Supporting Statement for Paperwork Reduction Act Submissions

Medicare Enrollment Application: Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers
CMS-855S/OMB Control Number: 0938-1056)

A. BACKGROUND

The primary function of the CMS-855S Medicare enrollment application for suppliers, also known as durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers, is to gather information from the supplier that tells us who the supplier is, whether the supplier meets certain qualifications to be a Medicare health care DMEPOS supplier, where the supplier practices or renders services, and other information necessary to establish correct claims payments.

There are two principal facets of this submission:

1. **Re-sequencing and re-numbering of sections** - This revision includes a re-sequencing and re-numbering of the sections and sub-sections of the application to create a more logical flow of the data to make it easier for the supplier to complete (for example, by putting most address collection information in one section). The re-sequencing and re-numbering of the application was also necessary to maintain continuity with other CMS-855 applications. One example of the re-sequencing and re-numbering is the CMS-855A, CMS-855B, and CMS-855I all have organizational and individual ownership information collection in sections five and six of the applications. The CMS-855S was re-sequenced to also have organizational and individual ownership information collection in sections five and six of the application. The sections of the applications have been re-ordered to be consistent with the other CMS-855 enrollment applications.

2. **Corrections to the content of the CMS-855S -** The goal of evaluating and revising the CMS-855S enrollment application is to simplify and clarify the information collection without jeopardizing our need to collect specific information. In addition, periodically new congressional legislation or regulations require CMS to update the Medicare Provider Enrollment Applications (CMS-855s). The majority of these changes are in content and minor in nature for the purposes of supplier enrollment, such as instruction clarification for the supplier, adding new specialty codes for the supplier to choose from, questions with "Yes/No" check boxes, spelling and formatting corrections, removal of duplicate fields, and indicating which addresses the suppliers wish to use for different types of correspondence.

   In this revision of the CMS-855S, some of the main revisions include an exemption from accreditation option for the supplier to check one of three checkboxes for the reason of the exemption, if applicable. An expanded definition of managing control was added. The contact person section was made optional to reduce the reporting burden for suppliers. Additional information, including a link to the website, was added regarding the application fee. Additionally, some obsolete questions were removed. Other minor editorial and clerical corrections were made to better clarify the current data collection. Some of the instructions were simplified for the suppliers

completing this application in response to comments received by the NSC MAC and suppliers during focus groups discussing the current version of this application.

JUSTIFICATION

1. *Need and Legal Basis*

Various sections of the Social Security Act (Act), the United States Code (U.S.C.), Internal Revenue Service Code (Code) and the Code of Federal Regulations (C.F.R.) 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. The CMS-855S application collect this information, including the information necessary to uniquely identify and enumerate the supplier. Additional information necessary to ensure that suppliers meet all applicable Medicare requirements and to process claims accurately and timely are also collected on the CMS-855S application. This information also ensures that the data collected allows CMS to make correct payments to suppliers.

- C.F.R. section 424.500 state the requirements for enrollment, periodic resubmission and certification of enrollment information for revalidation, and timely reporting of updates and changes to enrollment information. These requirements apply to all providers and suppliers. Providers and suppliers must meet and maintain these enrollment requirements to bill either the Medicare program or its beneficiaries for Medicare covered services or supplies.
- Title XVII of the Act ensures that the data collected allows CMS to make correct payments to providers and suppliers in the Medicare program.
- 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 provider/supplier 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 1866(j)(1)(C) of the Act requires us to consult with providers and suppliers of services before making changes in provider enrollment forms.
- 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.
- 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 provide their Tax Identification Number (TIN).
- Section 1866(b)(2)(D) and 1842(h)(8) of the Act require denial of enrollment (directly or indirectly) of persons convicted of a felony for a period not less than 10 years from the date of conviction.
- 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 501(c) requires each Medicare provider/supplier to report information about its proprietary/non-profit structure to the IRS for tax withholding determination.
- Section 1834(a)(20)(G)(i) of the Act allows certain Medicare supplier types to be exempt from the

accreditation requirement.

