SEIM JOHNSON

June 19, 2011

PRIVATE AND CONFIDENTIAL

OMB, Office of Information and Regulatory Affairs
Email: OIRA_submission@omb.eop.gov

Dear OMB Desk Officer:

In the May 20, 2011 Federal Register, the Centers for Medicare and & Medicaid Services (CMS), Department of Health and Human Services, published the Agency Information Collection Activities: Submission for OMB Review (OMB# 0938-0685) for public comment.

Enclosed are our comments relating to the following forms and corresponding instructions.

- Form CMS-855A, Medicare Enrollment Application – Institutional Providers
- Form CMS-855B, Medicare Enrollment Application – Clinics/Group Practices and Certain Other Suppliers
- Form CMS-855I, Medicare Enrollment Application – Physicians and Non-Physician Practitioners
- Form CMS-855O, Medicare Enrollment Application – For Eligible Ordering and Referring Physicians and Non-Physician Practitioners
- Form CMS-855R, Medicare Enrollment Application – Reassignment of Medicare Benefits
- Form CMS-855S, Medicare Enrollment Application – Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Suppliers

SEIM JOHNSON

If you have any questions regarding the comments or need any clarification, please contact me at (402) 330-2660.

Sincerely,

SEIM JOHNSON, LLP

Dennis K. Grindle

DKG:kc
Enclosures
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Form CMS-855A (07/11)

Comments Relating to Instructions and Form

Page Number	Section/Line Numbers	Comments
Page 10	Section 2.A.1.	We suggest adding the various units, such as swing-bed unit, etc., under the critical access hospital designation since these are set up as separate PECOS records from that of a critical access hospital. It would eliminate Medicare contractor confusion when units are being added to a critical access hospital after the initial enrollment of a critical access hospital or simply updating PECOS records for critical access hospital units. The result would be similar to the units for prospective payment hospitals in §2.A.2.
Page 10	Section 2.A.3.	Please clarify in the instructions if question 2.A.3. applies if the critical access hospital box is checked in 2.A.1. and/or if any box is checked in 2.A.2. Please address if question 2.A.3. applies if any type of provider is checked in 2.A.1. if the provider is owned by a hospital or critical access hospital.
Page 11	Section 2.B.	We noted that the tax identification number has been left out of this section as compared to the current form and question if this was the intent of CMS.
Page 11	Section 2.B.	It was our understanding that a cost report year end box was going to be added to the Form CMS-855A.
Page 13	Section 2.B.2.	We suggest CMS develop a consistent policy regarding the effective date to be listed in the license and certification boxes of this section. Some Medicare contractors request the original effective date of the license or certification and others request renewal dates. There are even inconsistencies within Medicare contractors on the effective date to be listed.
Page 13	Section 2.G.	We noted that the header for Acquisitions/Mergers, associated with §2.G. is missing from the middle of the page as compared to the current forms. The numbering noted on the form goes from 2.F. to 2.H.
Page 20	Section 4.A.	We suggest adding at the bottom of this page under the heading "Hospitals and HHAs only (Identify type of practice location)" a check box to note the "Main Hospital Location" to assist Medicare contractors in understanding which inpatient location is the main hospital location for provider-based purposes. We also suggest that more space be provided to describe the "Other Hospital Practice Location".
Page 21	Section 4.C.	We suggest adding instructions specific to how to complete medical record storage locations when electronic records are the sole type of medical record. Perhaps this would be completed for where servers are located or CMS may have other disclosure requirements in these situations.
Page 28	Section 5 Instructions	Could you please add additional language in the instructions under "5. Additional Information on Ownership" to clarify the definition of a holding company? Would this include parent corporations?
Pages 30, 31 &	Section 5.D.	The instructions in 5.D. are as follows, "If the organization listed in **(A)** above ("the Reporting Organization") has one of the interests identified in

Form CMS-855A (07/11)

Comments Relating to Instructions and Form

Page Number	Section/Line Numbers	Comments
32		**(B)(1)** in any other organization reported in **(A)** above……" We noted that although the instructions in 5.D. reference 5.A. and 5.B.1., neither of these sections exist. We suggest adding 5.A. to page 30 and 5.B.1. to page 31.
Pages 31 and 32	Sections 5.B. and 5.D.	We respectfully request CMS reconsider requiring the exact percentage of direct and indirect ownership the organization has in the provider as these can change frequently as owners are added and deleted.
Page 31	Section 5.B.	Could you please provide instructions as to the meaning of the following question? "Was the organization solely created to acquire/buy the provider and/or the provider's assets?"
Page 34	Section 6.A.	We suggest changing the language of "place of birth" to clarify if the intent is City, State, and/or Country of Birth.
Page 34	Section 6.A.	Regarding the available answers for type of interest the individual has in the provider, both "operational or managerial control" and "operational/managerial control" are listed. It appears these are the same type of interest and one should be deleted. If they are not the same, please clarify the difference between the two types of interest.
Pages 34 and 35	Sections 6.A. and 6.B.	It appears the type of interest questions listed in §6.A. and §6.B. are the same except as noted below. We are uncertain of the need for the type of interest to asked twice for each individual. We suggest the type of interest be consolidated into one question. Could you please comment on why Managing Employee (W-2) and Contracted Managing Employee are not included in §6.B.? We respectfully request CMS reconsider requiring the exact percentage of direct and indirect ownership the individual has in the provider as these can change frequently as owners are added and deleted.
Page 37	Section 7.C.	We suggest adding Change, Add and Delete with effective date boxes to the top of this section to accommodate changes to the chain home office information changes.
Page 39	Section 12.A.1.	We suggest removing this question as this information has already been provided in Section 2.B.1.
Page 40	Section 12.B.	We suggest moving Section 12.B. before Sections 12.A.2, 12.A.3 and 12.A.4. because Medicare contractors require information on nursing registries for PECOS records and Sections 12.A.2, 12.A.3 and 12.A.4. are only completed for initially enrolling HHAs and HHA sub-units. Many times §12.B. is overlooked because it is located farther down on the form.

