Comments and Responses on the CMS-855A, B, I and R, OMB: 0938-0685

Comments related to the proposed changes (DATA Collection)

Comment: Two commenters suggested that CMS revise the introductory paragraph of Section 2H (Advanced Diagnostic Imaging) of the CMS-855B from "This section must be completed by all Independent Diagnostic Testing Facilities (IDTF) that also furnish and will bill Medicare for ADI services. All IDTF suppliers furnishing ADI services MUST be accredited in each ADI modality checked below to qualify to bill Medicare for those services" to "Independent Diagnostic Testing Facilities (IDTF) and medical clinics/groups furnishing ADI services must complete this section. IDTFs and medical clinics/groups must be accredited for each ADI modality checked below to receive reimbursement for those services."

Response: CMS agrees with this suggestion and will consider this recommendation for future revision of these forms.

Comment: Two commenters suggested that CMS change the capitalized word, "Modality" in the introductory paragraph of Section 2H to lower-case.

Response: CMS agrees, and will make this change.

Comment: Two commenters suggested that CMS remove Advance Diagnostic Imaging (ADI) from Section 2A of the CMS-855B, since ADI is not a supplier type but rather a type of service.

Response: ADI is not listed as a supplier type in section 2A of the CMS-855B.

Comment: Two commenters suggested that CMS revise the question on page 5 of the CMS-855I regarding "New Patient Status Information" from "Do you accept new patients" to "Are you accepting new Medicare patients?"

Response: CMS believes that the question is appropriately worded as is. However, we added the word "Medicare" as suggested for further clarity.

Comment: One commenter stated a cost report year end box was not added to the CMS 855A.

Response: CMS has corrected this error.

Comment: One commenter suggested adding 5A to page 30 and 5B1 to page 31, stating the instructions in 5.D. are as follows, "If the organization in (A) above ("the Reporting Organization") has one of the interests identified in (B)(1) in any organization reported in (A) above ….." and noted that although the instructions state 5D and 5B1, neither of these sections exist.

Response: CMS has corrected this error.

Comment: One commenter requested CMS reconsider requiring the exact percentage of direct and indirect ownership the organization has in the provider as these can change frequently as owners are added and deleted.

Response: This is a legislative requirement in order to capture exact ownership/interest information on Part A providers and is mandated by section 6001 of the ACA and cannot be changed.

Comment: One commenter asked CMS to provide instructions as to the meaning of the following question on the CMS 855A: "Was the organization solely created to acquire/buy the provider and/or provider's assets?"

Response: CMS believes additional instructions would confuse the intent of the question.

Comment: One commenter stated that regarding the available answers for type of interest the individual has in the provider, both "operational or managerial control" and "operational/managerial control" are listed and it appears these are the same type of interest and one should be deleted. The commenter requests clarification of the difference between the two types of interest.

Response: CMS has corrected this error.

Comment: One commenter stated it appears the type of interest questions listed in section 6A and 6B are the same except as noted below and was uncertain of the need for the type of interest to be asked twice for each individual. The commenter suggests the type of interest be consolidated into one question.

Response: CMS has corrected this error.

Comment: One commenter asked if CMS could comment on why Managing Employee (W-2) and Contracted Managing Employee are not included in section 6B.

Response: Section 6B has been reformatted. Managing Employee (W-2) and Contracted Managing Employee are included in section 6A.

Comment: One commenter requested CMS reconsider requiring the exact percentage of direct and indirect ownership the individual has in the provider as these can change frequently as owners are added and deleted.

Response: This is a legislative requirement in order to capture exact ownership/interest information on Part A providers and is mandated by section 6001 of the ACA and cannot be changed.

Comment: A commenter requested if CMS could clarify if a physician-owned hospital would complete section 5, 6 and Attachment 1 because sections 5 and 6 appear to collect the same information.

Response: Currently, Attachment 1 is specific to physician-owned hospitals and the information collected in Attachment 1 is mandated by section 6001 of the ACA. Providers enrolling as physician-owned hospitals are required to complete sections 5 and 6 as well as Attachment 1.

Comment: One commenter stated that the listing of suppliers (in the general instructions) that must complete the CMS 855B does not match the listing of available supplier types in section 2A of the CMS 855B. Specifically, the listings are missing Advanced Diagnostic Imaging Suppliers and Intensive Cardiac Rehabilitation suppliers.

Response: CMS has added Intensive Cardiac Rehabilitation suppliers to the listing of suppliers in the general instructions and section 2A of the CMS 855B and will consider adding Advanced Diagnostic Imaging (ADI) suppliers in a future revision of the CMS 855B and the CMS 855I. The addition of section 2H, which collects information pertaining to ADIs only, allowed for deletion of Attachment 3.

Comment: One commenter suggested adding a check box in the accreditation section enabling the supplier to indicate it has a pending accreditation.

Response: CMS enrollment contractors have been instructed to reject CMS 855 applications being submitted without the required accreditation. Therefore, a checkbox indicating a pending accreditation would serve no purpose to the supplier.

Comment: One commenter requested clarification regarding the reason for the language in the checkbox indicating the supplier is accredited specifies "…including the business location in Section 4A…"

Response: CMS has clarified the language in this question to indicate if the enrolling ambulatory surgical center supplier is either accredited or not accredited (including exempt suppliers) in section 2F of the CMS 855B.

Comment: One commenter noted inconsistencies between the CMS 855A and the CMS 855B in section 6A, Individuals with Ownership Interest and/or Managing Control – Identification Information, as noted:

- On the CMS 855A, the individual's title is requested on the second line from the bottom of the page, whereas the title for the individual in the CMS 855B is requested in the first line item of information and

Response: CMS will format section 6A of the CMS 855B to mirror the format of the same information in the CMS 855A.

- The CMS 855A includes many types of interest not included on the CMS 855B.

Response: The CMS 855A has additional ownership and interest data collections specific to Part A providers. Some types of interest data collected on the CMS 855A is not required to be reported by Part B providers/suppliers, which currently accounts for the differences in the interest types between applications.