- Section 1866(j)(2)(A) of the Act requires the Secretary, in consultation with the Department of Health and Human Services' Office of the Inspector General, to establish procedures under which screening is conducted with respect to providers of medical or other items or services and suppliers under Medicare, Medicaid, and CHIP.
- Section 1866(j)(2)(B) of the Act requires the Secretary to determine the level of screening to be conducted according to the risk of fraud, waste, and abuse with respect to the category of provider or supplier.
- Section 1848(k)(3)(B) defines covered professional services and eligible professionals.
- Section 3004(b)(1) of the Public Health Service Act (PHSA) requires the Secretary to adopt an initial set of standards, implementation guidance, and certification criteria and associated standards and implementation specifications will be used to test and certify complete EHRs and EHR modules in order to make it possible for eligible professionals and eligible hospitals to adopt and implement Certified EHR Technology.
- Section 1834(j) of the Act states that no payment may be made for items furnished by a supplier of durable medical equipment, prosthetics, and supplies (DMEPOS) unless that supplier obtains, and renews at such intervals as we may require, a billing number. In order to issue a billing number, we need to collect information unique to that supplier.
- Section 6401(2) of the Affordable Care Act (ACA) requires the Secretary to impose a fee on each "institutional provider of medical or other items or services and suppliers." The fee is to be used by the Secretary to cover the cost of program integrity efforts including the cost of screening associated with provider enrollment processes, including those under section 1866(j) and section 1128(J) of the Social Security Act.
- Section 1866(j) of the Act requires the revalidation of all provider and supplier enrollment data every five years – every three years for DMEPOS suppliers.
- 42 C.F.R. Section 424.57 requires DMEPOS suppliers comply with 30 specific standards in order to receive and maintain Medicare billing privileges.
- 42 C.F.R. Section 424.58 requires accreditation in order to qualify for the Medicare program.
- Section 6201(c), of the Affordable Care Act (ACA) Subtitle C, requires DHHS to obtain state and national background checks on prospective employees, including national fingerprint-based criminal history record checks.
- The Patient Protection and Affordable Care Act, section 3109(a) allows certain Medicare supplier types to be exempt from the accreditation requirement.
- Section 3004(b)(1) of the Public Health Service Act (PHSA) requires the Secretary to adopt an initial set of standards, implementation guidance, and certification criteria and associated standards and implementation specifications will be used to test and certify complete EHRs and EHR modules in order to make it possible for eligible professionals and eligible hospitals to adopt and implement Certified EHR Technology.
- Executive Order 12600 requires the pre-disclosure of notification procedures for confidential commercial information.
- 5 U.S.C. 522(b)(4) requires privileged or confidential commercial or financial information be protected from public disclosure.
- 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.

2. *Purpose and users of the information*

The C.F.R. section 424.500 state the requirements for enrollment, periodic resubmission and certification of enrollment information for revalidation, and timely reporting of updates and changes to enrollment information. These requirements apply to all providers and suppliers except for physicians and practitioners who have entered into a private contract with a beneficiary as described in part 405, subpart D of this chapter. Providers and suppliers must meet and maintain these enrollment requirements to bill either the Medicare program or its beneficiaries for Medicare covered services or supplies. 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, supplier, or other person.

The CMS-855S is submitted by an applicant to the National Supplier Clearinghouse Medicare Administrative Contractor (NSC MAC) to initially apply for a Medicare billing number, and thereafter to add a new business location, revalidate Medicare enrollment, reactivate Medicare enrollment, to report a change to current Medicare enrollment information, changing the tax identification number, and to voluntary terminate the supplier's Medicare enrollment, as applicable. It is used by new applicants as well as suppliers already enrolled in Medicare but need to submit the form for a reason other than initial enrollment into the Medicare program. A DMEPOS supplier that will bill for DMEPOS complete this form for the submittal reasons above.