Form CMS-855A (07/11)

Comments Relating to Instructions and Form

Page Number	Section/Line Numbers	Comments
Page 49	Section 17	The note regarding disregarded entities appears to be copied straight from the general instructions of the Form 8832. The first sentence is correct, but we question if the second sentence should remain in the Form CMS-855A since these two sentences contradict one another. If you would like to continue to include the second sentence, we suggest adding the additional information included in the Form 8832 instructions about when a "disregarded entity" is treated as separate from its owner as noted below. • "Employment tax purposes, effective for wages paid on or after January 1, 2009; and" • "Excise taxes reported on Forms 720, 730, 2290, 11-C, or 8849, effective for excise taxes reported and paid after December 31, 2007"
Page 50	Attachment A	Could you please clarify if a physician owned hospital would complete Section 5, Section 6 and Attachment 1? If they need to complete Section 5, Section 6 and Attachment 1, we suggest consideration been given to either having only Sections 5 and 6 completed or only Attachment 1 due to similar information being requested.

Form CMS-855B (07/11)

Comments Relating to Instructions and Form

Page Number	Section/Line Numbers	Comments
Page 1	General Instructions	The listing of suppliers that must complete this application does not match up with the listing of available supplier types in Section 2.A., specifically missing are: • Advanced Diagnostic Imaging • Intensive Cardiac Rehabilitation
Page 8	Section 1.C.	For consistency with Attachment 1 and Attachment 2, we suggest that this information continue to be included in Section 1.B. but titled "Attachment 3: Advanced Diagnostic Imaging Services (Only)"
Page 8	Section 1.C.	We would suggest that you add 2.H. in the "Required Sections" to be completed for all four modalities listed of MRI, CT, Nuclear and PET or we would suggest moving the information in Section 2.H. to Attachment 3 since this section is only required for Advanced Diagnostic Imaging Service Suppliers. If the information in Section 2.H. was moved to Attachment 3 you could remove the information in 2.H.1. since this information will already be provided in Attachment 3.
Page 9	Section 2.A.	Under type of supplier we would suggest changing the type of supplier to Advanced Diagnostic Imaging by adding the letter d to the word Advance.
Page 9	Section 2.B.1.	For the last question in this section, "Is this supplier **and** Indian Health Facility enrolling with Trailblazers Health Enterprises", we would suggest changing the word **and** to **an**.
Page 11	Section 2.F.	We would suggest adding a box under "Check one of the following...." stating, "The enrolling supplier has a pending accreditation."
Page 11	Section 2.F.	Could you clarify why the first check box includes the language, "including the business location in Section 4.A"? An Ambulatory Surgical Center enrollment would be for one location per Form CMS-855B so the accreditation would only apply to the location in §4.A. Because of this comment and the preceding comment, we would structuring these questions similar to the boxes on the (02/08) (EF 07/09) form stating "Is this ASC accredited?" With answers of Yes, No and Pending.
Page 16	Section 4.A.	We suggest expanding the options under "Is this practice location a:" to include the following: • Ambulatory Surgical Center • Skilled Nursing Facility and/or Nursing Facility These two practice locations are routinely put on the "Other health care facility line."
Page 17	Section 4.B.	The change, add and delete boxes have been removed from the remittance notices and special payment section. There are times where this may be the only change needed to the enrollment record. We suggest adding these boxes to be consistent with the current forms.
Page 17	Section 4.C.	We suggest adding instructions specific to how to complete medical record storage locations when electronic records are the sole type of medical record. Perhaps this would be completed for where servers are located or CMS may have other disclosure requirements in these situations.

Form CMS-855B (07/11)

Comments Relating to Instructions and Form

Page Number	Section/Line Numbers	Comments
Page 24	Section 5.B.1.	We suggest changing the instructions after the "No" box to state "Skip to Section **6**" and not Section 4 to be consistent with the current forms.
Page 26	Section 6.A	The instructions state "If you are changing, adding or deleting information, check the applicable box..."; however, the change, add and delete boxes are not included on the form. We suggest adding these boxes to be consistent with the current forms.
Page 26	Section 6.A.	We would like to note that the change, add and delete boxes are being handled inconsistently between contractors. Some contractors require that these boxes be used only in situations where the provider/supplier is changing their information, which we are in agreement with. Other contractors are requiring that dates be included in these boxes when completing other reasons for application, specifically new enrollee applications. We would suggest that additional contractor education be done in this area for consistency.
Page 26	Section 6.A.	We noted numerous inconsistencies between the CMS-855A (07/11) and the CMS-855B (07/11) in this section. Each of these items are noted below: • On the CMS-855A, the individual's title is requested on the second line from the bottom of the page, whereas the title for the individual in the CMS-855B is requested in the first line item of information • The CMS-855A includes the following types of interest not included on the CMS-855B o Specificity between the 5% or greater direct and indirect ownership interest o 5% or greater mortgage interest o 5% or greater security interest o General partnership interest o Limited partnership interest o Specificity between Officer and Director o Operational or managerial control o Other (please specify) • On the CMS-855B, the question, "How long has this owner had ownership.....", ends with (mm/dd/yyyy). This format would not be used to report how long, but instead the effective date. We suggest changing the language of the sentence or the format in which you would like this reported for consistency purposes. On the CMS-855A, this question reads "Effective date of ownership/control relationship (mm/dd/yyyy)."
Page 26	Section 6.A.	We suggest changing the language of "place of birth" to clarify if the intent is City, State, and/or Country of Birth.
Page 36	Section 17	The note regarding disregarded entities appears to be copied straight from the general instructions of the Form 8832. The first sentence is correct, but we question if the second sentence should remain in the Form CMS-855A since these two sentences contradict one another.