Comment: One commenter asked for CMS to explain the purpose of the question "Will you accept new patients?" and asked if that information will be published.

Response: The question is mandated by the Affordable Care Act and will be published in the Physician Directory.

Comment: One commenter noted the misspelling of the word "advanced" in section 2D1 of the CMS 855I.

Response: Section 2D1 has been deleted from the CMS 855I.

Comment: one commenter suggested combining section 2L with Attachment 1 – Advanced Diagnostic Imaging Service Suppliers.

Response: Attachment 1 has been deleted and section 2L has been reformatted.

Comment: One commenter noted the specialties of "hospice" and "palliative care" are missing from the specialty options in the CMS 855I.

Response: CMS has added "hospice" and "palliative care" to section 2D of the CMS 855I.

Comment: One commenter suggested changing the language of "place of birth" to clarify if the intent is City, State, and/or Country of Birth.

Response: CMS has clarified the Place of Birth requires State data and Country of Birth data fields are present in all applicable CMS 855 applications.

Comment: One commenter stated the formatting of the question "How long has this owner had ownership…" is such that it would not be used to state the amount of time, but rather the effective date of ownership in both the organizational and individual ownership sections.

Response: CMS concurs and has revised the language to accurately reflect the effective date of ownership in sections 5A and 6A of the CMS 855B and section 6 of the CMS 855I.

Comments related to the proposed changes (Instructions)

Comment: Two commenters requested that CMS add the web page that provides additional information about ADI accreditation to Section 2L of the CMS-855B.

Response: CMS are disinclined to accept this recommendation, as the specific Web page may be subject to change.

Comment: One commenter suggests removing the language "Advanced Diagnostic Imaging Suppliers must complete Attachment 1" in section 1A from the box "You are changing your Medicare information."

Response: Attachment 1 had been deleted and references to Attachment 1 have been removed from the CMS 855B and CMS 855I.

Comments that are Out-of-Scope for these proposed changes (DATA Collection)

Comment: Two commenters recommended that CMS delete or replace the statements found in the "Additional Information" section of the CMS-855A, CMS-855B, CMS-855I and CMS-855R that read "The information you provide on this application will not be shared. It is protected under …." with "The information you provide will only be disclosed according to the routine uses found in the Privacy Act Statement."

Response: CMS will consider this recommendation for future revision of these forms.

Comment: Two commenters suggested that CMS add the following information prior to the introductory paragraph of Section 2H (Advanced Diagnostic Imaging) of the CMS-855B: "Section 135(a) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) amended section 1834(e) of the Social Security Act and required the Secretary to designate organizations to accredit suppliers, including but not limited to physicians, non-physician practitioners and Independent Diagnostic Testing Facilities, that furnish the technical component (TC) of advanced diagnostic imaging services. In order to furnish the TC of advanced diagnostic imaging services for Medicare beneficiaries, suppliers must be accredited by January 1, 2012."

Response: CMS believes this level of detail to be out of scope for this information collection and would cause confusion among the providers and suppliers completing the CMS 855 applications. CMS has clearly stated the instructions and requirements for completing the ADI section of the CMS 855B enrollment application.

Comment: Two commenters recommended that CMS revise the introductory paragraph of Section 2.L (Advanced Diagnostic Imaging) of the CMS-855I from "This section must be completed by all individual practitioners that also furnish and bill Medicare for ADI services" to "Physicians furnishing ADI services to Medicare beneficiaries and billing for these services through their Type 1 (individual) or Type 2 (organization) NPI must complete this section. Physicians and non-physicians furnishing ADI services to Medicare beneficiaries through a reassignment of benefits can skip this section."

Response: CMS believes this level of detail to be out of scope for this information collection and would cause confusion among the providers and suppliers completing the CMS 855 applications. CMS has clearly stated the instructions and requirements for completing the ADI section of the CMS 855B enrollment application. In addition, as previously stated, CMS believes that physicians and non-physician practitioners are already aware that they must use their Type 1 NPI when enrolling as individuals and their Type 2 NPI when enrolling as an organization.

Comment: Two commenters asked CMS to add the following information prior to the introductory paragraph of Section 2L (Advanced Diagnostic Imaging) of the CMS-855I: "Section 135(a) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) amended section 1834(e) of the Social Security Act and required the Secretary to designate organizations to accredit suppliers, including but not limited to physicians, non-physician practitioners and Independent Diagnostic Testing Facilities, that furnish the technical component (TC) of advanced diagnostic imaging services. In order to furnish the TC of advanced diagnostic imaging services for Medicare beneficiaries, suppliers must be accredited by January 1, 2012."

Response: As previously stated, CMS believes this level of detail to be out of scope for this information collection.

Comment: Two commenters suggested that CMS add information to Section 17 of the CMS-855A and CMS-855B to remind providers and suppliers, as applicable, to submit the Medicare application fee and hardship waiver process with the initial enrollment application or revalidation package.

Response: CMS will consider this recommendation for a future revision of the CMS-855A and CMS-855B.

Comment: Two commenters suggested that CMS add information to Section 17 of the CMS-855A to remind owners of a home health agency to submit their fingerprints and capitalization information with their initial enrollment application.

Response: For reasons already stated, CMS is not in a position to address fingerprinting in this version of the CMS-855A. As for capitalization, we will consider this recommendation for a future revision of the CMS-855A.

Comment: Two commenters suggested that CMS change the bullet "Ensure that the legal business name shown in Section 2 matches the name on tax documentation" found on page 2 of the CMS-855A and CMS-855B to read "Ensure that the legal business name shown in Section 2 matches the name on tax documentation and the National Plan and Provider Enumeration System."

Response: CMS believes the instructions and requirements concerning the legal business name have been clearly stated.

Comment: Two commenters recommended that CMS delete the supplier type "Part B Drug Vendor" from page 1 (Who Should Submit This Application" of the CMS-855B, or add "Part B Drug Vendor" to page 8 (Type of Supplier, in Section 2.A."

