

Supporting Statement for Paperwork Reduction Act Submissions

Medicare Enrollment Application - Registration for Eligible Ordering and Referring Physicians and Non-Physician Practitioners - CMS-855O/OMB Control Number: 0938-1135

A. BACKGROUND

The principal function of the Form CMS-855O is to gather information from a physician or other eligible professional to help CMS determine whether he or she meets certain qualifications to enroll in the Medicare program for the sole purpose of ordering or certifying certain Medicare items or services. The Form CMS-855O allows a physician or other eligible professional to enroll in Medicare without approval for billing privileges.

The purpose of this Paperwork Reduction Act (PRA) submission is to propose an update to the currently approved Form CMS-855O burden estimates to include those in a proposed rule published in the **Federal Register** on April 4, 2023 titled “Medicare Program; FY 2024 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, Hospice and Home Health Quality Reporting Program Requirements, Hospice Certifying Physician Provider Enrollment Requirements” (88 FR 20022). Specifically, we are proposing in that rule to revise 42 CFR § 424.507 to require physicians who order or certify hospice services for Medicare beneficiaries (hereafter occasionally referenced as “hospice physicians”) to be enrolled in or opted-out of Medicare as a prerequisite for payment of the hospice service in question. The burden projections we proposed in that rule involve the hospice physician’s submission of the Form CMS-855O application to enroll in Medicare.

No revisions to the Form CMS-855O are being proposed in this PRA submission. Only the Form CMS-855O burden estimates are changing. We note that we published notices in the **Federal Register** on September 21, 2022 and December 21, 2022 regarding a PRA submission that proposed burden changes (but not actual form revisions) to the Form CMS-855O.¹ However those burden changes only involved voluntary terminations of one’s Form CMS-855O rather than an initial Form CMS-855O application as envisioned in the aforementioned April 4, 2023 proposed rule. As such, the proposed burden changes per the September 21 and December 21 notices would not impact those in the present PRA submission.

B. 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 (CFR) 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 allowing payment. These statutes and regulations include:

¹ 87 FR 57700; 87 FR 78109

- 42 C.F.R. section 424.500, et al. states the requirements for enrollment, periodic resubmission and certification of enrollment information for revalidation, and timely reporting of updates and changes to enrollment information. Providers and suppliers must meet and maintain these enrollment requirements to bill either the Medicare program or its beneficiaries for Medicare covered services or item.
- The Balanced Budget Act of 1997 (BBA) (Public Law 105-33) section 4313, amended sections 1124(a)(1) and 1124A of the Act to require disclosure of both the Employer Identification Number (EIN) and Social Security Number (SSN) of each provider or supplier, each person with an ownership or control interest in the provider or supplier, and any managing employees. The Secretary of Health and Human Services (the Secretary) signed and sent to the Congress a “Report to Congress on Steps Taken to Assure Confidentiality of Social Security Account Numbers as Required by the Balanced Budget Act” on January 26, 1999, with mandatory collection of SSNs and EINs effective on or about April 26, 1999.
- Section 31001(I) of the Debt Collection Improvement Act of 1996 (DCIA) (Public Law 104-134) amended 31 U.S.C. 7701 by adding paragraph (c) to require that any person or entity doing business with the Federal Government 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.
- 42 C.F.R. section 424.502 defines enrollment and enrollment related terms.
- The Patient Protection and Affordable Care Act (PPACA), section 6405 ("Physicians Who Order Items or Services Required to be Medicare Enrolled Physicians or Eligible Professionals") contains a requirement for certain physicians and other eligible professionals to enroll in the Medicare program for the sole purpose of ordering or certifying items or services for Medicare beneficiaries.
- Sections 1102 and 1871 of the Act provide general authority for the Secretary to prescribe regulations for the efficient administration of the Medicare program
- 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.
- 5 U.S.C. 522(b)(4) and Executive Order 12600 protect privileged or confidential commercial or financial information from public disclosure.

The Form CMS-855 applications collect this information, including the information necessary to uniquely identify and enumerate the provider/supplier. Additional data needed to ensure that providers and suppliers meet all applicable Medicare requirements and to process claims accurately and timely and are also collected on the Form CMS-855 applications.

