added together to determine the total payment amount for each provider/supplier.

III. Waiver of Proposed Rulemaking

We ordinarily publish a proposed notice in the **Federal Register** and provide a period for public comment before we make final the provisions of the notice. We can waive this procedure, however, if we find good cause that notice-and-comment procedure is impracticable, unnecessary, or contrary to the public interest and we incorporate a statement of finding and its reasons in the notice issued. We find it unnecessary to undertake notice and comment rulemaking in this instance because the law specifies the method of computation of annual updates, and we have no discretion in this matter. Further, this notice does not change substantive policy, but merely applies the statutorily-specified update method. Therefore, under 5 U.S.C. 553(b)(B), for good cause, we waive notice and comment procedures.

IV. Regulatory Impact Statement

We have examined the impacts of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 16, 1980, Pub. L. 96–354), section 1102(b) of

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

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

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

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. This notice does not apply to small rural hospitals.

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

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

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

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

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

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

Dated: October 4, 2002.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

Approved: November 1, 2002.

Tommy G. Thompson,

Secretary.

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

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare and Medicaid Services

Notice of Proposed Settlement and Fairness Hearing

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

Summary of Agreement

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

Fairness Hearing

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