Response: CMS has deleted "Part B Drug Vendor" from page 1 of the CMS 855B.

Comment: Two commenters suggested that CMS delete the provider type "Indian Health Service Facility" from page 1 of the CMS-855A and delete the "Indian Health Services Facility" from page 10.

Response: CMS is disinclined to accept this recommendation, as the Indian Health Facilities must be identified to be directed to the designated Indian Health Services (HIS) Medicare Administrative Contractor (MAC).

Comment: Two commenters suggested that CMS add the terms "disregarded entity" and "government owned entity" to section 2.B.1 of the CMS-855A and CMS-855B.

Response: CMS will consider the recommendation to add "disregarded entity" to the Organizational Structure options in section 2B1 of the CMS 855A and the CMS 855B in a future revision. However, if the supplier is a government-owned entity, the owning governmental entity must be identified in section 5 of the application.

Comment: Two commenters recommended that CMS change the spelling of "Proprietaryship" on page 8 of the CMS-855B.

Response: CMS agrees, and will correct the spelling.

Comment: Two commenters suggested that CMS:

1. change the title of Section 6B on the CMS-855B from "Final Adverse History" to "Final Adverse Action History";

2. revise the first sentence in section 3 of the CMS-855A to add the word, “final” before adverse action;
3. replace the term, “Adverse Legal Action/Convictions” on page 8 (section 1.B) of the CMS-855A with “Final Adverse Action”;
4. replace the term “Final Adverse Legal History” with “Final Adverse Action” on page 32 (section 5.B) of the CMS-855A;
5. replace the term “Final Adverse Legal Action” with “Final Adverse Action” in the table on page 32 (section 5.B) of the CMS-855A;
6. replace the term “Final Adverse Legal History” with “Final Adverse Action” on page 23 of the CMS-855B;
7. replace the term, “Adverse Legal History” with “Final Adverse Action” on page 33 of the CMS-855A; and
8. replace the term, “Adverse Legal History” with “Final Adverse Action” on page 25 of the CMS-855B.

Response: CMS agrees with the need for language consistency, and as such, has revised all CMS 855 Medicare enrollment applications to use the phrase “Final Adverse Legal Actions” and “Final Adverse Legal Action History” in sections 3, 5 and 6 of the CMS 855A, CMS 855B and CMS 855S applications, sections 3 and 6 of the CMS 855I.

Comment: Two commenters suggested that CMS: (1) revise item 4 in Section 3 of the CMS-855A, CMS-855B, and CMS-855I to state, “Any Medicare payment suspension,” and (2) revise item 5 in Section 3 of the CMS-855A, CMS-855B, and CMS-855I to state “Any Medicare revocation.”

Response: CMS is disinclined to accept this suggestion as a provider or supplier could have had a previous Medicare payment suspension and/or a previous Medicare revocation and due to individual circumstances, still be approved as a Medicare provider or supplier with billing privileges.

Comment: Two commenters suggested that CMS revise Section 3 of the CMS-855B to ensure that air ambulance suppliers understand their responsibility to report the revocation or suspension of a FAA license.

Response: CMS considers the revocation or suspension of an FAA license to be included into the responsibilities and requirements a provider or supplier has when any applicable license has been suspended or revoked. These responsibilities are made clear throughout the application and in the Certification Statement.

Comment: Two commenters recommended that CMS revise item 1 in section 3 of the CMS-855A, CMS-855B, and CMS-855I to delete the phrase, “that CMS has to be detrimental to the best interest of the program and its beneficiaries.”

Response: CMS believes that retention of this language is necessary.

Comment: Two commenters recommended that CMS delete the reference to the Medicare Identification Number in section 3 of the CMS-855A, CMS-855B, and CMS-855I.

Response: CMS will be retaining the term "Medicare Identification Number" in section 3 of these forms.

Comment: Two commenters suggested that CMS revise item 2 in the section titled, "Obtaining Medicare Approval" on page 2 of the CMS-855A to state "The fee-for-service contractor will review and conduct an initial assessment of the application and either recommend the application for approval to the CMS Regional Office or deny the application."

Response: CMS believes this level of detail is out of scope for this information collection. However, CMS agrees with this suggestion and will make the change.

Comment: Two commenters suggested that CMS add a new bullet to page 4 of the CMS-855A and page 3 of the CMS-855B that reads: "Enrolling a practice location which was deactivated due to 12 consecutive months of non-billing." The commenters also suggested that CMS delete the paragraph on reactivation on page 4 of the CMS-855A and page 3 of the CMS-855B.

Response: CMS will retain the language in the paragraph on reactivation on page 4 of the CMS 855A and page 3 of the CMS 855B as they do not specify deactivation due to a specific reason, such as 12 consecutive months of non-billing.

Comment: Two commenters suggested that CMS add a new statement to the CMS-855A and CMS-855B Certification Statements to address the concept of nominee owners and responsible parties.

Response: As previously stated, CMS believes "the concept of nominee owners and responsible parties" are out of scope for this information collection.

Comment: Two commenters suggested that CMS verify that the information found in the Privacy Act statement of the CMS-855A, CMS-855B, CMS-855I, and CMS-855R is consistent with PECOS Systems of Records document.

Response: CMS will verify that the information found in the Privacy Act statement of the above referenced applications is consistent with the PECOS Systems of Records document. CMS will include Privacy Act statement updates in a future revision of the CMS 855 applications, if applicable.

Comment: Two commenters requested that CMS change the sentence "You are revalidating your Medicare enrollment" on page 7 of the CMS-855A, page 5 of the CMS-855B, and page 4 of the CMS-855I to "CMS or its contractor requested a revalidation."

Response: CMS believes this terminology follows the language format in these sections of the CMS 855A, CMS 855B and CMS 855I and is clear as written.

Comment: Two commenters requested that CMS revise the check box on page 8 of the CMS-855B from “Ambulatory Surgical Center Clinic/Group Practice” to “Ambulatory Surgical Center”.

