

element to be considered in determining whether a belief would be reasonable is the time period over which the requests have occurred. The CSB will presume that multiple requests of this type made within a 30-day period have been made in order to evade fees. Where requests are separated by a longer period, the CSB shall aggregate them only where there exists a solid basis for determining that such aggregation is warranted, *e.g.*, where the requests involve clearly related matters. Multiple requests regarding unrelated matters will not be aggregated.

(c) *Advance payment of fees.* (1) The CSB does not require an advance payment before work is commenced or continued, unless:

(i) The CSB estimates or determines that the fees are likely to exceed \$250. If it appears that the fees will exceed \$250, the CSB will notify the requester of the likely cost and obtain satisfactory assurance of full payment where the requester has a history of prompt payment of FOIA fees. In the case of requesters with no history of payment, the CSB may require an advance payment of fees in an amount up to the full estimated charge that will be incurred; or

(ii) The requester has previously failed to pay a fee in a timely fashion, *i.e.*, within 30 days of the date of a billing. In such cases, the CSB may require the requester to pay the full amount owed plus any applicable interest, as provided in paragraph (d) of this section, or demonstrate that the fee owed has been paid, prior to processing any further record request. Under these circumstances, the CSB may require the requester to make an advance payment of the full amount of the fees anticipated before processing a new request or finishing processing of a pending request from that requester.

(2) A request for an advance deposit shall ordinarily include an offer to the requester to confer with identified CSB personnel to attempt to reformulate the request in a manner which will meet the needs of the requester at a lower cost.

(3) When the CSB requests an advance payment of fees, the administrative time limits described in 5 U.S.C. 552(a)(6) begin only after the CSB has received the advance payment.

(d) *Interest.* The CSB may assess interest charges on an unpaid bill starting on the 31st day following the day on which the bill was sent. Once a fee payment has been received by the CSB, even if not processed, the accrual of interest shall be stayed. Interest charges shall be assessed at the rate prescribed in 31 U.S.C. 3717 and shall accrue from the date of the billing.

(e) Whenever a total fee calculated under paragraph (d) of this section is \$14.00 or less for any request, no fee will be charged.

Dated: November 16, 2000.

**Christopher W. Warner,**  
*General Counsel.*

[FR Doc. 00-29973 Filed 11-22-00; 8:45 am]

**BILLING CODE 6350-01-U**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Office of the Secretary

### Office of Inspector General

#### 45 CFR Part 61

RIN 0906-AA46

#### Health Care Fraud and Abuse Data Collection Program: Reporting of Final Adverse Actions; Correction

**AGENCY:** Office of Inspector General (OIG), HHS.

**ACTION:** Final rule; correction amendment.

**SUMMARY:** This document contains a correction to the final regulations which were published in the **Federal Register** on October 26, 1999 (64 FR 57740). These regulations established a national health care fraud and abuse data collection program for the reporting and disclosing of certain adverse actions taken against health care providers, suppliers and practitioners, and for maintaining a data base of final adverse actions taken against health care providers, suppliers and practitioners. An inadvertent error appeared in the text of the regulations concerning the definition of the term "health plan." As a result, we are making a correction to 45 CFR 61.3, Definitions, to assure the technical correctness of these regulations.

**EFFECTIVE DATE:** November 24, 2000.

**FOR FURTHER INFORMATION CONTACT:** Joel Schaer, OIG Regulations Officer, (202) 619-0089.

**SUPPLEMENTARY INFORMATION:** The HHS Office of Inspector General (OIG) issued final regulations on October 26, 1999 (64 FR 57740) that established a national health care fraud and abuse data collection program—the Healthcare Integrity and Protection Data Bank (HIPDB)—for the reporting and disclosing of certain final adverse actions taken against health care providers, suppliers and practitioners, and for maintaining a data base of final adverse actions taken against health care

providers, suppliers and practitioners. The final rule established a new 45 CFR part 61 to implement the requirements for reporting of specific data elements to, and procedures for obtaining information from, the HIPDB. In that final rule, an inadvertent error appeared in § 61.3—the definitions section of the regulations—and is now being corrected.