Form CMS-855B (07/11)

Comments Relating to Instructions and Form

Page Number	Section/Line Numbers	Comments
		If you would like to continue to include the second sentence, we suggest adding the additional information included in the Form 8832 instructions about when a "disregarded entity" is treated as separate from its owner as noted below. • "Employment tax purposes, effective for wages paid on or after January 1, 2009; and" • "Excise taxes reported on Forms 720, 730, 2290, 11-C, or 8849, effective for excise taxes reported and paid after December 31, 2007"

Form CMS-855I (07/11)

Comments Relating to Instructions and Form

Page Number	Section/Line Numbers	Comments
Page 3 & 4	Section 1.A.	We would suggest changing the required section language to "Complete all applicable sections." This would clarify that not every section is needed for each type of enrollment situation. We suggest removing the language, "Advanced Diagnostic Imaging suppliers must complete Attachment 1" from the box "You are changing your Medicare information" because it implies that Attachment 1 would need to be completed every time an enrollment change occurred which is not always the case, i.e. board member change. Section 1.C. accounts for any Attachment 1 updates to be made with a change of information.
Page 5	Section 2.A.	Could you please explain the purpose of the new question, "Do you accept new patients?" Will this information be published?
Page 7	Section 2.D.1.	In accordance with the Medicare Claims Processing Manual (Pub. 100-4), Chapter 26, 10.8.2, effective 04/01/2011, the specialty of Hospice and Palliative Care is missing from the list of specialties available. We suggest this specialty be added to this listing.
Page 7	Section 2.D.1.	We noted the new specialty of Advance Diagnostic Imaging should include the letter **d** in the word Advance.
Page 11	Section 2.L.	We would suggest moving the information in Section 2.L. to Attachment 1 since this section is only required for Advanced Diagnostic Imaging Service suppliers. If the information in Section 2.L. was moved to Attachment 1 you could remove the information in 2.L.1. since this information will already be provided in Attachment 1.
Page 14	Section 4.A.	For the question in this section, "Is this supplier **and** Indian Health Facility enrolling with Trailblazers Health Enterprises", we would suggest changing the word **and** to **an**.
Page 16	Section 4.C.	We would like to suggest expanding the options under "Is this practice location a:" to include the following: • Ambulatory Surgical Centers • Skilled Nursing Facility and/or Nursing Facility These two practice locations are routinely put on the "Other health care facility line."
Page 20	Section 6	The question, "How long has this owner had ownership.....", ends with a date format of (mm/dd/yyyy). This format would not be used to report how long, but instead the effective date. We suggest changing the language of the sentence or the format in which you would like this reported for consistency purposes. On the CMS-855A, this question reads "Effective date of ownership/control relationship (mm/dd/yyyy)." In addition, we suggest the wording in the sentence be changed from "provider" to "supplier" and removal of the words "ownership and/or" since this section is for reporting of managing control and not ownership.
Page 21	Section 8	The instructions state "If you are changing, adding or deleting information,

Form CMS-855I (07/11)

Comments Relating to Instructions and Form

Page Number	Section/Line Numbers	Comments
		check the applicable box...", however the change, add and delete boxes are not included on the form as requested. We suggest adding these boxes to be consistent with the current forms.
Page 26	Section 17	The note regarding disregarded entities appears to be copied straight from the general instructions of the Form 8832. The first sentence is correct, but we question if the second sentence should remain in the Form CMS-855A since these two sentences contradict one another. If you would like to continue to include the second sentence, we suggest adding the additional information included in the Form 8832 instructions about when a "disregarded entity" is treated as separate from its owner as noted below. • "Employment tax purposes, effective for wages paid on or after January 1, 2009; and" • "Excise taxes reported on Forms 720, 730, 2290, 11-C, or 8849, effective for excise taxes reported and paid after December 31, 2007"

Form CMS-855O (07/11)