Response: CMS agrees, and will make this change.

Comment: Two commenters suggested that CMS replace the word “local” with “designated” in the last sentence of page 9 of the CMS-855B.

Response: CMS agrees, and will make this change.

Comment: Two commenters requested that CMS revise the CMS-855B so that all requests for accreditation information are grouped together.

Response: Accreditation requests are specific to provider/supplier type and are formatted to as requested as a result of design input including, but not limited to, contractors, focus groups, and provider/supplier suggestions.

Comment: Two commenters recommended that CMS revise the form name for the CMS-588 on page 14 of the CMS-855I from “(Electronic Funds Transfer Authorized Agreement)” to “(Electronic Funds Transfer Authorization Agreement).”

Response: CMS agrees, and will make this change.

Comment: Two commenters stated that with respect to section 15 of the forms, CMS should: (1) make the certification statements in the CMS-855A, CMS-855B, and CMS-855I consistent, (2) revise section 15, item 5 of CMS-855I from “Neither I, no any managing employee list in this application, is currently …” to “I am not currently …”

Response: CMS will consider this suggestion for a future revision of these forms.

Comment: Two commenters suggested that CMS change the sentence “You are revalidating your Medicare enrollment” in section 1A of the CMS-855A, CMS-855B, and CMS-855I to “The Medicare contractor requested a revalidation.”

Response: CMS believes that the current verbiage is appropriate and does not need to be altered. We also note that additional instruction in the applications clearly state that providers/suppliers need not submit a revalidation application unless requested by the Medicare contractor.

Comment: Two commenters recommended that CMS change the “Reason for Submission” section 1A of the CMS-855A, CMS-855B, and CMS-855I from “You are a new enrollee in Medicare” to “You are a new enrollee or you are voluntarily updating your enrollment information with Medicare for the first time in more than 5 years.”

Response: CMS believes that the current language is sufficient. A provider or supplier voluntarily updating its enrollment with Medicare for the first time in more than 5 years must provide the same information and documentation as a new enrollee in addition to identifying their Medicare billing number on the application.

Comment: Two commenters recommended that CMS add a new certification on page 11 of the CMS-855I that states: “I certify that the signature below is mine and that I have not authorized another individual to sign this application on my behalf. I understand and certify that if I do not sign this application that CMS will return this application to me and that the Medicare contractor will not preserve my application date.”

Response: CMS will consider this suggestion for a future revision of these forms.

Comment: Two commenters asked CMS to explain what is meant by the check box “Enrolling in another fee-for-service contractor’s jurisdiction” found page 4 on page 3 of the CMS-855B.

Response: The checkbox means that the supplier is already enrolled in one or more contractor jurisdictions and is now enrolling in another contractor jurisdiction.

Comment: Two commenters suggested that CMS replace the explanation for the term “Reactivation” on page 4 of the CMS-855A and page 3 of the CMS-855B with the explanation for the term, “Reactivation” found on page 4 of the CMS-855S. They believed that the definition found in the CMS-855S is clearer.

Response: CMS will consider this suggestion for a future revision of these forms.

Comment: Two commenters suggested that CMS delete the word “Convictions” from the check box titled, “Final Adverse Action/Convictions” on page 6 (section 1.B) of the CMS-855B and page 4 (section 1.B) of the CMS-855I.

Response: For reasons already stated, CMS believes that the term “Convictions” is appropriately included in the checkbox title in question.

Comment: Two commenters suggested that CMS add information to Section 2.D of the CMS-855A to capture information about providers who meet the Conditions of Participation for their provider type via the State survey process.

Response: CMS believes this level of detail to be out of scope for this information collection and would cause confusion among the providers and suppliers completing the CMS 855 applications.

Comment: Two commenters suggested that CMS delete the paragraph that refers to final adverse actions on page 8 of the CMS-855I, in that it seems misplaced.

Response: CMS agrees, and will delete the paragraph in question.

Comment: Two commenters suggested that CMS move the request for supporting documentation for CLIA Number and/or FDA/Radiology Certification Number from page 15 of the CMS-855I to Section 17 of the CMS-855I.

Response: CMS had moved the documentation requirement to section 17 of the CMS 855I but has kept the current language on page 15 as well, for additional provider/supplier clarification.

Comment: We suggest adding the various units, such as swing-bed unit, etc., under the critical access hospital designation since these are set up as separate PECOS records from that of a critical access hospital. It would eliminate Medicare contractor confusion when units are being added to a critical access hospital or simply updating PECOS records for critical access hospital units. The result would be similar to the units for prospective payment hospitals §2A2.

Response: CMS will consider this suggestion for a future revision of these forms.

Comment: One commenter requested CMS clarify in the instructions if question 2A3 applies of the CMS 855A if the critical access hospital box is checked in 2A1 and/or if any box is checked in 2A2 and address if question 2A3 applies if any type of provider is checked in 2A1 if the provider is owned by a hospital or critical access hospital.

Response: CMS has revised the instructions for clarity.

Comment: One commenter noted that the tax identification number has been left out of this section as compared to the current from and question if this was the intent of CMS.

Response: CMS has corrected this error.

Comment: One commenter noted that the header for Acquisitions/Mergers, associated with section 2G is missing from the middle of the page as compared to the current forms stating the numbering noted on the form goes from 2F to 2H.

Response: CMS has corrected this error.

Comment: One commenter suggested adding at the bottom of the page in section 4A, under the heading "Hospitals and HHAs only (Identify type of practice location)" a check box to note the "Main Hospital Location" to assist Medicare contractors in understanding which inpatient location is the main hospital location for provider-based purposes and also suggested that more space be provided to describe the "other Hospital Practice Location."

Response: CMS concurs and has added a check box to note the "Main Hospital Location" as well as provided more space to describe the "other Hospital Practice Location."

Comment: A commenter suggested removing the question indicating proprietary or non-profit status in section 12A1 because it has already been provided in section 2B1.

Response: At this time, CMS must collect this information in section 12A1 because it is specific to home health agencies. However, CMS will consider this suggestion for a future revision of these forms.