Section 61.3 expanded on previous regulatory definitions and provided additional examples of the scope of various terms set forth in the statute. In the preamble of the final rule, we reiterated that the statutory intent of the definition for the term "health plan" was not meant to be exclusive or exhaustive, and interpreted congressional use of the word "includes" in the statutory definition of this term as an indication that additional entities may be recognized as "health plans" if they meet the basic definition of providing health benefits. The preamble of the final rule stated that the statutory language indicated that Congress intended that guarantors of payment for health care items and services—including "self insured employers" who are often the subjects of health care fraud—have access to HIPDB information. As a result, in order to make the term more inclusive, we indicated our intention of modifying the fourth element defining this term to include, but not be limited to, a plan, program, agreement or other mechanism established, maintained or made available by a self insured employer or group of self insured employers. This clarifying language, however, was not properly reflected in the regulatory text that appeared in the October 26, 1999 final regulations.

To be consistent with the intent of the final rule's preamble, we are correcting the inadvertent error that appeared in § 61.3 that failed to accurately reflect the definition of the term "health plan."

#### List of Subjects in 45 CFR Part 61

Billing and transportation services, Durable medical equipment suppliers and manufacturers, Health care insurers, Health maintenance organizations, Health professions, Home health care agencies, Hospitals, Penalties, Pharmaceutical suppliers and manufacturers, Privacy, Reporting and recordkeeping requirements, Skilled nursing facilities.

Accordingly, 45 CFR part 61 is corrected by making the following correcting amendment.

**PART 61—HEALTHCARE INTEGRITY AND PROTECTION DATA BANK FOR FINAL ADVERSE INFORMATION ON HEALTH CARE PROVIDERS, SUPPLIERS AND PRACTITIONERS**

1. The authority citation for part 61 continues to read as follows:

**Authority:** 42 U.S.C. 1320a–7e.

2. Section 61.3 is amended by republishing the introductory text, and by revising the definition for the term Health plan to read as follows:

**§ 61.3 Definitions.**

The following definitions apply to this part:

\* \* \* \* \*

Health plan means a plan, program or organization that provides health benefits, whether directly, through insurance, reimbursement or otherwise, and includes but is not limited to—

- (1) A policy of health insurance;
- (2) A contract of a service benefit organization;

(3) A membership agreement with a health maintenance organization or other prepaid health plan;

(4) A plan, program, agreement or other mechanism established, maintained or made available by a self insured employer or group of self insured employers, a practitioner, provider or supplier group, third party administrator, integrated health care delivery system, employee welfare association, public service group or organization or professional association; and

(5) An insurance company, insurance service or insurance organization that is licensed to engage in the business of selling health care insurance in a State and which is subject to State law which regulates health insurance.

\* \* \* \* \*

Dated: November 1, 2000.

**William E. Clark,**

*Acting Director for Information Resource Management.*

[FR Doc. 00–29991 Filed 11–22–00; 8:45 am]

**BILLING CODE 4152–01–M**

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**Office of the Secretary**

**45 CFR Parts 160 and 162**

[HCFA–0149–CN]

RIN 0938–AI58

**Health Insurance Reform: Standards for Electronic Transactions; Correction**

**AGENCY:** Office of the Secretary, HHS.

**ACTION:** Correction of final rule.

**SUMMARY:** This document corrects technical and typographical errors that appeared in the final rule published in the **Federal Register** on August 17, 2000, entitled “Health Insurance Reform: Standards for Electronic Transactions” (65 FR 50312). The final rule adopted standards for eight electronic transactions and for code sets to be used in those transactions.

**DATES:** The effective date of this correction notice is November 24, 2000. The final rule adopted standards for eight electronic transactions and for code sets to be used in those transactions.

