Supporting Statement for Paperwork Reduction Act Submissions

CMS-855O Medicare Enrollment Application Package Revision

A. BACKGROUND

The primary function of the Medicare enrollment application is to gather information from a provider or supplier that tells us who it is, whether it meets certain qualifications to be a health care provider or supplier, where it practices or renders its services, the identity of the owners of the enrolling entity, and information necessary to establish correct claims payments.

Goal of the Provider/Supplier Enrollment Application Revisions

There are two principal facets of this submission:

1. CMS-855O Addition - CMS is adding a new CMS-855 Medicare Enrollment Application (CMS 855O – Medicare Enrollment Application for Ordering and Referring Physicians only). CMS has found that many providers and suppliers who are not enrolled in Medicare are ordering and referring physicians for Medicare enrolled providers and suppliers. The ordering and referring data field on the CMS 1500 claims submission form requires an ordering or referring physician to have a Medicare identification number. Without an ordering or referring physician, specific types of claims submitted by Medicare approved providers and suppliers are rejected by Medicare Administrative Contractors (MAC) as required by Medicare regulation. Therefore, if an ordering or referring physician does not participate in the Medicare program, but orders or refers his/her patients to a Medicare provider or supplier, the claim submitted by the Medicare provider or supplier for the given ordered or referred service is automatically rejected by the MAC. The CMS 855O allows a physician to receive a Medicare identification number (without being approved for billing privileges) for the sole purpose of ordering and referring beneficiaries to Medicare approved providers and suppliers. This new Medicare application form allows physicians who do not provide services to Medicare beneficiaries to be given a Medicare identification number without having to supply all the data required for the submission of Medicare claims. It also allows the Medicare program to identify ordering and referring physicians without having to validate the amount of data necessary to determine claims payment eligibility (such as banking information), while continuing to identify the physician's credentials as valid for ordering and referring purposes.

2. CMS 855O Exclusion from the Current CMS 855 Enrollment Application Package - CMS believes that the regulations governing the standards and information required of ordering and referring physicians will be revised and increased less frequently than the other provider types reimbursed by Medicare. Consequently, CMS may revise the CMS 855O application for ordering and referring physicians less often than the CMS 855A, CMS 855B, CMS 855I and CMS 855R enrollment applications. The ability to revise the CMS 855O separately from the CMS 855A, CMS 855B, CMS 855I and CMS 855R

enrollment applications will lessen the burden on both CMS and OMB as well as the public during the Federal Register notice period, as only one subset of providers will be effected by CMS 855O revisions. CMS intends to maintain the continuity of the CMS 855 enrollment applications by using the same formats and lay-out of the current CMS 855 enrollment applications, regardless of the exclusion of the CMS 855O from the current collective enrollment application package.

JUSTIFICATION

1. *Need and Legal Basis*

Various sections of the Act and the Code of Federal Regulations require providers and suppliers to furnish information concerning the amounts due and the identification of individuals or entities that furnish medical services to beneficiaries before payment can be made.

- Sections 1814(a), 1815(a), and 1833(e) of the Act require the submission of information necessary to determine the amounts due to a provider or other person.
- Section 1842(r) of the Act requires us to establish a system for furnishing a unique identifier for each physician who furnishes services for which payment may be made. In order to do so, we need to collect information unique to that provider or supplier.
- Section 1842(u) of the Act requires us to deny billing privileges under Medicare to physicians and certain other health care professionals certified by a State Child Support Enforcement Agency as owing past-due child support.
- Section 1866(j)(1)(C) of the Act requires us to consult with providers and suppliers of services before making changes in provider enrollment forms.
- The Balanced Budget Act of 1997 (BBA) (Public Law 105-33) section 4313, amended sections 1124(a)(1) and 1124A of the Act to require disclosure of both the Employer Identification Number (EIN) and Social Security Number (SSN) of each provider or supplier, each person with ownership or control interest in the provider or supplier, as well as any managing employees. The Secretary of Health and Human Services (the Secretary) signed and sent to the Congress a "Report to Congress on Steps Taken to Assure Confidentiality of Social Security Account Numbers as Required by the Balanced Budget Act" on January 26, 1999, with mandatory collection of SSNs and EINs effective on or about April 26, 1999.
- Section 31001(I) of the Debt Collection Improvement Act of 1996 (DCIA) (Public Law 104-134) amended 31 U.S.C. 7701 by adding paragraph (c) to require that any person or entity doing business with the Federal Government must provide their Tax Identification Number (TIN).
- The Social Security Act, section 302 of the Medicare Modernization Act of 2003, paragraph 1834(a)(20) requires us to collect additional information about accreditation of Advanced Diagnostic Imaging Suppliers.
- The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), section 135(a) 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 of advanced diagnostic imaging services.

