Supporting Statement for Paperwork Reduction Act Submissions

Medicare Enrollment Application – Reassignment of Medicare Benefits - CMS 855R

A. BACKGROUND

The primary function of the CMS 855R enrollment application is to allow physicians and non-physician practitioners to reassign their Medicare benefits to a group practice and to gather information from the individual that tells us who he/she is, where he or she renders services, and information necessary to establish correct claims payment. The goal of periodically evaluating and revising the CMS 855R enrollment application is to simplify and clarify the information collection without jeopardizing our need to collect specific information.

On May 22, 2013, in accordance with the Paperwork Reduction Act, OMB approved a reinstatement without change of a previously approved collection of the Medicare enrollment applications (specifically, the CMS 855A, CMS 855B, CMS 855I and CMS 855R Medicare enrollment application bundle, OMB control number 0938-0685, ICR reference number 201210-0938-009). This was necessary in order to allow the CMS 855A, CMS 855B and CMS 855I to remain active. That collection expires on May 31, 2016. While the CMS 855R enrollment form is included in that collection, it is not active and not being used by the public as CMS now uses the revised CMS 855R, OMB control number 0938-1179, approved by OMB on November 1, 2012 (ICR reference number 201206-0938-007). The CMS 855R application under OMB control number 0938-0685 will be removed from the Medicare application bundle collection during its next resubmission cycle. There is no duplication of CMS 855R Medicare application forms as only the CMS 855R Medicare application form under OMB control number 0938-1179 is active.

Goals of the Provider/Supplier Enrollment Application Revisions

At this time, CMS is making very few minor revisions to the CMS 855R (Reassignment of Benefits) Medicare enrollment application (OMB control number 0938-1179). Two sections within the form are being reversed to maintain sync with online and paper forms. The previously approved CMS 855R section 2 collected information regarding the individual practitioner who is reassigning benefits and section 3 collected information regarding the organization/group receiving the reassigned benefits. These two sections have been reversed so that section 2 now collects information regarding the organization/group receiving the reassigned benefits and section 3 now collects information on the individual practitioner who is reassigning benefits. No information or data collection within these sections was revised. The sections were merely re-sequenced and re-numbered to maintain sync between online and paper forms. With the exception of this section reversal and adding the word “optional” to sections 4 and 5 (primary practice location and contact person information), there are no other revisions. These revisions offer no new data collection in this revision package. The addition of the optional choice in sections 4 and 5 could potentially reduce the burden to providers who choose not to complete either or both optional sections.

JUSTIFICATION

1. Need and Legal Basis

Various sections of the Social Security Act (Act), the United States Code (U.S.C.), Code of Federal Regulations (CFR) and the Internal Revenue Code (Code) require providers and suppliers to furnish information concerning the identification of individuals or entities that furnish medical supplies and services to beneficiaries before payment can be made.

- Sections 1833(e) of the Act require the submission of information necessary to determine the amounts due to a provider, supplier or other person.
- 31 U.S.C. 7701(c) requires that any person or entity doing business with the Federal Government must provide their Tax Identification Number (TIN).
- 42 CFR Section 424.500 requires all providers and suppliers to enroll in Medicare to obtain and maintain Medicare billing privileges.
- CMS is authorized to collect information on the form CMS 855R OMB control number 0938-1179) to ensure that correct payments are made to physicians and non-physician practitioners under the Medicare program as established by Title XVIII of the Act.

The revised CMS 855R enrollment application collects this information, including the information necessary to uniquely identify the practitioner.

2. Information Users

Health care practitioners who wish to reassign their benefits in the Medicare program must complete the CMS 855R enrollment application. It is submitted at the time the physician or non-physician practitioner first requests reassignment of his/her Medicare benefits to a group practice, as well as any subsequent reassignments or terminations of established reassignments as requested by the physician or non-physician practitioner. The application is used by the Medicare Administrative Contractor (MAC) to collect data to ensure the applicant has the necessary information that allows the MAC to correctly establish or terminate the reassignment.

3. Use of Information Technology

This collection lends itself to electronic collection methods and is currently available through the CMS website. CMS has adopted an electronic signature standard; however, practitioners will have the choice to e-sign via the CMS website or to submit a hard copy of the CMS 855R certification page with an original signature.

4. Duplication of Efforts

There is no duplicative information collection instrument or process.

5. Small Business

This form will affect small businesses; however, these businesses have always been required to provide CMS with the same information in order to reassign benefits in the Medicare Program and for CMS to successfully process their claims.

