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 renumbering 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 resequencing 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 reordered 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.

- 42 C.F.R. section 424.500 et seq. states 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.
- 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).
- 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.
- 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)(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 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 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.

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) (which are captured on the application pursuant to sections 1124(a)(1) and 1124A of the Social Security Act) 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.

Please see Appendix 1 of this Supporting Statement for a list of the revisions to the CMS-855S.

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 Internetbased 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. We note that submission of the Form CMS-855S is the only means for an individual or entity to become eligible for Medicare payments as a DMEPOS supplier.

The 30-day notice published in the Federal Register on November 27, 2019 (84 FR 65396). No comments were received.

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 CMS855S' 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)

Reason for Submittal	Hours to Complete by a Chief Executive of a Large Organization per CMS855S	Hours to Complete by a Physician per CMS855S	Hours to Complete by a General and Occupational Manager per CMS-855S	Total Hours to Complete per CMS855S	Cost to Complete by a Chief Executive of a Large Organization per CMS855S	Cost to Complete by a Physician per CMS855S	Cost to Complete by a General and Occupational Manager per CMS-855S
Initial Enrollment	4	4	4	4	$760.96	$841.76	$483.60
Adding a New Business Location	1	1	1	1	$190.24	$216.44	$120.900
Reactivation	4	4	4	4	$760.96	$841.76	$483.60
Revalidation	2	2	2	2	$380.48	$420.88	$241.80
Reporting a Change of Medicare Enrollment Information	1	1	1	1	$190.24	$210.44	$120.90
Voluntary Termination of Medicare Enrollment	0.5	0.5	0.5	0.5	$95.12	$105.22	$60.45

For this proposed revision of the CMS-855S, CMS has recalculated the estimated burden costs. 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 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 2020, the mean hourly wage for the general category of "Chief Executive" is $95.12 per hour (see http://www.bls.gov/oes/current/oes_nat.htm). With fringe benefits and overhead, the total per hour rate is $190.24
    - The most recent wage data provided by the BLS for May 2020 (see http://www.bls.gov/oes/current/oes_nat.htm), the mean hourly wage for the category of "Physicians and Surgeons" is $105.22. With fringe benefits and overhead, the total hourly rate is $210.44.
    - The most recent wage data provided by the Bureau of Labor Statistics (BLS) for May 2020, the mean hourly wage for the general category of "General and Occupational Manager" is $60.45 per hour (see http://www.bls.gov/oes/current/oes_nat.htm). With fringe benefits and overhead, the total per hour rate is $120.90.
- 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.

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%) $760.96 Physicians and Surgeons (25%) $841.76 total General and Occupational Managers (25%) $483.60 total $2,086.32 total	$28,615,965.12
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%) $190.24 Physicians and Surgeons (25%) $210.44 total General and Occupational Managers (25%) $120.90 total $521.58 total	$647,802,36
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	2,378 per year	4 hours	9,512 hours	Chief Executives (50%) $760.96 Physicians and Surgeons (25%) $841.76 total General and Occupational Managers (25%)	$19,845,075.84

		Managers (25%) 594 total				$483.60 total $2,086.32 total	

		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%) $380.48 Physicians and Surgeons (25%) $420.88 total General and Occupational Managers (25%) $241.80 total $1,043.16 total	$54,152,521.92
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%) $190.24 Physicians and Surgeons (25%) $210.44 total General and Occupational Managers (25%) $120.90 total $521.58total	$647,802,36

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%) $95.12 Physicians and Surgeons (25%) $105.22 total General and Occupational Managers (25%) $60.45 total $260.79 total	$912.77
		7 total					
3-year total	**0938-1056**	**135,351 Respondents**	**135,351 Responses**	**37.5 hours total**	**265,471.5 hours**	**Varied**	**$311,730,241.11**

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 threeiyear 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 renumbering 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.