Comment: A commenter suggested rearranging sections 12A2, 12A3 and 12A4 in order to ensure they are not overlooked by enrolling providers.

Response: CMS believes the flow within this section best suit the needs of logical data flow.

Comment: One commenter noted the last question of section 2B1 of the CMS 855B contained a spelling error.

Response: CMS has corrected the error, deleting the "d" from "and" as suggested by the commenter.

Comment: One commenter suggested adding Ambulatory Surgical Centers and Skilled Nursing Facilities and/or Nursing Facilities to the options under the question "Is this practice location a:" in section 4A of the CMS 855B as those types of practice locations are routinely put on the "Other health care facility" line.

Response: CMS will add Skilled Nursing Facilities and/or Nursing Facilities to the options under the question "Is this practice location a:" in section 4A of the CMS 855B as this type of supplier cannot be listed under the current options. However, as Ambulatory Surgical Centers can be subsets of other listed types of suppliers, CMS has decided at this time not to list Ambulatory Surgical Centers as a separate option for this question.

Comment: One commenter corrected the numbering error in section 5B1 of the CMS 855B.

Response: CMS has corrected the instructions to state “Skip to Section 6” and not to “Section 4.”

Comment: One commenter noted in section 4A of the CMS 855I contained a spelling error.

Response: CMS has corrected the error, deleting the “d” from “and” as suggested by the commenter.

Comment: One commenter suggested adding Ambulatory Surgical Centers and Skilled Nursing Facilities and/or Nursing Facilities to the options under the question “Is this practice location a:” in section 4C of the CMS 855I as those types of practice locations are routinely put on the “Other health care facility” line.

Response: CMS will add Skilled Nursing Facilities and/or Nursing Facilities to the options under the question “Is this practice location a:” in section 4C of the CMS 855I as this type of supplier cannot be listed under the current options. However, as Ambulatory Surgical Centers can be subsets of other listed types of suppliers, CMS has decided at this time not to list Ambulatory Surgical Centers as a separate option for this question.

Comment: One commenter suggested correcting the mandatory sections to be completed to terminate a reassignment.

Response: CMS concurs and added section 7 in section 1A of the CMS 855R to the mandatory sections to be completed to terminate a reassignment.

Comment: One commenter noted the change, add and delete boxes have been removed from various parts of the CMS 855 forms.

Response: CMS has added the change, add and delete box to the following CMS 855 sections:

- CMS 855A, Chain Home Office (section 7C)
- CMS 855B, the remittance notices and special payment section (section 4B);
- CMS 855B, Individuals with Ownership Interest and/or Managing Control – Identification Information (section 6A); and
- CMS 855I, Billing Agency Information (Section 8).

Comment: One commenter recommended adding instructions specific to how to complete medical record storage locations when electronic records are the sole type of medical record. It was suggested that perhaps this would be completed for where servers are located or CMS may have other disclosure requirements in these situations.

Response: CMS concurs with this recommendation. CMS will include the data fields necessary for this collection in future CMS 855 revisions.

Comments that are Out-of-Scope for these proposed changes (Instructions)

Comment: Two commenters suggested that CMS include information into the CMS-855A and CMS-855B about the Medicare application fee and fingerprint process.

Response: CMS has conducted substantial outreach on the application fee issue and plan to include a reference to it in future version of the CMS-855A and CMS-855B. As for fingerprinting, we are not in a position to address it in this iteration of these forms because there is currently no requirement that fingerprints be submitted as a condition of enrollment.

Comment: Two commenters suggested that CMS add the first two paragraphs found on page 2 of the CMS-855B to the “Billing Number Information” found in the CMS 855A. The commenters believed that this change would clarify which NPI should be submitted by a health care provider.

Response: CMS believes that the current language should be retained, as we believe that Part A providers are already aware what NPI to use when enrolling as a Part A provider in the Medicare program.

Comment: Two commenters suggested that CMS delete the reference to “misdemeanors” from items 2, 3, 4, 5 of the CMS-855A, CMS-855B, and CMS-855I because CMS does not have statutory or regulatory authority to deny or revoke Medicare billing privileges based on a misdemeanor conviction.

Response: As stated previously, CMS declines to accept this suggestion, as the Office of Inspector General has the authority under section 1128 of the Act to exclude a person or entity from the Medicare program based on certain health care-related misdemeanors.

Comment: Two commenters suggested that on page 2 of the CMS-855A, CMS: (1) revise the first sentence in item 3 in the section titled “Obtaining Medicare Approval” on page 2 of the CMS-855A to state “The State agency or approved accreditation organization conducts the Survey;” and (2) add a new item 4 in the section titled, “Obtaining Medicare Approval” on page 2 of the CMS-855A to state, “A CMS contractor conducts a second contractor review, as needed, to verify that a provider continues to meet the enrollment requirements prior to the issuance of a Medicare billing privileges.”

Response: CMS believes this level of detail is out of scope for this information collection. However, CMS agrees with this suggestion and will make the change.

Comment: Two commenters recommended that with respect to the Attachments section (Section 17) of the forms, CMS: (1) delete the checkbox on the CMS-855B labeled “Complete Form(s) CMS-855R, Reassignment of Medicare Benefits”; (2) clarify on the CMS-855B that the CMS-460 only applies to Multi-Specialty Clinics; (3) clarify on the CMS-855B that the CMS-460 must be submitted by a Multi-Specialty Clinic at the time of initial enrollment or reactivation; (4) clarify on the CMS-855I that the CMS-460 must be submitted by physician at the time of initial enrollment or reactivation to establish the clinic as a participating practitioner in Medicare; (5) delete the reference to the CMS-460 on the CMS-855R because a physician reassigning his or her payments to a clinic/group practice will be participating or non-participating based on the participation status of the clinic or group; and (6) add a new check box to the “Mandatory For Selected Provider/Supplier Types” section of the CMS-855B that reads: “Copy(s) of all documentation verifying the state licenses or certifications of the laboratory director or non-physician practitioner personnel of an independent clinical laboratory.”