6. Less Frequent Collection

This information is collected on an as needed basis. The information provided on the CMS 855R is necessary for individuals reassigning benefits to groups in the Medicare program. It is essential to collect this information so that the MAC can ensure that the practitioner meets all requirements necessary to establish or terminate a reassignment. 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.

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 February 6, 2015 (80 FR 6726).

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 and Wages)

A. Paperwork Burden Estimate (hours)

The currently approved total annual hour burden for the respondents for the CMS 855R is 50,000 hours (25,000 hours for establishing a reassignment + 25,000 hours for terminating a reassignment). The prior burden hour estimate is low because it was calculated using a different set of parameters.

For this proposed revision of the CMS 855R, CMS has recalculated the estimated burden hours.

CMS believes this recalculation is necessary because over the years of numerous revisions to this data collection tool, the number of affected users, actual data collected and the collection methods have changed significantly. CMS believes these new burden hours accurately reflects the current burden for the individual practitioner community when completing this proposed revision of the CMS 855R. CMS is basing the new burden amounts on data compiled from the Provider Enrollment Chain and Ownership System (PECOS). In addition, the amount of providers enrolling in the Medicare program has increased by 730,994 since 2011 (through November, 2014). Subsequently, the increasing amount of Medicare enrolled providers has also increased the number of respondents. The new numbers for reassigning and terminating Medicare benefits are taken directly from the actual applications processed for fiscal year 2014 (October, 2013 through September, 2014). The new figures are exact and therefore more accurate than the prior estimates.

CMS estimates the new total burden hours for this information collection to be 94,905 hours. These figures are calculated based on why/when a supplier must complete and submit this enrollment application (CMS 855R). The figures are reflected below and in the calculations in Part II of the 83 Worksheet.

CMS is requesting approval of the revised number of burden hours as follows:

Hours associated with establishing/adding a new reassignment of benefits enrollment application:

335,744 respondents @ 0.25 hours for each application = 83,936 hours

Hours associated with terminating reassignment of benefits enrollment information:

43,875 respondents @ 0.25 hours for information reporting = 10,969 hours

B. Paperwork Burden Estimate (cost)

The CMS 855R is typically completed by the office or administrative support person and reviewed and signed by the individual physician or non-physician practitioner who is establishing or terminating a reassignment.

It is estimated that the office or administrative support person takes 0.17 hours (10 minutes) to complete the form and the physician or non-physician practitioner 0.08 (5 minutes) to review the information and sign the certification statement on the form.

The cost per respondent per form has been determined using as follows:

- The most recent wage data provided by the Bureau of Labor Statistics (BLS) for May, 2015, the mean hourly wage for the general category of "Office and Administrative Support Occupations" is $17.08 per hour (see http://www.bls.gov/oes/current/oes_nat.htm#43-0000). With fringe benefits and overhead, the total per hour rate is $34.16.

- The most recent wage data provided by the BLS for May, 2015 (see http://www.bls.gov/oes/current/oes_nat.htm#43-0000), the mean hourly wage for the

general category of "Physicians and Surgeons" is $93.74, and the mean hourly wage for the general BLS category of "Health Diagnosing and Treating Practitioners, All Other" is $40.89. With fringe benefits and overhead, the respective totals per hour rates are $187.48 and $81.78.

Office or administrative support person = $34.16 x 0.17 hours = $5.81
Physician or non-physician practitioner = $187.48 x 0.08 hours = $15.00 per CMS-855R application

Total cost to complete CMS-855R = $20.81 ($5.81 + $15.00)

Hours associated with establishing/adding a new reassignment of benefits enrollment application:

335,744 respondents @ $20.81 per application = $6,986,832.64

Hours associated with terminating reassignment of benefits enrollment information:

43,875 respondents @ $20.81 per application for information reporting = $913,038.75

13. Capital Cost

There is no capital cost 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 to Burden

The currently approved total annual hour burden for the respondents for the CMS 855R is 50,000 hours. Due to better reporting methods and more accurate data collection via PECOS, CMS is seeking approval of new burden estimates based on current data collection information. CMS estimates the new total burden hours for this information collection to be 83,936 hours to establish a reassignment and 10,969 hours to terminate a reassignment. Due to new wage data information being released by the BLS, CMS estimates the total cost burden to be $6,986,832.64 to establish a reassignment and $913,038.75 to terminate a reassignment.

16. Publication/Tabulation Dates

N/A

17. Expiration Date

We are planning on displaying the revision approval date and 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