The NSC MAC establishes Medicare Identification Numbers, also known as Medicare Billing Numbers, for suppliers of DMEPOS. The NSC MAC stores these numbers and information in CMS' Provider Enrollment, Chain and Ownership System (PECOS). The application is used by the CMS' contractor (NSC MAC) to collect data to ensure that the applicant has the necessary information for unique identification. The license numbers that come through paper applications are validated against state licensing websites. All the license numbers are captured and stored in the NSC MAC database. Social Security Numbers (SSNs) are validated against the Social Security Administration database (SSA) and only the valid entries are allowed to proceed in the process of getting a Medicare billing number. International Tax Identification Numbers (ITINs) are not validated. However, if a user enters ITIN, additional forms of identification (e.g., driver's license, passport or birth certificate) are required. Both ITINs and SSNs are captured in the NSC MAC database and disseminated only to approved CMS stakeholders. Mailing address, practice location address and contact information is captured to contact the supplier. Specialty type is captured to identify the specialty of the supplier. The information obtained is to help prevent fraud by allowing vetting of the suppliers as well as to ensure a supplier is not illegitimately attempting to get a Medicare billing number. In addition, the information collected allows CMS and the NSC MAC to determine relationships among those with Medicare billing numbers. For example, a supplier who enrolls as a group practice may also have an individual Medicare billing number for private practice as well as part ownership in a hospital. This information is determined during the enrollment process. If any relationship is prohibited by CMS regulation, the supplier would be denied a Medicare billing number and other measures may be taken, such as revocation of the supplier's individual Medicare billing number or an enrollment bar so the supplier will not get a Medicare billing number for a set number of years, depending on the enrollment bar issued to the supplier.

The collection and verification of this information defends and protects our beneficiaries from illegitimate suppliers. These procedures also protect the Medicare Trust Fund against fraud. It gathers information that allow Medicare contractors to ensure that the supplier is not sanctioned from the Medicare and/or Medicaid

program(s), or debarred, or excluded from any other Federal agency or program. The data collected also ensures that the applicant has the necessary credentials to provide the health care services for which they intend to bill Medicare, including information that allows the Medicare contractor to correctly price, process and pay the applicant's claims. This is sole instrument implemented for this purpose.

3. *Improved Information Techniques*

This collection lends itself to electronic collection methods and is currently available through the CMS website. 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 supplier has access to its own records. PECOS is an electronic Medicare enrollment system through which providers and suppliers can: submit Medicare enrollment applications, view and print enrollment information, update enrollment information, complete the enrollment revalidation process, voluntarily withdraw from the Medicare program, and track the status of a submitted Medicare enrollment application.

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 and transmit it to the Medicare contractor database for processing. Then the data is transferred from the Medicare contractor processing database into PECOS by the Medicare contractor. CMS also has the ability to allow suppliers to upload supporting documentation (required for enrollment) electronically. CMS has also adopted an electronic signature standard; however, suppliers will have the choice to e-sign via the CMS website or to submit a hard copy of the CMS-855S certification page with an original signature. 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. Currently, approximately 60% of DMEPOS suppliers use the electronic method of enrolling in the Medicare program via the PECOS system.

4. *Duplication and Similar Information*

There is no duplicative information collection instrument or process.

5. *Small Business*

A Medicare billing number is required of all health care suppliers/providers who wish to submit claims for payment to the Medicare Trust Fund so it will affect small businesses who wish to have a Medicare billing number. However, these businesses have always been required to provide CMS with the same information in order to enroll in the Medicare program to submit information for CMS to ensure the providers and suppliers are legitimate and to collect information to successfully process their Medicare claims.