Comments Relating to Instructions and Form

Page Number	Section/Line Numbers	Comments
Page 1	General Instructions	We would suggest after the sentence, "The physicians and non-physician practitioners who may wish to enroll in Medicare solely for the purpose of ordering and referring including those who are:" that dentists include the wording, "including oral surgeons" consistent with the wording from the One Time Transmittal 355 issued on September 17, 2010.
Page 3	Section 1	We suggest changing the "Required Section" language when checking the box "You are enrolled solely to order and refer and are updating your information" to "Complete all applicable sections." This would clarify that not every section needs to be completed when only updating information.
Page 3	Section 1	If a practitioner would change their status from enrolling solely for the purposes of ordering/referring to a billing provider would they need to voluntarily terminate by completing a Form CMS-855O? If so, we suggest adding another reason for completing the application that states, " You are voluntarily terminating your Medicare enrollment for the sole purpose of ordering/referring."
Page 4	Section 2.D.1.	In accordance with the Medicare Claims Processing Manual (Pub. 100-4), Chapter 26, 10.8.2, effective 04/01/2011, the following specialties are missing from the list of specialties available: • Cardiac Electrophysiology • Hospice and Palliative Care • Ophthalmology • Geriatric Psychiatry • Sports Medicine We would request that these specialties be added to this listing. In addition, we suggest that Osteopathic manipulative therapy should be changed to Osteopathic manipulative medicine for consistency with the Medicare Claims Processing Manual, listing of physician specialty codes.
General	General comment	Could you please confirm if a practitioner needs to enroll for the sole purpose of ordering/referring with more than one Medicare contractor or with the same Medicare contractor in different payment localities in the instructions?

Form CMS-855R (07/11)

Comments Relating to Instructions and Form

Page Number	Section/Line Numbers	Comments
Page 1	General Instructions	We suggest adding clarifying language to the general instructions stating that the CMS-855R should not be completed for physician assistants.
Page 4	Section 1	We suggest adding Section 7 to the required sections for an individual practitioner terminating a reassignment reason for application.

Form CMS-855S (07/11)

Comments Relating to Instructions and Form

Page Number	Section/Line Numbers	Comments
Page 5	Section 1.B.	We suggest changing the wording under the reason for application "you are **reenrolling**" from reenrolling to revalidation consistent with changes made by CMS to the enrollment regulations.
Page 8	Section 2.A.3.	We believe that the wording, "Where should we mail your **reenrollment** request package if different from Section **2A2** above?" includes a number of items that need to be addressed. • We suggest that sections be numbered to match current forms along with references to each section. • We suggest that the word reenrollment be changed to revalidation consistent with changes made by CMS to the enrollment regulations.
Page 12	Section 2.G.	We would suggest for consistency between the CMS-855B and the CMS-855S, that the wording "(includes exempt providers)" be added to the end of the sentence that states, "The enrolling provider is not accredited."
Page 12	Section 2.G	Could you clarify why the first check box includes the language, "including the business location in Section 4.A"? Only one practice location can be reported for a Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Supplier, which would be listed in Section 4.A.
Page 20	Section 5.A.	The question, "How long has this owner had ownership.....", ends with a date format of (mm/dd/yyyy). This format would not be used to report how long, but instead the effective date. We suggest changing the language of the sentence or the format in which you would like this reported for consistency purposes. On the CMS-855A, this question reads "Effective date of ownership/control relationship (mm/dd/yyyy)."
Page 23	Section 6.A.	The question, "How long has this owner had ownership.....", ends with a date format of (mm/dd/yyyy). This format would not be used to report how long, but instead the effective date. We suggest changing the language of the sentence or the format in which you would like this reported for consistency purposes. On the CMS-855A, this question reads "Effective date of ownership/control relationship (mm/dd/yyyy)."
Page 23	Section 6.A.	We suggest changing the language of "place of birth" to clarify if the intent is City, State, and/or Country of Birth.
Page 35	Section 17	The note regarding disregarded entities appears to be copied straight from the general instructions of the Form 8832. The first sentence is correct, but we question if the second sentence should remain in the Form CMS-855A since these two sentences contradict one another. If you would like to continue to include the second sentence, we suggest adding the additional information included in the Form 8832 instructions about when a "disregarded entity" is treated as separate from its owner as noted below. • "Employment tax purposes, effective for wages paid on or after January 1, 2009; and"

Form CMS-855S (07/11)

Comments Relating to Instructions and Form

Page Number	Section/Line Numbers	Comments
		• "Excise taxes reported on Forms 720, 730, 2290, 11-C, or 8849, effective for excise taxes reported and paid after December 31, 2007"

Office of Management and Budget
Office of Information and Regulatory Affairs
Attention: CMS Desk Officer
Fax: (202) 395-6974
e-mail: OIRA_submission@omb.eop.gov

Document Identifier: CMS-855(O), CMS-855(S) and CMS-855(A, B, I, R)), Medicare Enrollment Application for Eligible Ordering and Referring Physicians and Non-Physician Practitioners; OMB: New.

I am submitting 23 pages of comments and recommendations to the Centers for Medicare & Medicaid Services (CMS) information collection package titled, "CMS-855O, Medicare Enrollment Application for Eligible Ordering and Referring Physicians and Non-Physician Practitioners;" CMS-855S, Medicare Enrollment Application for Durable Medial Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), OMB: 0938-1056; and the CMS-855 (A, B, I, R), OMB: 0938-0685". **This submission is in response to the 30-day Paperwork Reduction Act (PRA) information collection request published in Federal Register on May 20, 2011.**

Based on my review of the aforementioned forms and the related supporting statements, I recommend that the Office of Management and Budget (OMB) and CMS review and address the legal, policy, technical, and paperwork burden issues described below before OMB approves the proposed information collection for the CMS-855(O), CMS-855(S) and CMS-855(A, B, I, R)).