Response: CMS believes the language deletions in recommendation number 1 above is not necessary and could potentially cause a CMS 855R to be excluded when necessary from Part B provider/suppliers. The CMS 460 (Participation Agreement) applies to provider/suppliers other than multi-specialty clinics, therefore CMS does not agree with recommendations number 2 and 3 above. CMS believes the language instructing provider/suppliers when they must submit the CMS 460 is clearly written (recommendation number 4 above). After review, CMS notes there is no reference to the CMS 460 on the CMS 855R (number 5 above). CMS added, per recommendation number 6, the suggested checkbox to section 17 of the CMS 855B requesting “Copy(s) of all documentation verifying the state licenses or certifications of the laboratory director or non-physician practitioner personnel of an independent clinical laboratory.”

Comment: Two commenters suggested that CMS delete the word “Convictions” from the title found in Section 3 of the CMS-855A, CMS-855B, and CMS-855I.

Response: For reasons previously stated, CMS believes that the term “Convictions” should be retained in the Section 3 title.

Comment: Two commenters suggested that CMS add the following statement to section 4A of the CMS-855A, CMS-855B, and CMS-855I: “The address must be a specific street address as recorded by the United States Postal Service. A practice location must be the physical location where you furnish services. This address cannot be P.O. Box.”

Response: CMS notes that the providers/suppliers are instructed the practice location must be a physical location and not a P.O. Box on p. 18 of the CMS 855A, p. 14 of the CMS 855B, page 15 of the CMS 855I and page 15 of the CMS 855S.

Comment: Two commenters suggested that CMS remove the list of IDTF performance standards on pages 39 and 40 of the CMS-855B and refer IDTFs to a CMS’ web site to obtain a list of the performance standards that apply to them. They felt that this change would reduce the number of pages

contained the CMS-855B and is consistent with CMS' decision to remove the DMEPOS supplier standards from page 36 the CMS-855S.

Response: CMS will consider this suggestion for a future revision of these forms.

Comment: Two commenters suggested that CMS align the meaning of provider enrollment terms found under "Enrolled Medicare Suppliers" on page 3 of the CMS-855B with the "Reason for Application Submission" on pages 4 and 5, so that information is presented in the following manner in both sections: 1. New Enrollee, 2.Reactivation, 3.Change of Ownership, 4.Changing Your Medicare Information, 5. Enrolling in another fee-for-service contractor's justification, 6. Revalidation, 7. Voluntarily Termination. Similarly, they recommended that CMS align the order of provider enrollment terms found under "Enrolled Medicare Suppliers" on page 4 and 5 with the "Reason for Application Submission" on pages 6 and 7 of the CMS-855A, so that information is presented in the following manner in both sections: 1. New Enrollee, 2.Reactivation, 3.Change of Ownership, 4. Acquisition or Merger, 5. Consolidation, 6. Changing Your Medicare Information, 7. Revalidation, 8. Voluntarily Termination.

Response: CMS believes that the current alignment on page 3 of the CMS-855B is adequate.

Comment: Two commenters suggested that CMS delete "hospital" from the "Change of Ownership" explanations on pages 3 and 6 of the CMS-855B. They stated that hospitals do not complete the CMS-855B. They also urged CMS to: (1) replace the explanation for "Change of Ownership" on page 3 of the CMS-855B with the explanation of "Change of Ownership" on page 4 of the CMS-855A, and (2) revise the CMS-855A to address home health agency changes in majority ownership.

Response: CMS will consider these suggestions for a future revision of these forms.

Comment: Two commenters suggested that CMS remove the paragraph regarding "Non-Profit, Charitable or Religious Organization from page 24 of the CMS-855B and add this information to Section 17 of the CMS-855B because CMS is requesting supporting documentation (e.g., the 501(c)(3)).

Response: CMS believes that the paragraph in question is appropriately located on page 24 and need not be moved.

Comment: Two commenters recommended that CMS delete the sentence on page 21 of the CMS-855B that states "Each non-profit organization should submit a copy of a 501(c)(3) document verifying its non-profit status."

Response: CMS disagrees with this recommendation, as the 501(c)(3) document is necessary to verify non-profit status.

Comment: Two commenters recommended that with respect to the CMS-855R, CMS should: (1) correct the regulatory citation for reassignment on page 1 referring to 42 CFR 424.520(b); (2) add a closing parenthetical after the words "…eligible supplier." on page 3; (3) delete the reference to "health care delivery system" on page 6 because the fee-for-service program does not have "health care delivery systems" as a supplier type; (4) add the "Penalties for Falsifying Information" in Section 14 of the CMS-855B and CMS-855I to the CMS-855R; and (5) delete or clarify the statement, "The signatures below acknowledge………"

Response: CMS concurs with the first two recommendations and will make these changes, with the exception of including the closing parenthetical after the term "CMS 855I." We will consider the remaining three recommendations for a future revision to the CMS-855R.

Comment: Two commenters suggested that CMS correct the web site address on page 3 (Mail Your Application) to remove the "hhs" from the web site address.

Response: CMS agrees, and has made this change on the CMS 855A, CMS 855B and CMS 855R. CMS would like to note that the website including the "hhs" does re-direct itself to the proper location so that providers and suppliers are not affected by the site address at this time.

Comment: Two commenters recommended that CMS correct the regulatory citations found on page 1 of the CMS-855B. Specifically, they recommended that CMS: (1) change the IDTF citation to 42 CFR 410.33(g)(2) and change the multi-specialty clinic citation to 42 CFR 424.516(d). They also recommended that CMS change the citation for all other suppliers (except DMEPOS suppliers) to 42 CFR 424.516(e).

Response: CMS believes the current citation of 42 CFR 410.33 is referenced to give the reader a broad understanding of the various statutory provisions that impact IDTFs and will therefore retain the current language. CMS will revise the reference for other suppliers to 42 CFR 424.516(d), which is specific to Part B suppliers.