APPENDIX 1

List of Changes to the Form CMS-855S

Section Number	Revision
Entire 855S	Punctuation, grammar and spelling corrections were made throughout the CMS-855S as necessary (e.g., upper case/lower case corrections, apostrophe corrections, etc.).
Entire 855S	Section references were updated to coincide with new section sequencing where necessary.
Entire 855S	Minor text corrections were made to clarify instructions and delete redundancy.
Entire 855S	All website links and legal references were reviewed and updated where necessary.
Entire 855S	Removed all references to "Medicare fee-for-service contractor(s)" and replaced language with "Medicare Administrative Contractors (MACs)."
Entire 855S	Removed the instruction for that the Certification Statement be signed in blue ink.
Entire 855S	All acronyms were reviewed and updated where necessary.
Entire 855S	All section symbols (§) were replaced with the word "section" or "sections".
Entire 855S	All section and sub-section headers were standardized (Numbering, Bold, Upper and Lower Case, etc.) to create a uniform format throughout the application.
Entire 855S	Reformatted checkboxes for "change", "add", and "remove", with effective date line.
TITLE PAGE	Corrected page number references and section number references concerning information on who should complete the application, where to mail the application, and the location of the list of supporting documentation to be submitted with the application.
INSTRUCTION PAGES	Language change in section "DMEPOS Supplier Standards for Medicare Enrollment." Number 20 changed "Health Insurance Claim Number" to "Medicare Beneficiary Identifier."
INSTRUCTION PAGES	Changed title of the Instructions' subsection "Who Should Complete This Application" to "Who Should Complete and Submit This Application"
INSTRUCTION PAGES	Updated paragraph about obtaining National Provider Identifiers (NPIs) to the subsection entitled "Billing Number and National Provider Identifier Information".

Section Number	Revision
INSTRUCTION PAGES	Added a note explaining that the Legal Business Name (LBN) and Tax Identification Number (TIN) the supplier furnishes in section 4A must be the same LBN and TIN used to obtain the supplier's NPI.
INSTRUCTION PAGES	Changed title of the Instructions' subsection "Instructions for Completing This Application" to "Instructions for Completing and Submitting This Application"
INSTRUCTION PAGES	Added three bullets to "Tips To Avoid Delays In Your Enrollment" subsection: (1) Added application fee requirement; (2) Sign and date section 15; and (3) Ensure all supporting documents are sent to the NSC MAC.
INSTRUCTION PAGES	Updated link for application fee payment.
INSTRUCTION PAGES	Added bullet from section 12 titled "Include Copy of Certification of Insurance for comprehensive liability policy" to the "Tips to Avoid Delays In Your Enrollment" subsection.
INSTRUCTION PAGES	Added line item number 7 "Billing privileges not effective until the NSC MAC assigns your Medicare Identification Number" to the "Process for Obtaining Medicare Approval" subsection.
INSTRUCTION PAGES	Added subsection for "Additional Information" to include helpful website links, C.F.R. citations, and Privacy Act Information regarding the information submitted on the application.
INSTRUCTION PAGES	Added "Indian Health Service (IHS)" and "Provider Transaction Access Number (PTAN)" to the list of acronyms used throughout the CMS-855S.
INSTRUCTION PAGES	Added a list of definitions specific to the checkboxes for "add", "change" and "remove".
SECTION 1	Changed layout of the entire section.
1A	Moved from previous section 1C.

Section Number	Revision
1B	Moved from previous section 1D.
SECTION 2	Changed layout of the entire section.
2A	Added "Business Location" section from its previous section 1A. Simplified instructions and reordered sections and applicable subsections.
2A1	Added "Add" and "Remove" to provide options for adding or removing business location information.
2B	Added "Business Identification Information" section from its previous section 1B. Simplified instructions and reordered sections and applicable subsections.
2B	Added rows to "Business Identification Information" table to collect additional information about other business names. Also, added checkboxes for: "Type of other name; Former Legal Business Name; Doing Business As Name; and Other (Describe)."
2C	Updated to combine sections "Business Structure Information" and "Internal Revenue Service Registration Information."
2D	Changed section title from "States Where Items Provided" to "States Where Items Are Provided"
2D	Placed Add/Remove checkboxes beside each state where items are provided.
2E	Added section 2E “Products/Accreditation Information” from previous section 3.