- The Tax Increase Prevention and Reconciliation Act of 2005 (TIPRA), section 511 requires us to collect information necessary to withhold 3% withholding tax from Medicare providers/suppliers.
- The Internal Revenue (IRS) Code, section 3402(t) requires us to collect additional information about the proprietary/non-profit structure of a Medicare provider/supplier to allow exclusion of non-profit organization from the mandatory 3% tax withholding.
- The IRS section 501C requires each Medicare provider/supplier to report information about its proprietary/non-profit structure to the IRS for tax withholding determination.
- The Affordable Care Act, section 3109(a) allows certain Medicare supplier types to be exempt from the accreditation requirement.
- Social Security Act, section 6401 - Provider Screening and Other Enrollment Requirements under Medicare, Medicaid, and CHIP.
- Patient Protection and Affordable Care Act (PPACA), section 6405 – “Physicians Who Order Items or Services Required to be Medicare Enrolled Physicians or Eligible Professionals” (regulation CMS 6010-F), contains a requirement for certain physicians and non-physician practitioners to enroll in the Medicare program for the sole purpose of ordering or referring items or services for Medicare beneficiaries.
- Section 508 of the Rehabilitation Act of 1973, as incorporated with the Americans with Disabilities Act of 2005 requires all Federal electronic and information technology to be accessible to people with disabilities, including employees and members of the public.
- We are authorized to collect information on the CMS-855 (Office of Management and Budget (OMB) approval number 0938-0685) to ensure that correct payments are made to providers and suppliers under the Medicare program as established by Title XVIII of the Act.

The Medicare Enrollment Application collects this information, including the information necessary to uniquely identify and enumerate the provider/supplier. Additional information necessary to process claims accurately and timely is also collected on the CMS-855 application.

2. *Purpose and users of the information*

The CMS-855O is submitted at the time the applicant first requests a Medicare identification number for the sole purpose of ordering and referring Medicare beneficiaries to providers and suppliers who are credentialed to provide the health care services for which they intend to bill Medicare. The application is used by Medicare contractors to collect data to ensure the applicant has the necessary credentials to order and refer Medicare beneficiaries to providers and suppliers who are credentialed to provide the health care services for which they intend to bill Medicare, including information that allows Medicare contractors to ensure that the physician is not sanctioned from the Medicare program, or debarred, suspended or excluded from any other Federal agency or program.

3. *Improved Information Techniques*

This collection lends itself to electronic collection methods. The Provider Enrollment, Chain and Ownership System (PECOS) is a secure, intelligent and interactive national data storage system maintained and housed within the CMS Data Center with limited user access through strict CMS systems access protocols. Access to the data maintained in PECOS is limited to CMS and Medicare contractor employees responsible for provider/supplier enrollment activities. The data stored in PECOS mirrors the data collected on the CMS 855s (Medicare Enrollment Applications) and is maintained indefinitely as both historical and current information. CMS also supports an internet based provider/supplier CMS 855 enrollment platform which allows the provider/supplier to complete an online CMS 855 enrollment application, transmit it to the Medicare contractor database for processing and then the data is transferred from the Medicare contractor processing database into PECOS by the Medicare contractor. Periodically CMS will require adjustment to the format of the CMS 855 form (either paper, electronic or both) for clarity or to improve form design. These adjustments do not alter the current OMB data collection approval.

CMS plans to make the CMS 855O application available through the CMS website to comply with the Government Paperwork Elimination Act. However, until CMS adopts an electronic signature standard, providers will be required to submit a hard copy signature page of the CMS-855O with an original signature.

