documentation of the teaching physician's presence or participation in the administration of the anesthesia and a preoperative and postoperative visit by the teaching physician. The teaching physician must be present during all critical portions of the procedure and immediately available to furnish services during the entire service or procedure. The teaching physician cannot receive an unreduced fee if he or she performs services involving other patients during the period the anesthesia resident is furnishing services in a single case. Respondents who will provide this information are teaching physicians.

The information collection requirements in § 415.180 (''Teaching setting requirements for the interpretation of diagnostic radiology and other diagnostic tests''), paragraph (b), concern documentation that the teaching physician personally performed the interpretation or reviewed the resident's interpretation with the resident. Physician fee schedule payment will be made in those situations. Respondents who will provide this information are teaching physicians.

The table below indicates the annual number of responses for each regulation section in this final rule containing information collection requirements, the average burden per response in minutes or hours, and the total annual burden hours.

ESTIMATED ANNUAL REPORTING AND RECORDKEEPING BURDEN

CFR sections	Annual No. of responses	Annual frequency	Average burden per response	Annual burden hours
415.60	17,979	1	11 hours	197,769
415.130	9,273	1	3 minutes	464
415.162	40	1	2 hours	80
415.172	3,200,232	1	1 minute	53,337
415.174	1,237,516	1	1 minute	20,625
415.178	106,819	1	1 minute	1,780
415.180	1,000,107	1	1 minute	16,668

The information collection requirements were approved by OMB for §§ 415.60 and 415.162 as §§ 405.481 and 405.465, respectively, under OMB control number 0938–0301 and expire August 31, 1998.

We have submitted a copy of this final rule with comment period to OMB for its review of the information collection requirements in §§ 415.130, 415.172, 415.174, 415.178, and 415.180. These requirements are not effective until they have been approved by OMB. A document will be published in the Federal Register when OMB approval is obtained.

Organizations and individuals desiring to submit comments on the information collection and recordkeeping requirements should send them to the Health Care Financing Administration, Office of Financial and Human Resources, Management Planning and Analysis Staff, 7500 Security Boulevard, Baltimore, Maryland, 21244–1850 and to the Office of Management and Budget official whose name appears in the **ADDRESSES** section of this preamble.

VIII. Response to Comments

Because of the large number of items of correspondence we normally receive on Federal Register documents published for comment, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, if we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

IX. Regulatory Impact Analysis

A. Regulatory Flexibility Act

Consistent with the Regulatory Flexibility Act (5 U.S.C. 601 through 612), we prepare a regulatory flexibility analysis unless the Secretary certifies that a rule will not have a significant economic impact on a substantial number of small entities. For purposes of the Regulatory Flexibility Act, all physicians are considered to be small entities.

This final rule will not have a significant economic impact on a substantial number of small entities. Nevertheless, we are preparing a regulatory flexibility analysis because the provisions of this rule are expected to have varying effects on the distribution of Medicare physician payments across specialties and across geographic areas. We anticipate that virtually all of the approximately 500,000 physicians who furnish covered services to Medicare beneficiaries will be affected by one or more provisions of this rule. In addition, physicians who are paid by private insurers for non-Medicare services will be affected to the extent that they are paid by private insurers that choose to use the RVUs. However, with few exceptions, we expect that the impact on individual medical practitioners will be limited.

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

B. Budget-Neutrality Adjustment

Section 1848(c)(2)(B) of the Act requires that adjustments to RVUs in a year may not cause the amount of expenditures for the year to differ by more than $20 million from the amount of expenditures that would have been made if these adjustments had not been made. We refer to this as the budget-neutrality adjustment.

In past years, we have made this adjustment across all RVUs. This year, as we proposed, we are making this adjustment on the conversion factors instead of the RVUs. This alternative approach is administratively simpler, and it facilitates policy and data analysis of RVUs. It does not significantly affect the final payments that are made to physicians because any changes to payments will be the result of rounding and will be minimal.

The issues discussed in sections IX.C. through IX.K. will have no impact on Medicare program expenditures because the effects of these changes have been neutralized in the calculation of the conversion factors for 1996.

We have estimated the net increase in program costs in calendar year 1996