Section Number	Revision
2E1	Added "Chiropractor" as an option for type of supplier.
2E1	Added following note to "Other" option: "Only use “other” checkbox if your supplier type is eligible to enroll and bill the Medicare program but is not reflected in the list of suppliers. If you are unsure if you are eligible to enroll, contact your designated NSC MAC before you submit this application."
2E2	Added checkboxes to collect information regarding the following accreditation exemption reasons: "The supplier is exempt from DMEPOS accreditation based on supplier type; The supplier location is previously enrolled pharmacy with attestation on file; or The supplier is a pharmacy providing only non-accredited products."
2E2	Added the following language: "Note: Copy and complete this section if more than one accreditation needs to be reported" to "Accreditation Information" section.”
2E3	Placed Add/Remove checkboxes beside each non-accredited product provided.
2E4	Placed Add/Remove checkboxes beside each product and service provided.
2E4	Added "Oxygen" to the subsection "Products and Services Furnished By This Supplier."
SECTION 3	Moved "Final Adverse Legal Actions" section from previous Section 7.
3C	Removed "Resolution, if any" column from adverse legal action history table.

Section Number	Revision
4B2	Added Medical Record Correspondence Address which included the following instructions "This is the address where the medical record correspondence will be sent to the supplier listed in section 2A by your designated MAC. This information will be used for any medical record review requests. This address cannot be a billing agency, Management Service Organization, or the supplier's representative." Data fields also included are a checkbox to use the supplier's regular correspondence address, a checkbox to use the supplier's business address in section 2A, a checkbox to change the Medical Record Correspondence Address, and the address data fields (Attention (optional), 2 Address lines, City/Town, State, Zip Code, Telephone Number, Fax Number, and E-mail Address).
SECTION 4B & 4C	Added the following note: "This address cannot be a billing agency, Management Services Organization, or the supplier's representative."
4B & 4C & 4D	Added the following note: "If changing, this will replace your current address on file."
4D	Added the following: "Note: Furnish an address where remittance notices and special payments should be sent for services rendered at the practice location(s) reported in section 2A. Please note that payments will be made in your name or, if a business is reported in section 4A, payments will be made in the name of the business."
4E	Added "Change" checkbox to include option to change storage location, along with the following language: "If removing, ensure the NSC MAC has a valid record storage address on file. If changing, this will replace your current record storage address on file."
SECTION 5	Moved from entire previous section 8.

Section Number	Revision
5	Expanded instructions and examples for Managing Control (Organizations). Added the following language: "Report the entity under the role of “managing control if, for instance, an entity: a. has direct responsibility for the performance of your organization AND b. is capable of changing the leadership, allocation of resources, or other processes of your organization to improve performance. Faculty practice plans, university-based health systems, hospital outpatient departments, medical foundations, and groups that primarily treat enrollees of group model HMOs should review this definition carefully to determine if it applies. Suppliers should also report any managing relationship with a management services organization under contract with the supplier to furnish management services for the business."
5	Added "NOTE: All organizations that complete this section must also complete section 5B."
5	Added one bullet point to "All organizations for which the following apply must be reported in section 5: "A management services organization under contract with the supplier to furnish management services for the business."
5A	Updated Identification Information subsection language to "If you are changing information about your current ownership interest and/or managing control information for this organization, check the applicable box, furnish the effective date, and complete the appropriate fields in this section."
5B	Added instruction under adverse legal action history, "If you need additional information regarding what to report, please refer to section 3 of this application.”
5B	Added: "NOTE: If reporting more than one organization, copy and complete sections 5A and 5B for each organization reported."
5B	Added: "NOTE: To satisfy the reporting requirement, section 5B2 must be filled out in its entirety, and all applicable attachments must be included."
5B	Removed "Resolution, if any" column from adverse legal action history table.

Section Number	Revision
SECTION 6	Moved entire previous section 9.
6	Expanded note to "A supplier MUST have at least ONE organizational or individual owner, ONE managing employee and ONE Authorized Official. In addition, all Authorized Officials and/or Delegated Officials must complete this section."
6	Moved "For more information on “direct” and “indirect” owners, go to www.cms.hhs.gov/MedicareProviderSupEnroll." to the instructions regarding 5 percent or more ownership.
6	Expanded Authorized and Delegated Officials bullet with "All Authorized Officials must identify one other relationship of 5% or greater direct/indirect owner, Partner or Director/Officer. All Delegated Officials must identify one other relationship but can select managing employee as other relationship."
6A	Added the following sentence under Individuals with Ownership Interest and/or Managing Control—Identification Information: "If you are changing information about your current ownership interest and/or managing control information for this individual, check the applicable box, furnish the effective date, and complete the appropriate fields in this section."
6A	Added the following sentence on Individual Tax Identification Numbers (ITINs): "IRS issues Individual Tax Identification Numbers (ITINs) to foreign nationals and others who have federal tax reporting or filing requirements and are not eligible to obtain a Social Security Number (SSN) from the Social Security Administration (SSA). Please report your ITIN in this section, if applicable."
6A	Deleted the following data fields: Country of Birth, Supplier Billing Number (if issued), and NPI (if issued).