4. *Duplication and Similar Information*

There is no duplicative information collection instrument or process.

5. *Small Business*

The addition of the CMS 855O to this package will not affect small businesses.

6. *Less Frequent Collections*

This information is collected on an as needed basis. The information provided on the CMS-855O is necessary for identification in the Medicare program. It is essential to collect this information for all ordering/referring physicians to ensure each physician applicant has the necessary credentials to order and refer Medicare beneficiaries to Medicare approved providers/suppliers. In addition, Medicare contractors must ensure that the ordering/referring physicians meet all statutory and regulatory requirements and are properly credentialed.

In addition, to ensure uniform data submissions, CMS requires that all changes to previously submitted enrollment data be reported via the appropriate provider enrollment application. However, ordering/referring physicians will not be required to revalidate their identifying information every 5 years as required by the Act for certain Medicare provider/supplier types.

7. *Special Circumstances*

There are no special circumstances associated with this collection.

8. *Federal Register Notice/Outside Consultation*

The 60-day Federal Register notice published on March 11, 2011.

9. *Payment/Gift to Respondents*

N/A.

10. *Confidentiality*

CMS will comply with all Privacy Act, Freedom of Information laws and regulations that apply to this collection. Privileged or confidential commercial or financial information is protected from public disclosure by Federal law 5 U.S.C. 522(b)(4) and Executive Order 12600.

11. *Sensitive Questions*

There are no sensitive questions associated with this collection.

12. *Burden Estimate (hours)*

<u>HOURS ASSOCIATED WITH COMPLETING THE INITIAL CMS 855O ENROLLMENT APPLICATION</u>

<u>CMS 855O</u> – 40,000 respondents @ 1 hour each = 40,000 hours

Cost to the respondents is calculated as follows based on the following assumptions:

- The CMS 855O can be completed by administrative staff and reviewed and signed by professional staff, and
- The record keeping burden is included in the time determined for completion by administrative staff.

The cost per respondent per form has been determined using the follow wages:

- $20.00 per hour (administrative wage)
- $150.00 per hour (professional wage)

The cost per respondent per form has been determined using the follow wages:

- $15.00 (administrative wage for 45 minutes)
- $37.50 (professional wage for 15 minutes)

CMS 8550 = $52.50

HOURS ASSOCIATED WITH REPORTING CHANGES OF ENROLLMENT INFORMATION:

CMS 855O – 8,000 respondents @ 0.75 hours each = 6,000 hours

Cost to the respondents is calculated as follows based on the following assumption:

- The CMS 855O can be completed by administrative staff and reviewed and signed by professional staff, and
- The record keeping burden is included in the time determined for completion by administrative staff.

The cost per respondent per form has been determined using the follow wages:

- $20.00 per hour (administrative wage)
- $150.00 per hour (professional wage)

The cost per respondent per form has been determined using the follow wages:

- $13.20 (administrative wage for 40 minutes)
- $12.50 (professional wage for 5 minutes)

CMS 8550 = $25.70

Note: Ordering and referring physicians and non-physician practitioners will not be required to revalidate their enrollment information on a regular or periodic basis.

Medicare contractors currently process approximately 400,000 provider/supplier enrollment applications a year. This requirement is and will continue to be a cost of doing business with Medicare.

13. *Cost to Respondents (Capital)*

There are no capital costs associated with this collection.

14. *Cost to Federal Government*

There is no additional cost to the Federal government. Applications will be processed in the normal course of Federal duties.

15. *Changes in Burden/Program Changes*

The burden increase is based on the addition of the hours associated with the CMS 855O. The new total annual burden associated with this information collection is approximately 46,000 hours.

During the 60 day comment period, which ended on May 10, 2011, there were no comments that altered the information collection burden above.

Public comments for the CMS 855O and CMS responses are listed in a separate document.

16. *Publication/Tabulation*

N/A.

17. *Expiration Date*

We are planning on displaying the expiration date.

18. *Certification Statement*

There are no exceptions to item 19 of OMB Form 83-I.

B. COLLECTIONS OF INFORMATION EMPLOYING STATISTICAL METHODS

N/A.