2. *Purpose and users of the information*

Physicians and practitioners complete the Form CMS-855O if they are enrolling in Medicare strictly to order, refer, or certify certain Medicare items and services and not to obtain Medicare billing privileges. It is used by Medicare contractors to collect data that helps ensure the applicant has the necessary credentials to order, refer, or certify certain Medicare items and services.

The Medicare Administrative Contractor (MACs) establishes Medicare identification numbers. The MACs store Medicare identification numbers and other information in CMS' Provider Enrollment, Chain and Ownership System (PECOS). The MACs collect data via the Form CMS-855O to ensure that the applicant has the necessary information for unique identification. The license numbers are validated against state licensing websites. Social Security Numbers (SSNs) are validated against the Social Security Administration database (SSA). The correspondence address and contact information are captured to contact the provider/supplier.

The collection and verification of this information protects our beneficiaries from illegitimate providers/suppliers. These procedures also protect the Medicare Trust Funds against fraud. The Form CMS-855O gathers information that allow Medicare contractors to ensure that the physician or eligible professional is not sanctioned from the Medicare and/or Medicaid program(s), or debarred, or excluded from any other Federal agency or program. Furthermore, and as already stated, the data collected help to confirm that the applicant has the required credentials to order and certify health care services. This is the sole instrument implemented for this purpose.

3. Improved Information Techniques

This collection lends itself to electronic collection methods. 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. 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 various Form CMS-855 applications and is maintained indefinitely as both historical and current information. At present, approximately 67% of individual provider/suppliers use the electronic method of enrolling in Medicare via PECOS.

4. Duplication and Similar Information

There is no duplicative information collection instrument or process.

5. Small Business

The Form CMS-855O is not completed by small businesses and therefore will not affect them.

6. *Less Frequent Collections*

The information provided on the Form CMS-855O is necessary for identification of certain physician and other eligible professionals in the Medicare program. It is essential to collect this information for all ordering/certifying physicians and other eligible professionals to verify the individual's qualifications to order and certify certain Medicare items and services. In addition, Medicare contractors must ensure that the ordering/certifying physicians or other eligible professionals meet all statutory and regulatory requirements and are properly credentialed.

After initial enrollment, this information is collected on an as needed basis; it is often initialized by the individual to report a change of information. To ensure uniform data submissions, CMS requires that all changes to previously submitted enrollment data be reported via this enrollment application or its equivalent in PECOS.

7. *Special Circumstances*

There are no special circumstances that would require an information collection to be conducted in a manner that requires respondents to:

- Report information to the agency more often than quarterly;
- Prepare a written response to a collection of information in fewer than 30 days after receipt of it;
- Submit more than an original and two copies of any document;
- Retain records, other than health, medical, government contract, grant-in-aid, or tax records for more than three years;
- Collect data in connection with a statistical survey that is not designed to produce valid and reliable results that can be generalized to the universe of study,
- Use a statistical data classification that has not been reviewed and approved by OMB;
- Include a pledge of confidentiality that is not supported by authority established in statute or regulation that is not supported by disclosure and data security policies that are consistent with the pledge, or which unnecessarily impedes sharing of data with other agencies for compatible confidential use; or
- Submit proprietary trade secret, or other confidential information unless the agency can demonstrate that it has instituted procedures to protect the information's confidentiality to the extent permitted by law.

CMS agrees to the aforementioned list and the subject request fully complies with the regulation.

8. *Federal Register Notice/Outside Consultation*

A Notice of Proposed Rulemaking published on April 4, 2023 (88 FR 20022). No outside consultation was sought.

9. *Payment/Gift to Respondents*

There are no payments or gifts to respondents as the respondents are merely ordering or certifying services or items for Medicare beneficiaries.

10. Confidentiality

Data will be kept private to the extent allowed by law.

The SORN title is Provider Enrollment, Chain and Ownership System (PECOS), number 09-70-0532 (71 FR 60536).

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 commonly considered private.

12. Burden Estimates (hours and cost)

This Section 12 discusses the proposed increase in the existing OMB-approved Form CMS-855O initial enrollment burden in light of our proposed change to § 424.507.

Using wage data from the U.S. Bureau of Labor Statistics' (BLS) May 2021 National Occupational Employment and Wage Estimates for all salary estimates (http://www.bls.gov/oes/current/oes_nat.htm), the hour burden associated with the Form CMS-855O is calculated based on the assumption that the application will likely be completed by the physician. The applicable burden per application is 0.5 hours. The mean hourly wage for the general BLS category of "Physicians, All Other" is \$111.30 (see http://www.bls.gov/oes/current/oes_nat.htm). With fringe benefits and overhead, the total per hour rate is \$222.60.