6. *Less Frequent Collections*

This information is collected on an as needed basis. The information provided on these forms is necessary for initial enrollment in the Medicare program. It is essential to collect this information the first time a provider/supplier enrolls with a Medicare contractor so that CMS' contractors can uniquely identify the provider/supplier, ensure the provider's/supplier's eligibility and legitimacy, to determine if the provider/supplier meets all statutory and regulatory requirements, are properly credentialed in their specialty (if applicable), and to collect relevant information to process the provider's/supplier's claims in a timely and accurate manner.

After the initial enrollment and approval, the information collected is less frequent and often initialized by the supplier for reasons such as a change of information, adding a business location, and to voluntarily withdraw from the Medicare program. It will be collected to complete the enrollment revalidation process every three years. In addition, to ensure uniform data submissions, CMS requires that all changes to previously submitted enrollment data be reported via this enrollment application.

7. *Special Circumstances*

There are no special circumstances associated with this collection.

8. *Federal Register Notice/Outside Consultation*

A 60-day Notice published in the Federal Register on July 10, 2019 (84 FR 32924). No comments were received. No outside consultation was sought.

9. *Payment/Gift to Respondents*

No payments and/or gifts will be provided to respondents.

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.

The SORN title is Provider Enrollment, Chain and Ownership System (PECOS), number 09-70-0532.

11. *Sensitive Questions*

There are no sensitive questions associated with this collection. Specifically, the collection does not solicit questions of a sensitive nature, such as sexual behavior and attitudes, religious beliefs, and other matters that

are commonly considered private.

12. *Burden Estimate (hours and cost)*

A. Burden Estimate (hours)

HOURS ASSOCIATED WITH COMPLETING THE CMS-855S ENROLLMENT APPLICATION

For this proposed revision of the CMS-855S, CMS has recalculated the estimated burden hours. CMS believes this recalculation is necessary because 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 purposes of this application when completing this proposed revision of the CMS-855S. CMS is basing the new burden amounts on data compiled from PECOS and the NSC MAC. The new estimates for completing the CMS-855S Medicare enrollment application form for the six submission reasons shown in the burden tables (initial enrollment, adding a new business location, reactivation, revalidation, reporting a change of Medicare enrollment information, and voluntary termination of Medicare enrollment) are taken directly from the actual applications processed for calendar year 2017. The new figures of processed applications are exact and therefore more accurate than the prior estimates. CMS contacted the NSC MAC through conference calls to determine how the application was typically completed (by chief executives of large organizations, physicians, or retail store managers).

The hour burden to the respondents is calculated based on the following assumptions:

- The NSC MAC currently processes approximately 45,117 CMS-855S applications per year (as seen in Table 1).
- Completion of the CMS-855S hour burden depends on the reason for submittal.
- Hour burden of the respondents is calculated as follows based on the following assumptions:
    - The CMS-855S will likely be completed by large organizations (50%), physicians (25%), or retail store managers (25%) (BLS category = Chief Executives (50%), Physicians and Surgeons (25%), and General and Occupational Managers (25%)),
    - The record keeping burden is included in the time determined for completion, and
    - The CMS-855S applications are signed by the enrolling or enrolled supplier (BLS categories listed above).
- The hours are calculated based on the respondent's submission reason, which also determines the time it takes for completion and submission to the NSC MAC as well as the cost per individual submission completion (as seen in Table 2).

Table 1 – Total Number of CMS-855S' Processed per Year by Reason for Submittal (2017)

Reason for Submittal	Total Number of CMS-855S' Processed per year (2017)
Initial Enrollment	3,429
Adding a New Business Location	1,242
Reactivation	2,378
Revalidation	25,956

Reporting a Change of Medicare Enrollment Information	12,105
Voluntary Termination of Medicare Enrollment	7
GRAND TOTAL (Total Processed CMS-855S' for All Reasons for Submission)	**45,117**

Table 2 – Individual Burden Hours and Costs for Completion of the CMS-855S per Reason for Submittal*

* For Table 2 - CMS adjusted the employee hourly wage estimates by a factor of 100 percent. Additional information on cost can be found in 12 B.