Comments on the CMS-855(O)

I recommend that CMS withdraw the CMS-855O proposed information collection, begin a new 60-day public comment period, and exclude these changes from any updates to Internet-based Provider Enrollment, Chain and Ownership System (PECOS) until OMB approves a subsequent information collection for the following reasons, CMS:

- Does not have statutory or regulatory authority to create an information collection that allows a physician or non-physician practitioner to enroll in the Medicare program for a purpose other than receiving Medicare billing privileges (see 42 CFR 424.500 and 42 CFR 424.505). Moreover, as the May 20, 2011 Federal Register Notice states, "Therefore, if an ordering or referring physician does not participate in the Medicare program, but orders and refers his/her patients to a Medicare provider or supplier for the given ordered or referred service is automatically rejected by the MAC." Thus, if a physician or non-physician practitioner does not participate in Medicare, they must enroll in the Medicare program to participate. On May 5, 2010, CMS published Medicare and Medicaid Programs; Changes in Provider and Supplier Enrollment, Ordering and Referring, and Documentation Requirements; and 424.507(a)(iii) states that, "The physician or eligible professional who ordered or referred must have an approved enrollment record or valid opt-out record in the Provider Enrollment, Chain and Ownership System." On February 2, 2011, CMS published a final regulation titled, "Medicare, Medicaid, Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions

and Compliance Plans for Providers and Suppliers" and while this final regulation cited the non-existent CMS-855O, CMS did not seek comment on allowing a physician or non-physician practitioner to enroll in the Medicare program for a purpose other than receiving Medicare billing privileges. Accordingly, infrequent billers should complete the CMS-855I.

- Incorrectly stated in the May 20, 2011 Federal Register Notice that a "The ordering and referring field of the CMS1500 claims submission form requires an ordering or referring physician to have a Medicare Identification Number." With the implementation of the National Provider Identifier on May 23, 2008, certain providers (e.g., home health agencies) and suppliers (e.g., DMEPOS suppliers, independent clinical laboratories, and independent diagnostic testing facilities) are required to include the National Provider Identifier, not a Medicare Identification Number, of an eligible physician or non-physician practitioner in the ordering and referring field of the paper and electronic claim submission forms.

- Incorrectly stated in the May 20, 2011 Federal Register Notice that a MAC automatically rejects a service furnished by a physician that does not participate in the Medicare program. To date, CMS has not implemented a process whereby a MAC automatically rejects a claim from a physician that is not enrolled in the Medicare program. In fact, the CMS Medicare Provider and Supplier Enrollment web site states, "At this time CMS has not turned on the automated edits that would deny claims for services that were ordered or referred by a physician or other eligible professional simply for lack of an approved file in PECOS. CMS is working diligently to resolve backlog and other systems issues and will provide ample advance notice to the provider and beneficiary communities before CMS begins any such automatic denials. While there are some rumors that the edits will be turned on in January, we want to reiterate that CMS has not announced any date (January 3 or otherwise) as to when ordering/referring edits will be turned on."

- Violated the PRA by modifying the CMS-855I (OMB approval number 0938-0685) and allowing physicians to submit a modified CMS-855I for the sole purpose of ordering and referring (see download titled, "Special Enrollment Fact Sheet for Physicians and with Infrequent Reimbursements" on CMS' Medicare Provider and Supplier Enrollment web site.) **Note**: According to the OMB web site: In complying with the PRA, agencies must ensure that they have OMB approval to implement new or revise existing information collections, prior to their use. Whenever an agency implements a new information collection, or revises an existing collection, without obtaining OMB's approval to do so, it is considered a violation of the PRA.

- Did not modify the PECOS Systems of Records (09-70-0532), which was published in the Federal Register on October 13, 2006, to include this new proposed information collection (i.e., CMS-855O.)

- Did not include the use of Internet-based PECOS by physicians and non-physician practitioners in the CMS-855O paperwork burden estimates.

Technical Comments and Recommendations on the CMS-855O

If OMB decides to approve the revisions to the CMS-855O in lieu of the concerns discussed above, then I recommend that CMS:

- Clarify that physicians and non-physician practitioners submit their type 1 National Provider Identifier (NPI) on page 2 and 3 of the CMS-855O. A type 1 NPI is associated with an individual practitioner.

- Revise the sentence under D.1 on page 5 of the CMS-855O to remove the reference "all Federal" in the sentence, "A physician must meet all Federal and State requirements for the type of specialty(s) checked." There are no Federal requirements for physician licensure or specialty designation.

- Revise page 6 (item 1 under Convictions) of the CMS-855O from "The provider, supplier, or owner of the provider or supplier…" to state, "The physician or non-physician practitioner was…" Since the CMS-855 only applies to physicians and non-physician practitioners the form as written is incorrect.

- Delete item 2 and item 3 under "Convictions" from page 6 since CMS does not have statutory or regulatory authority to deny or revoke Medicare billing privileges based on a misdemeanor conviction.

- Revise item 4 and 5 under Convictions from page 6 to delete the term, "or misdemeanor" from the CMS-855O since CMS does not have statutory or regulatory authority to deny or revoke Medicare billing privileges based on misdemeanor conviction.

- Revise item 1 under Convictions on page 6 to delete the phrase, "that CMS has to be detrimental to the best interest of the program and its beneficiaries." Since CMS must make a qualitative judgment regarding whether physician or non-physician practitioner felony conviction is detrimental to the best interest of the Medicare program, a physician or non-physician practitioner should report all felony convictions.