Proposed Physician Requirements

As stated in the aforementioned April 4, 2023 proposed rule, CMS data indicates that approximately 2,173 physicians who have ordered or certified Medicare hospice services are not enrolled in or opted-out of Medicare. These physicians would be required to do so under our proposal. Strictly for purposes of establishing a burden estimate, we project that the average hospice physician would complete an initial Form CMS-855O to comply with our proposed requirement. The foregoing results in a total burden of 1,087 hours (0.5 hr x 2,173) at a total cost of \$241,966 (2,173 x \$222.60). Averaged over the 3-year OMB approval period, the annual burden is 362 hours and \$80,655.

The current OMB-approved annual figures and burden for Form CMS-855O initial enrollment applications is as follows:

- 45,098 annual respondents
- 45,098 annual responses

- 0.5-hour per response
- Hour burden – 22,549 hours (45,098 x 0.5)
- Cost burden - \$1,703,656

Per the proposed ICR changes associated our proposed revision to § 424.507

- 45,822 respondents (45,098 + 724)
- 45,822 responses (45,098 + 724)
- 22,911 hours (22,549 + 362)
- \$1,784,311 (\$1,703,656 + 80,655)

The burden estimates for completing a CMS-855O Medicare enrollment application for the three submission reasons shown below in Table A – Summary of Burden (initial enrollment, reporting a change of Medicare enrollment information, and voluntary termination of Medicare enrollment) are taken directly from the actual applications processed for calendar year 2021. These figures are exact as they are generated directly from the PECOS.

The CMS-855O form is completed by the individuals in the general category of health diagnosing and treating practitioners. Respondent burden is calculated based on the following assumptions:

- Completion of the CMS-855O takes 0.5 hours for initial enrollments, changes of enrollment information, and reporting voluntary withdrawals of enrollment information from the Medicare program.
- Recordkeeping time is included in the total of 0.5 hours for completion of the CMS-855O.

Voluntary Terminations

Of the 12,380 annual applications, roughly 50 percent are in cases where the physician or practitioner seeks to enroll in Medicare via the CMS-855I. Since he or she need not complete a CMS-855O voluntary termination application in this instance, the annual overall CMS-855O burden is reduced by:

- 6,190 respondents (12,380 x 50 percent)
- 6,190 responses (12,380 x 50 percent)
- 3,095 hours (6,190 x 50 percent)
- \$333,764.80 (6,190 x \$107.84)

Table A - Summary of Burden

Requirements	Existing Respondents	Proposed Respondents	Proposed Responses	Proposed Time (hours)	Existing Costs (\$)	Proposed Cost (\$)
Initial Enrollment Application	45,098 (CARES Act x 3 years) = 45,098	45,098 +724 (NPRM) = 45,822	45,822	22,911	\$1,703,656	\$1,784,311
Changes of	2,250	No change	No change	1,125	\$121,320	121,320

Enrollment Information						
Reporting a Voluntary Withdrawal	6,190	No change	No change	3,095	\$333,765	333,765
Cumulative Annual Year Totals	40,760	54,262	40,760	27,131	\$2,965,895	\$2,239,396
Cumulative Three Year Totals	122,280	162,786	122,280	81,393	\$8,897,686	\$6,718,188

13. *Cost to Respondents (Capital)*

There are no capital costs associated with this collection.

14. *Cost to Federal Government*

We anticipate additional costs to the MACs with respect to processing (e.g., collecting, verifying) the aforementioned Form CMS-855O initial applications. Total costs are based on a MAC hourly wage equivalent to a GS-9, Step 5 (Washington/Baltimore/Arlington locality), which is \$35.27. (See https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/pdf/2023/DCB_h.pdf.) We anticipate that it would take the MAC approximately 3 hours to process each Form CMS-855O initial application, though we recognize that this figure could vary by application. This results in a total cost of \$229,925 (2,173 x 3 x \$35.27), which we expect will be incurred in the first year of our proposed provisions.

15. *Changes in Burden/Program Changes*

As a result of proposing to revise initial enrollment requirements, burden hours are increasing by from 20,018 to 27,131.

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 each instrument.