**FOR FURTHER INFORMATION CONTACT:** Joy Glass, (410) 786–6125.

**SUPPLEMENTARY INFORMATION:** The August 17, 2000 final rule published at 65 FR 50312 (FR Doc. 00–20820) contained technical and typographical errors. Therefore, we are making the following corrections:

1. On page 50312, in the middle column, in the eighteenth and nineteenth lines, “http://www.access.gpo.gov/su-docs/aces/aces140.html” is corrected to read “http://www.access.gpo.gov/su\_\_docs/aces/aces140.html.”

2. On page 50324, in the first column, in the twenty-ninth line, paragraph “6. Proprietary coding systems” is corrected to read, “b. Proprietary coding systems.”

3. On page 50332, in the first column, in the fourth line from the bottom, “276 comments” is corrected to read “267 comments.”

4. On page 50338, in the first column, in the twelfth line, “Title VII” is corrected to read “Title VI.”

5. On page 50358, in Table 4—Ten Year Net Savings, the figure “0.1” for Savings from Manual Transactions for Health Plans in 2007 is corrected to read “0.0.”

6. On page 50361, in the third column, section “N. Transaction Standards” is corrected as follows:

A. Paragraph N.1. is corrected to read as follows:

“Specific Impact of Adoption of the NCPDP Telecommunication Standard Implementation Guide, Version 5 Release 1 and Equivalent Batch Standard Implementation Guide Version 1 Release 0 for the Health Care Claim and Equivalent Encounter Information, Eligibility for a Health Plan, Referral Certification and Authorization, and Coordination of Benefits Transactions.”

B. In paragraph 1.a., in the sixth line, the words “encounter is” are corrected to read “encounter, eligibility, and referral certification and authorization are.”

C. In paragraph 1.a., in the third sentence, the word “claim” is removed.

D. In paragraph 1.b., in the last line of the column, the word “claim” is removed.

**Authority:** Secs. 1171 through 1179 of the Social Security Act (42 U.S.C. 1320d–1320d–8), as added by sec. 262 of Public Law 104–191, 110 Stat. 2021–2031, and sec. 264 of Pub. L. 104–191, 110 Stat. 2033–2034 (42 U.S.C. 1320d–2 (note)).

(Catalog of Federal Domestic Assistance Program No. 93.774, Medicare—Supplementary Medical Insurance Program)  
Dated: November 17, 2000.

**Brian P. Burns,**

*Deputy Assistant Secretary for Information Resources Management.*

[FR Doc. 00–29989 Filed 11–22–00; 8:45 am]

**BILLING CODE 4120–01–M**

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**Administration for Children and Families**

**45 CFR Parts 1355, 1356 and 1357**

[RIN 0970–AA97]

**Title IV–E Foster Care Eligibility Reviews and Child and Family Services State Plan Reviews**

**AGENCY:** Administration on Children, Youth and Families (ACYF), Administration for Children and Families (ACHF), Department of Health and Human Services (DHHS).

**ACTION:** Final rule; correction.

**SUMMARY:** This document corrects the regulatory text of the final rule on Title IV–E Foster Care Eligibility Reviews and Child and Family Services State Plan Reviews published in the **Federal Register** on January 25, 2000 (65 FR 4019–4093).

**DATES:** Effective November 24, 2000.

**FOR FURTHER INFORMATION CONTACT:** Kathleen McHugh, Children’s Bureau, 202–401–5789.

**SUPPLEMENTARY INFORMATION:**

**Correction**

In the final rule, 45 CFR Part 1355 through 1357, beginning on page 4019 in the issue of January 25, 2000, make the following correction. On page 4075 in the second column, instruction 2 currently says, “Section 1355.20 is amended by revising the definition of Foster care and by adding the following definitions in alphabetical order to read as follow:” It is corrected to read, “Section 1355.20 is amended by revising the definitions of *Foster care*