- Delete the reference to the Medicare Identification Number in items 4 and 5 (under Exclusions, Revocation, or Suspension) on page 6 since providers and suppliers submit claims using a National Provider Identifier not a Medicare Identification Number.

- Replace the term, "Medicare law" with "Social Security Act (Act)" on page 11 (Certification Statement). Statutory provisions regarding Medicare are found in the Social Security Act.

- Delete the words, "will not knowingly present" in item 6 on page 11 (Certification Statement) since the physician is only ordering or referring the service. Thus, the revised item 6 would read, "I will cause to be presented a false or fraudulent claim for payment by Medicare."

- Remove item 3 from section 15 of the CMS-855O because non-enrolled physicians and non-physician practitioners do not have a statutory or regulatory responsibility to report changes to CMS or its contractor.

- Add Section 1866 of the Social Security Act to the first paragraph found on page 13 of the CMS-855O. On page 13 of the CMS-855O, CMS does not include Section 1866(j)(1)(C) of Social

Security Act in the Privacy Act Statement, but contains this statutory citation in the "Supporting Statement for Paperwork Reduction Act Submission".

I would like to recommend the following technical comments and recommendations regarding the "Supporting Statement for Paperwork Reduction Act Submission" for the CMS-855O. I recommend that CMS:

- Remove the phrase, "the identity of the owners of the enrolling entity" from section A (Background) of the CMS-855O Supporting Statement. This document does not include information about owners.

- Remove the Social Security Act citations regarding Advanced Diagnostic Imaging Services, Independent Diagnostic Testing Facilities, PPACA, Accreditation, the Tax Increase Prevention and Reconciliation Act of 2005 from section 1 (Need and Legal Basis) in the supporting statement for the CMS-855O since these statutory citations are not relevant to this proposed information collection.

- Remove the references to Section 31001(I) of the Debt Collection Improvement Act of 1996 (DCIA), IRS section 501(C) from section 1 (Need and Legal Basis) in the supporting statement for the CMS-855O since these statutory citations are not relevant to this proposed information collection.

- Remove the reference to OMB approval number (0938-0685) from section 1 (Need and Legal Basis) in the supporting statement for the CMS-855O since OMB has not approved this new information collection and CMS is requesting a new OMB approval number for this proposed information collection.

- Review and consider removing the reference to Section 1842(r) of Social Security Act. With the implementation of the National Provider Identifier, this citation may no longer be relevant. If CMS adopts this change, then I recommend that CMS update the Privacy Statement found in the CMS-855O.

- Review and consider removing the reference to Section 1842(u) of Social Security Act since this citation is not relevant to this proposed information collection. If CMS adopts this change, then I recommend that CMS update the Privacy Statement found in the CMS-855O.

- Correct item 4 (Duplication and Similar Information) of the Justification section found in "Supporting Statement for Paperwork Reduction Act Submission," CMS states that there is no duplicative information instrument or process. This is not correct. The CMS-855I contains the same information found on this proposed information collection (e.g., CMS-855O).

- Remove the sentence that states, "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" since this information collection does not have privileged or confidential commercial or financial information.

- Delete the word "Convictions" from the title found in Section 3 of the CMS-855O. Since a conviction is only one type of Final Adverse Action, the word conviction should be removed from the title of section 3.

- Revise the paper work burden estimate from one (1) hour to two (2) hours for the CMS-855O. Since the CMS-855I has a burden estimate of four (4) hours and the CMS-855O has 13 pages and the CMS-855I has 27 pages, it seems that the paperwork burden associated with the CMS-855O should be at least two (2) hours.

- Add a new Certification Statement on page 11 that that states, "I further certify that I signature below is mine and that I have not authorized another individual to sign this application on my behalf. I further understand and certify that if I do not sign this application that CMS will return this application to me." This change would reduce the likelihood of office staff signing the enrollment application on behalf a physician or non-physician practitioner.

Comments on the CMS-855S, Medicare Enrollment Application for Durable Medial Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS); OMB: 0938-1056.

I recommend that CMS withdraw this proposed information collection (i.e., CMS-855S), begin a new 60- day public comment period for this information collection, and exclude these changes from any updates to Internet-based PECOS until OMB has approved a subsequent information collection for the following reasons, CMS:

- Did not update the CMS-855S to reflect regulatory changes found in the final regulation titled, "Medicare, Medicaid, Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers" or section 3109 of the Patient Protection and Affordable Care Act into this proposed information collection.

- Did not include the paperwork burden associated with the Medicare application fee and/or hardship waiver (see 42 CFR 424.514) or fingerprinting (see 42 CFR 424.518) into this proposed information collection. Moreover, by excluding information regarding the application fee/hardship wavier process, CMS is delaying the processing of enrollment applications submitted by DMEPOS suppliers.

- Did not include the paperwork burden associated to confirm that a provider or supplier is a "Disregarded Entity".

- Did not include the paperwork burden associated providing the IRS-CP-575 or a copy of the IRS Determination Letter, if the provider or supplier is registered with the IRS as non-profit on the CMS-855S. These are new requirements.

- Did not modify the paperwork burden estimates for this information collection instrument to reflect the use of Internet-based PECOS by DMEPOS suppliers. CMS states that it made Internet-based PECOS available to DEMPOS supplies in October 2010.

- Did not update the paperwork burden estimates for the CMS-855S to reflect the actual application submission statistics using CY 2010 or CY 2011 workloads (initial, changes, revalidations).