B. Burden Estimate (costs)

For this proposed revision of the CMS-855S, CMS has recalculated the estimated burden costs. CMS

Reason for Submittal	Hours to Complete by a Chief Executive of a Large Organization per CMS-855S	Hours to Complete by a Physician per CMS-855S	Hours to Complete by a General and Occupational Manager per CMS-855S	Total Hours to Complete per CMS-855S	Cost to Complete by a Chief Executive of a Large Organization per CMS-855S	Cost to Complete by a Physician per CMS-855S	Cost to Complete by a General and Occupational Manager per CMS-855S
Initial Enrollment	4	4	4	4	$754.00	$825.76	$474.80
Adding a New Business Location	1	1	1	1	$188.50	$206.44	$118.70
Reactivation	4	4	4	4	$754.00	$825.76	$474.80
Revalidation	2	2	2	2	$377.00	$412.88	$237.40
Reporting a Change of Medicare Enrollment Information	1	1	1	1	$188.50	$206.44	$118.70
Voluntary Termination of Medicare Enrollment	0.5	0.5	0.5	0.5	$94.25	$103.22	$59.35

believes this recalculation is necessary because the number of affected users, actual data collected and the collection methods have changed significantly. CMS believes these new burden costs accurately reflects the current burden for the purposes of this application when completing this proposed revision

of the CMS-855S. CMS is basing the new burden amounts on data compiled from PECOS and the NSC MAC. The new estimates for completing the CMS-855S Medicare enrollment application form for the six submission reasons shown above in table 2 (initial enrollment, adding a new business location, reactivation, revalidation, reporting a change of Medicare enrollment information, and voluntary termination of Medicare enrollment) are taken directly from the actual applications processed for calendar year 2017. The new figures of processed applications are exact and therefore more accurate than the prior estimates. CMS contacted the NSC MAC through conference calls to determine how the application was typically completed (by chief executives of large organizations, physicians, or retail store managers).

To derive average costs, CMS used data from the U.S. Bureau of Labor Statistics' (BLS) May 2017 National Occupational Employment and Wage Estimates for all salary estimates (http://www.bls.gov/oes/current/oes_nat.htm). For the purposes of this application, CMS used the wages under the general categories of "Chief Executives," "Physicians and Surgeons," and "General and Occupational Managers." In this regard, CMS adjusted the employee hourly wage estimates by a factor of 100 percent. This is necessarily an estimated adjustment, both because fringe benefits and overhead costs vary significantly from employer to employer, and because methods of estimating these costs vary widely from study to study. Nonetheless, there is no practical alternative and CMS believes that doubling the hourly wage to estimate total cost is an accurate estimation method that has been used successfully in previous burden calculations.

The cost burden to the respondents is calculated based on the following assumptions:

- The NSC MAC currently processes approximately 45,117 DMEPOS supplier CMS-855S applications per year.
- Completion of the CMS-855S costs burden depends on the reason for submittal and respondent.
    - The reason for submittal of the CMS-855S determines the hour burden.
    - The hour burden multiplied by the cost per hour of the respondents determine the cost burden, as seen in Table 2 (above).
- Cost to the respondents is calculated as follows based on the following assumptions:
    - The CMS-855S will likely be completed by large organizations (50%), physicians (25%), or retail store managers (25%) (BLS category = Chief Executives (50%), Physicians and Surgeons (25%), and General and Occupational Managers (25%)).
    - The record keeping burden is included in the time determined for completion.
    - The most recent wage data provided by the Bureau of Labor Statistics (BLS) for May 2017, the mean hourly wage for the general category of "Chief Executive" is $94.25 per hour (see http://www.bls.gov/oes/current/oes_nat.htm). With fringe benefits and overhead, the total per hour rate is $188.50
    - The most recent wage data provided by the BLS for May 2017 (see http://www.bls.gov/oes/current/oes_nat.htm), the mean hourly wage for the category of "Physicians and Surgeons" is $103.22. With fringe benefits and overhead, the total hourly rate is $206.44.
    - The most recent wage data provided by the Bureau of Labor Statistics (BLS) for May 2017, the mean hourly wage for the general category of "General and Occupational Manager" is $59.35 per hour (see http://www.bls.gov/oes/current/oes_nat.htm). With fringe benefits and overhead, the total per hour rate is $118.70