Comment: Two commenters suggested that CMS clarify whether a "mass immunization roster biller" should complete the CMS-855I or the CMS-855B, since it appears that CMS deleted the supplier type of "mass immunization roster biller" from the CMS-855I.

Response: CMS will attempt to clarify this issue in a future version of the CMS-855I.

Comment: One commenter suggested CMS develop a consistent policy regarding the effective date to be listed in the license and certification boxes of the section (2B2). Some Medicare contractors request the original effective date of the license or certification and others request renewal dates. There are even inconsistencies within Medicare contractors on the effective date to be listed.

Response: CMS believes this level of detail to be out of scope for this information collection. However, CMS will furnish additional contractor training on this issue.

Comment: One commenter requested CMS add additional language in the instructions under "5. Additional Information on Ownership" to clarify the definition of a holding company and asked if a holding company would include parent corporations.

Response: CMS will consider this suggestion for a future revision of these forms.

Comment: One commenter suggested adding clarifying language that the CMS 855R should not be used by Physician Assistants.

Response: CMS added a disclaimer stating the CMS 855R should not be used by Physician Assistants to the instructions of the CMS 855R.

Comment: One commenter stated that the note regarding disregarded entities appears to be copied straight from the general instructions of the Form 8832. The first sentence is correct, but the commenter questions if the second sentence should remain in the CMS 855s as the two sentences contradict themselves.

Response: CMS concurs. The second sentence has been removed from section 17 of the CMS 855A, CMS 855B and the CMS 855I.

Comment: One commenter noted that contractors are processing the change, add and delete boxes inconsistently stating that some contractors require that these boxes be used only in situations where the provider/supplier is changing their information, while others are requiring that dates be included in these boxes when completing other reasons for application, specifically new enrollee applications and suggests additional contractor education be done in that area for consistency.

Response: CMS believes this level of detail to be out of scope for this information collection. However, CMS will instruct contractors to process applications, requiring only the change, add and delete boxes be completed for only provider/supplier changes of information.

Comment: One commenter suggests changing the required section language in section 1A to "Complete all applicable sections" to clarify that not every section is needed for each type of enrollment situation.

Response: CMS concurs and has revised the language in section 1A in the CMS 855A, CMS 855B, and CMS 855I. This does not apply to the CMS 855R.

Comments Directed at the Supporting Statement

Comment: Two commenters suggested that CMS delete the word "always" in item A5 (Small Business) of the Supporting Statement Justification for CMS-855S and in statement in B5 of the Summary Statement for the CMS 855A, CMS 855B, CMS 855I and CMS 855R. They contended that the use of the word "always" is incorrect, since CMS did not begin to use the CMS-855 family of forms until the mid-1990s.

Response: Since CMS started utilizing the CMS-855 Medicare enrollment applications, small businesses have always been required to provide CMS with substantially the same information in order to enroll in the Medicare Program and for CMS to successfully process their claims. Therefore, CMS will keep the current language in the Supporting Statements.

Comment: Two commenters suggested that CMS: (1) revise the paperwork burden estimate for the CMS-855R from 15 minutes to 30 minutes, and (2) increase the hourly wage for administrative staff from $20 per hour to $30 per hour in section B.12.

Response: CMS has used $20 as an administrative wage in previous information collection submissions; for purposes of consistency, we believe a similar figure should be used in this Supporting Statement. As for the CMS-855R estimate, we believe that the proposed 15-minute timeframe is accurate.

Comment: Two commenters recommended that CMS delete the reference to section 3109 of PPACA from section B.1 of the Supporting Statement, since section 3109 of PPACA refers to pharmacies enrolling via the CMS-855S.

Response: Section B1 of the Supporting Statement is designed in part to give the reader a broad understanding of the various statutory provisions that impact the provider enrollment process either in part or in full. CMS therefore believes that the reference to section 3109 should be retained.

Comment: Two commenters suggested that CMS change the statement found in B.2 of the Supporting Statement by replacing "The CMS-855 is submitted at the time the applicant first request a Medicare billing number" to "The CMS-855 is submitted prior to the applicant's first request for Medicare billing privileges, when a change of information occurs, including a change of ownership, or in response to a MAC request for revalidation."

Response: The statement in question in section B2 and the sentence before it in the Supporting Statement was being used purely in the context of an initial enrollment. CMS will therefore retain them.

Comment: Two commenters suggested that CMS change the statement in B2 that reads "Access to the data maintained in PECOS is limited to CMS and Medicare contractor employees responsible for

provider enrollment activities" to "Access to the data maintained in PECOS is limited to CMS and Medicare contractor employees responsible for provider enrollment activities and the routine uses described in the Privacy Statement."

Response: CMS believes that the statement as it currently reads in the Supporting Statement is accurate.

Comment: Two commenters recommended that CMS replace the references found in B.1 of the Supporting Statement from bill titles (e.g., PPACA) to the amended section of the Social Security Act (Act).

Response: As stated previously, since members of the public may be more familiar with the commonly-known names of particular statutes (e.g., PPACA), CMS believes it is appropriate to use said names in the Supporting Statement.

Comment: Two commenters recommended that CMS clarify Section B.1 of the Supporting Statement to indicate that Section 6401 of PPACA modified Section 1866 of the Social Security Act.

Response: CMS believes that the preference to section 6401 is sufficient.

Comment: Two commenters suggested that CMS delete the statement from section A.1 of the Supporting Statement that refers to section 6001 of PPACA, since CMS did not publish final regulations implementing section 6001 of PPACA.

Response: The statement is simply designed as an informational reference to section 6001. There is no need to remove it from the Supporting Statement.

Comment: Two commenters recommended that CMS replace the statement in section B.3 of the Supporting Statement that reads: "PECOS began housing provider/supplier information 2004 in compliance with Government Paperwork Elimination Act. However, until CMS adopts an electronic signature standard, providers/suppliers will be required to submit a hard copy signature page of the applicable CMS-855 with an original signature" with "CMS began storing CMS-855 data in PECOS in 2003. However, until CMS adopts an electronic signature standard for Internet-based PECOS enrollment applications, providers/suppliers will be required to submit a hard copy signature page with the their enrollment submission. "

Response: CMS will change the 2004 date in the sentence in question to 2003.