- Did not include a summary of changes with 30-day proposed information collection for the CMS-855S on the CMS PRA Listing web site and CMS' response to comments on the 60-day proposed information collection.

- Did not modify the Privacy Act Statement found on page 37 in the CMS-855S to ensure consistency with the PECOS Systems of Records (09-70-0532). Specifically, the PECOS System of Records document does not include the American Medical Association (AMA), State licensing boards, or commercial insurers, health maintenance organizations, multiple employer trust, and other health care groups as routine uses. As such, the AMA, State licensing board, commercial insurers, health maintenance organizations, multiple employer trust, and other health care groups references found in the Privacy Act statement should be removed.

Technical Comments and Recommendations on the CMS-855S

If OMB decides to approve the revisions to the CMS-855S in lieu of the concerns discussed above, then I recommend that CMS:

- Include information into the CMS-855S that provides DMEPOS suppliers information about the Medicare application fee and fingerprint processes (Note: CMS established an application fee process for all DMEPOS suppliers in a final regulation published in the Federal Register on February 2, 2011. By not including information about the application fee in CMS-855S, CMS is "hiding the ball on DMEPOS suppliers" and delaying application processing by the NSC.)

- Add information to Section 17 of the CMS-855S to remind DMEPOS suppliers to submit the Medicare application fee and hardship waiver process with the initial enrollment application or revalidation package.

- Add information to Section 17 of the CMS-855S to remind DMEPOS suppliers to submit the fingerprints with their initial enrollment application.

- Delete the bullet "Report the NPI and provide a copy of the NPI notification from the NPI enumerator" found on page 2 (Avoid Delays In Your Enrollment) of the CMS-855S. CMS does not require any other provider or supplier to submit their NPI notification with their enrollment application.

- Delete the check box "Copy of the National Provider Identifier notification that you received from the National Plan and Provider Enumeration System (NPPES) in Section 17 (Supporting Documents) of the CMS-855S. This requirement is no longer necessary and eliminating this requirement will reduce the paperwork burden on DMEPOS suppliers.

- Add a new bullet to page 2 (Avoid Delays In Your Enrollment) of the CMS-855S which states, "Ensure that the legal business name shown in Section 2 matches the name on tax documentation and the National Plan and Provider Enumeration System."

- Add a new bullets to page 2 (Obtaining Medicare Approval) of the CMS-855S which state:

  - "Prior to submitting an enrollment application (CMS-855S or Internet-based PECOS application), obtain a surety bond and/or accreditation, if necessary.
  - "Submit your Medicare application fee or hardship wavier with your initial enrollment application or revalidation submission"

- Add information to page 12 of the CMS-855 to explain how a pharmacy can be exempt from accreditation requirements.

- Add a new bullet to page 4 (New Enrollees) of the CMS-855S which states: "Enrolling a practice location which was deactivated due to 12 consecutive months of non-billing (see reactivation below).

- Delete the paragraph on Reactivation on page 4 (Existing Medicare New Enrollees). A DMEPOS supplier that is deactivated must initiate a new enrollment to re-enroll in the Medicare program.

- Revise the check box regarding "reactivation" on page 5 to state, "You are **reactivating** your Medicare Billing Privileges"

- Delete this reference in from items 2, 3, 4, 5 in Section 3 of the CMS-855S because CMS does not have statutory or regulatory authority to deny or revoke Medicare billing privileges based on a misdemeanor conviction.

- Revise item 1 in section 3 to delete the phrase, "that CMS has to be detrimental to the best interest of the program and its beneficiaries." This phrase requires the DMEPOS supplier to qualitative judgment regarding whether physician or non-physician practitioner felony conviction is detrimental to the best interest of the Medicare program. CMS or its contractor should make this qualitative determination.

- Delete the reference to the Medicare Identification Number in section 3 of the CMS-855S (under Exclusions, Revocation, or Suspension"). CMS requires DMEPOS suppliers submit claims using the National Provider Identifier not a Medicare Identification Number.

- Replace that the term, "Medicare law" with "Social Security Act (Act)" or "the Social Security Act" in the section 15 (Certification Statement).

- Add "disregarded entity" and "government owned entity" to page 12 (Organizational Structure) of the CMS-855S.

- Add "Expiration Date of Current Surety Bond (mm/dd/yyyy)" to Section 12 C on page 26 of the CMS-855S.

- Add the first two paragraphs found on page 2 of the CMS-855B to the "Billing Number Information" found in the CMS-855S. This change will clarify which NPI should be submitted by a health care provider.

- Add information to the "Billing Number Information" section of the CMS-855S to state that DMEPOS suppliers must have a separate NPI for each practice location unless the supplier is a sole proprietorship.

- Delete the word, "Convictions" from the check box titled, "Final Adverse Action/Convictions" on page 6 (section 1.B) of the CMS-855S. This change would ensure consistency with Section 3 of the CMS-855S. Moreover, a "conviction" is considered a "Final Adverse Action."

- Add a new statement to the CMS-855S Certification Statement to address the concept of nominee owners and responsible parties. The Internal Revenue Service (IRS) has become aware that nominee individuals are being listed as principal officers, general partners, grantors, owners, and trustors in the Employer Identification Number (EIN) application process. A nominee is not one of these people. Rather, nominees are temporarily authorized to act on behalf of entities during the formation process. The use of nominees in the EIN application process prevents the IRS from gathering appropriate information on entity ownership, and has been found to facilitate tax non-compliance by entities and their owners.