- The total number of respondents is calculated by the percentage of the type of respondent. For example, there were 3,429 initial enrollment applications processed. Chief Executives are 50% of the respondents, therefore, the number of Chief Executives respondents is 50% of 3,429 = 1,715.
- Numbers will be rounded to the closest full number when necessary.

The three year summary of all burden hours and costs are reflected in Table 3 (below).

Table 3 – Summary of Burden Hours and Costs for Three Years

Regulation Section(s)	OMB Control No.	Number of Respondents	Number of Responses	Burden per Response (hours)	Total Annual Burden (hours)	Hourly Labor Cost of Reporting ($) includes 100% fringe benefits	Total Cost ($)
Initial Enrollments - Medicare Enrollment Application for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) (CMS-855S)	0938-1056	Chief Executives (50%) 1,715 total Physicians and Surgeons (25%) 857 total General and Occupational Managers (25%) 857 total 3,429 total	3,429 per year	4 hours	13,716 hours	Chief Executives (50%) $754.00 Physicians and Surgeons (25%) $825.76 total General and Occupational Managers (25%) $474.80 total $2,055.00 total	$28,186,380.00
Adding a New Business Location – Medicare Enrollment Application for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) (CMS-855S)	0938-1056	Chief Executives (50%) 622 total Physicians and Surgeons (25%) 310 total General and Occupational Managers (25%) 310 total 1,242 total	1,242 per year	1 hour	1,242 hours	Chief Executives (50%) $188.50 Physicians and Surgeons (25%) $206.44 total General and Occupational Managers (25%) $118.70 total $514.00 total	$638,388.00
Reactivation - Medicare Enrollment Application for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) (CMS-855S)	0938-1056	Chief Executives (50%) 1,190 total Physicians and Surgeons (25%) 594 total General and Occupational Managers (25%) 594 total	2,378 per year	4 hours	9,512 hours	Chief Executives (50%) $754.00 Physicians and Surgeons (25%) $825.76 total General and Occupational Managers (25%) $474.80 total $2,055.00 total	$19,547,160.00

		2,378 total					
Revalidation - Medicare Enrollment Application for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) (CMS-855S)	0938-1056	Chief Executives (50%) 12,978 total Physicians and Surgeons (25%) 6,489 total General and Occupational Managers (25%) 6,489 total 25,956 total	25,956 per year	2 hours	51,912 hours	Chief Executives (50%) $377.00 Physicians and Surgeons (25%) $412.88 total General and Occupational Managers (25%) $237.40 total $1,028.00 total	$53,365,536.00
Reporting a Change of Information - Medicare Enrollment Application for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) (CMS-855S)	0938-1056	Chief Executives (50%) 6,053 total Physicians and Surgeons (25%) 3,026 total General and Occupational Managers (25%) 3,026 total 12,105 total	12,105 per year	1 hour	12,105 hours	Chief Executives (50%) $188.50 Physicians and Surgeons (25%) $206.44 total General and Occupational Managers (25%) $118.70 total $514.00 total	$6,221,970.00
Voluntarily Withdrawing from Medicare - Medicare Enrollment Application for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) (CMS-855S)	0938-1056	Chief Executives (50%) 4 total Physicians and Surgeons (25%) 1.5 total General and Occupational Managers (25%) 1.5 total	7 per year	0.5 hours	3.5 hours	Chief Executives (50%) $94.25 Physicians and Surgeons (25%) $103.22 total General and Occupational Managers (25%) $59.35 total $257.00 total	$900.00