Comment: Two commenters suggested that CMS correct the statements found in B.6 and B.10 of the Summary Statement that reads "The information is collected on an as needed basis" to "The information is collected on an as needed basis or every five years."

Response: CMS believes that the current language is sufficient, since it encompasses both periodic revalidations and off-cycle revalidations.

Comment: Two commenters recommended that CMS delete the reference to "privileged or confidential commercial or financial information" in B10 of the Summary Statement.

Response: CMS believes that this statement is appropriate and will retain it.

Comment: Two commenters suggested that CMS replace the estimate of 10,000 providers (CMS-855A) and 85,000 suppliers (CMS-855B and CMS-855I) used to create the increase in paperwork burden for the CMS-855(A, B, I, R) with a higher number. They added that CMS stated: (1) that it would conduct 87,000 revalidations annually in a final rule published on February 2, 2011, and (2) should use current enrollment data (i.e., CY 2010 or CY 2011) - plus the number of annual revalidations - to estimate the number of respondents subject to the increase in paperwork burden.

Response: In preparing our burden estimates, CMS used the most recent data available. However, we will revise the burden estimates to account for revalidations.

Comments that are the "Opinion" of the Commenter

Comment: Two commenters recommended that CMS withdraw this proposed information collection for the CMS-855(A, B, I, R), begin a new 60-day public comment period for this proposed information collection, and exclude these changes from any updates to Internet-based PECOS until OMB has approved a subsequent information for several reasons. First, CMS did not update the CMS-855A and CMS-855B to include recent regulatory changes. Second, CMS did not publish regulations associated with section 6001 of the PPACA or regulations that require Medicare providers to comply with Section 511 of the Tax Increase Prevention and Reconciliation Act of 2005. Third, CMS did not modify the Privacy Act Statement found in the CMS-855(A, I, B, R) to ensure consistency with the PECOS Systems of Records (09-70-0532). Fourth, CMS did not modify the PECOS Systems of Record document to reflect the types of information that could be published on the official CMS Internet site. Fifth, CMS did not update the paperwork burden to reflect the Medicare application fee, hardship waiver, fingerprinting, providing the IRS-CP-575, furnishing a copy of the IRS Determination Letter, or Advanced Diagnostic Imaging (ADI), and did not use actual application submission statistics using CY 2010 and CY 2011 workloads. Sixth, CMS did not modify the paperwork burden estimates for the CMS-855A, CMS-855B, CMS-855I, and CMS-855R to reflect the use of Internet-based PECOS by providers and suppliers. Seventh, CMS did not include a summary of changes with the 30-day proposed information collection found on the CMS web site for the CMS-855A, CMS-855B, CMS-855I, and CMS-855R and CMS' responses to comments received from the public in response to the 60-day proposed information collection. Eighth, CMS may have incorporated changes to the 30-day information collection instrument that did not come from the public. Ninth, CMS did not include information on the application fee its Medicare Provider Enrollment web site. Finally, the commenters

stated that CMS did not provide the public with 60 days to review the changes proposed in this information collection. While CMS published the 60-day Notice in the Federal Register on March 11, 2011, CMS did not place the information collection for the CMS-855 (A, B, I, R) on its CMS web site until April 18, 2011. In addition, while CMS published the 30-day Notice in Federal Register on May 20, 2011, CMS did not place the information collection for the CMS-855(A, B, I, R) on CMS web site until May 27, 2011. Accordingly, by limiting the public comment period associated with this information collection instrument during the 60-day and 30-day public comment periods, CMS violated the policies associated with the PRA and the Administration's goal of establishing a more transparent government.

Response: The commenters allege CMS did not update the CMS 855A and the CMS 855B did not include regulatory changes. Since this comment is non-specific and numerous regulatory requirements incorporated have been incorporated into the CMS 855A and CMS 855B, this allegation does not establish sufficient basis for withdrawing the proposed information collection. Please note however, pursuant the ACA, hospitals must begin to comply with the requirements of section 6001 by September 23, 2011 and begin reporting physician-ownership by September 23, 2012. Attachment 1 of the CMS 855A collects information necessary to comply with the aforementioned requirements.

As previously mentioned, CMS will verify that the information found in the Privacy Act statement of the above referenced applications is consistent with the PECOS Systems of Records document. In preparing our burden estimates, CMS used the most recent data available. However, we will revise the burden estimates to account for revalidations. As previously stated, the CMS-855 applications will be updated at a future time to make reference to the application fee. Fingerprinting, meanwhile, cannot be addressed in this information collection because fingerprinting is currently not a requirement for enrollment. Since this collection does not address the application fee or fingerprinting, no burden was or needs to be calculated for these activities in the Supporting Statement. Previous Supporting Statements for CMS-855 application revisions did include the paperwork burden associated with providing the IRS-CP-575 or a copy of the IRS Determination Letter, if the provider or supplier is registered with the IRS as non-profit on the CMS-855 applications. We recognize that the use of Internet-based PECOS would likely reduce the time it takes to submit an application and, henceforth, would reduce the overall paperwork burden. However, we chose to exclusively use the paper CMS-855 time figures so as not to underestimate the overall burden. In reference to the exclusion of summary changes for the 30 day proposed information collection for the CMS 855A, CMS 855B, CMS 855I and CMS 855R on the CMS PRA Listing website and CMS' response to comments on the 60 day proposed information collection, CMS only received comments on the CMS 855A and did provide responses to those comments. As previously mentioned CMS has conducted substantial outreach on the application fee issue and plan to include a reference to it in future versions of the CMS-855 applications. No burden was or needs be calculated for this activity in the Supporting Statement. Finally, CMS published the Notice in the Federal Register on March 11, 2011 and May 20, 2011 in accordance with established guidelines.