Section Number	Revision
6A	Added data field for "Title."
6A	Added ITIN to Social Security Number data field so that it now reads: "Social Security Number (SSN) or Individual Tax Identification Number (ITIN)"
6B	Added the following instruction under adverse legal action history: "If you need additional information regarding what to report, please refer to section 3 of this application."
6B	Added: "NOTE: If reporting more than one individual, copy and complete sections 6A and 6B for each individual reported."
6B	Added: "NOTE: To satisfy the reporting requirement, section 6B2 must be filled out in its entirety, and all applicable attachments must be included."
6B	Removed "Resolution, if any" column from adverse legal action history table.
SECTION 7	Moved from previous section 5.
7A	Isolated the sentence "The NSC MAC, with full mailing address as shown below, must be listed on the policy as a certificate holder" and added address.
7A	Update language to include "professional" insurance as one that does not meet compliance for the requirement.

Section Number	Revision
7B	Moved from previous section 6.
7B2	Updated language from "Surety Bond Information" to "Surety Bond Financial Information"
7C	Added new section for Surety Bond Exception Information to include checkbox options: "Government-operated facilities that have a comparable bond under state law that lists CMS as the obligee (payee). (i) The supplier is a federally owned or tribally owned or operated Indian Health Service. (ii) The supplier is a physician providing items to own patients as part of physician's own services. (iii) The supplier is a solely owned and operated OT/PT that furnishes only to their own patients and is only billing for orthotics/prosthetics and supplies. (iv) The supplier is an orthotist/prosthetist or occularist in private practice that is solely owned by the O/P personnel, is making custom-made orthotics/prosthetics and is only billing for orthotics/prosthetics and supplies."
SECTION 8	Moved from previous section 10.
8	Added "/Agent" after the word "Agency" to include individuals in the instructions.
8	Added "NOTE: The billing agency/agent address cannot be the correspondence mailing address completed in section 4B of this application."
SECTION 12	Updated language by removing "if applicable" from statement notifying applicants that this section lists documents that must be submitted with their application.
12	Updated language by inserting the word "Documentation" in the title of the subsections to now state: MANDATORY DOCUMENTATION FOR ALL NEW APPLICATIONS AND/OR ADDITIONAL LOCATIONS and MANDATORY DOCUMENTATION, (IF APPLICABLE)."

Section Number	Revision
SECTION 13	Moved from previous section 11.
13	Made section optional.
13	Updated the language in the instructions from "If questions arise while processing this application, the NSC MAC will contact the individual checked below." to "If questions arise during the processing of this application, your designated NSC MAC will contact the individual reported below."
13	Added checkboxes for "change", "add", and "remove", with effective date.
SECTION 14	Replaced current number 3 with updated language and references concerning the Civil False Claims Act.
SECTION 15	Replaced paragraph 6 of instructions from "Only an authorized official has the authority to sign (1) the initial enrollment application on behalf of the supplier or (2) the enrollment application that must be submitted as part of the periodic revalidation process. A delegated official does not have this authority" to "Only an authorized official has the authority to sign (1) the initial enrollment application on behalf of the supplier and (2) add or remove additional authorized officials and delegated officials. Once the delegation of authority has been established all other enrollment application submissions can be signed by either an authorized official or delegated official."
15A	Replaced #3 of the certification statement with updated language.
15A2	Added "(if applicable)" to the second Authorized Official data element.

Section Number	Revision
15B	Removed instruction "All applications must be original and signed in blue ink. Applications with signatures deemed not original or not dated will not be processed. Stamped, faxed, or copied signatures will not be accepted" and replaced it with "In order to process this application, it must be signed and dated."
15B1, 15B2, 15D1, and 15D2	Added "NOTE: Signatures must be less than 120 days old at the time of submission."
15	Combined sections 15 and 16 and updated headers and numbering.
15	Relocated OMB Statement from end of section 17 to end of section 15.
SECTION 16	Deleted section 16 and combined sections 15 and 16.
PRIVACY ACT STATEMENT (Last page)	Updated Privacy Act Statement,