		7 total					
3-year total	**0938-1056**	**135,351 Respondents**	**135,351 Responses**	**37.5 hours total**	**265,471.5 hours**	**Chief Executives (50%) $7,068.75** **Physicians and Surgeons (25%) $7,741.50 total** **General and Occupational Managers (25%) $1,483.75 total** **$16,294.00 total**	**$323,881,002.00**

13. *Cost to Respondents (Capital)*

There are no capital costs associated with this collection.

14. *Cost to Federal Government*

The application form revisions will not result in any additional cost to the federal government because the application revisions are designed for better flow and to reduce the burden on the supplier and the contractor. Medicare contractors currently finalize approximately 1.3 million provider/supplier enrollment applications a year. The CMS-855S form changes will not result in any additional cost to the federal government because Medicare contractors are already processing applications from suppliers who are enrolling or enrolled in the Medicare program. Applications will continue to be processed in the normal course of Federal duties.

15. *Changes in Burden/Program Changes*

The changes in burden since the last revision of this collection instrument cannot accurately be assessed. The previous burden statement was written to include additional suppliers enrolling due to regulation RIN: 0938-AS75 (CMS-1654-F). This rule required providers and suppliers to enroll in the Medicare program as a prerequisite to enrolling with a Medicare Advantage plan. The enrollment requirements in that regulation were replaced with the preclusion list requirements in RIN: 0938-AT08 (CMS-4182-F). CMS-4182-F has no enrollment requirements pertaining to the CMS-855S application.

In addition, the previous burden statement was inadvertently calculated using only singular data from the above regulation, RIN: 0938-AS75 (CMS-1654-F). Burden was calculated at only four hours and was not separated out per submission reason as previously done with past approvals. The CMS-855S hour and cost burden depends on the submission reason as well as the individual completing the application. The previous burden only calculated organizations to be DMEPOS suppliers. Organizations constitute approximately 50%

of the respondents. Physicians and retail managers are the other 50% of respondents. To that end, this burden statement calculated the burden using all parameters, both the individual completing the application and the submission reason for the completion of this application.

With the use of the PECOS system, updated information technology allows CMS to accurately count the hours per submittal reason and consequently, total annual hours. There are six submission reasons for completion of the CMS-855S enrollment application (initial enrollment, enrolling another business location, revalidation, reactivation, a change of Medicare enrollment information, and voluntary termination of Medicare enrollment). Currently, the burden hours for the entirety of all submission reasons and respondents over a three year period is 265,471.5 hours, with approximately 135,351 respondents. A breakdown of this burden hour count is shown in the three tables in #12 above. Both the burden hour per submission reason as well as the respondent are valued and calculated in this burden estimate.

This revision of the CMS-855S includes a re-sequencing and re-numbering of the sections and sub-sections of the application to create a more logical flow of the data to make it easier for the supplier to complete (for example, by putting most address collection information in one section). The re-sequencing and re-numbering of the application was also necessary to maintain continuity with other CMS-855 applications. Additionally, in this revision of the CMS-855S, some of the main revisions include an exemption from accreditation option for the supplier to check one of three checkboxes for the reason of the exemption, if applicable. An expanded definition of managing control was added. The contact person section was made optional to reduce the reporting burden for suppliers. Additional information, including a link to the website, was added regarding the application fee. Also, some obsolete questions were removed. Other minor editorial and clerical corrections were made to better clarify the current data collection. Some of the instructions were simplified for the suppliers completing this application in response to comments received by the NSC MAC during meetings discussing the current version of this application.

16. *Publication/Tabulation*

There are no plans to publish the outcome of the data collection.

17. *Expiration Date*

The expiration date will be displayed on the top, right-hand corner of page 1 of the CMS-855S application.