  A "nominee" is someone who is given limited authority to act on behalf of an entity, usually for a limited period of time, and usually during the formation of the entity. The "principal officer, general partner," etc., as defined by the IRS, is the true "responsible party" for the entity, instead of a nominee. The "responsible party" is the individual or entity that controls, manages, or directs the entity and the disposition of the entity's funds and assets, unlike a nominee, who is given little or no authority over the entity's assets.

  The IRS does not authorize the use of nominees to obtain EINs. All EIN applications (mail, fax, phone, electronic) must disclose the name and Taxpayer Identification Number (SSN, ITIN, or EIN) of the true principal officer, general partner, grantor, owner or trustor. This individual or entity, which the IRS will call the "responsible party," controls, manages, or directs the applicant entity and the disposition of its funds and assets.

  The IRS defines a "nominee owner as follows:

  For entities with shares or interests traded on a public exchange, or which are registered with the Securities and Exchange Commission, "responsible party" is (a) the principal officer, if the business is a corporation, (b) a general partner, if a partnership, (c) the owner of an entity that is disregarded as separate from its owner (disregarded entities owned by a corporation enter the corporation's name and EIN), or (d) a grantor, owner, or trustor if a trust.

  For all other entities, "responsible party" is the person who has a level of control over, or entitlement to, the funds or assets in the entity that, as a practical matter, enables the individual, directly or indirectly, to control, manage or direct the entity and the disposition of its funds and assets. The ability to fund the entity or the entitlement to the property of the entity alone, however, without any corresponding authority to control, manage, or direct the entity (such as in the case of a minor child beneficiary), does not cause the individual to be a responsible party.

- Change term “reenrollment” on page 4 and 5 of the CMS-855S to “revalidation”. This change is consistent with Federal Regulations published by CMS on February 2, 2011 where CMS changed the term “reenrollment” to “revalidation” for suppliers of DMEPOS.

- Replace the word, “reenroll” found in the explanation for “Revalidation” on page 4 of the CMS-855S with word, “revalidate”.

- Align the meaning of provider enrollment terms found under “Existing Medicare DMEPOS Suppliers” on page 4 with the “Reason for Application Submission” on pages 5 and 6 of the CMS-855S so that the information is presented in the following manner: 1. New Enrollee, 2. Adding a New Business Location, 3.Changing Your Medicare Information, 4. Reactivation, 5. Voluntarily Termination, 6. Revalidation.

- Change the sentence “You are revalidating your Medicare enrollment” on page 5 of the CMS-855S to “CMS or the NSC requested a revalidation.” This change will create less confusion for the public and help the NSC determine when a provider or supplier is actually revalidating its enrollment information rather than making a voluntary submission.

- Delete the word “Convictions” from the title found in Section 3 of the CMS-855S. Since a conviction is only one type of Final Adverse Action, the word conviction should be removed from the title of section 3.

- Revise and consolidate the information found on page 1 and 4 of the CMS-855S regarding who should submit the CMS-855S. By revising and consolidating the information found on page 1 and 4 of the CMS-855S, CMS will remove at least a half-page of text from this document.

- Delete or replace the statements found on page 3 (ADDITIONAL INFORMATION) of the CMS-855S that states, “The information you provide on this application will not be shared. It is protected under ….” with “The information you provide will only be disclosed according to the routine uses found in the Privacy Act Statement of this form.” As written, the statement that “The information you provide on this application will not be shared.” is incorrect or misleading.

- Delete the word “always” in item A.5 (Small Business) of the Supporting Statement Justification for CMS-855S. The word “always” is incorrect since CMS begin to use the CMS-855 family of forms until the mid-1990s.

- Correct the regulatory citations on page 2 (obtaining Medicare Approval) of the CMS-855S to add 42 CFR 424.58 and to delete 42 CFR 424.500-565.

- Change the title for section 2.E from “Section 2E Instructions: Liability Insurance Information” to “Section 2E: Comprehensive Liability Insurance”

- Delete the title “E. Liability Insurance Information” in the middle of page 11 (Section 2.E) of the CMS-855S.

- Correct the regulatory citation for limited insurance information on page 11 (Section 2.E) of the CMS-855S from "42 CFR 424.57(c)" to "42 CFR 424.57(c)(10)".

- Add information about authorized sureties to page 26 (Section 12) of the CMS-855S. DMEPOS suppliers are required to use a surety authorized by the Department of Treasury.

- Delete the list of DMEPOS supplier types on page 1 of the CMS-855S. While it makes sense to include a general list of provider or supplier types on page 1 of the CMS-855A, CMS-855B, and CMS-855I, it does not seem to make sense in CMS-855S.

I would like to recommend the following technical comments and recommendations regarding the "Supporting Statement for Paperwork Reduction Act Submission" for the CMS-855S. I recommend that CMS:

- Increase the paperwork burden estimate associated with the CMS-855S to include the burden associated with the application fee, fingerprinting, surety bond, accreditation.

- Delete the last bullet on page 6 of CMS-855S Supporting Statement. The last bullet states, "As a courtesy, Medicare produces the "Medicare Physician and Healthcare Provider Directory". Beneficiary feedback has asked that Medicare indicate if the Physicians are accepting new patients in this directory." While beneficiaries may have asked CMS to collect this information in CMS-855I, it is doubtful that beneficiaries asking CMS to indicate if a physician is accepting new patients in the CMS-855S.

- Correct the statement found in B.2 (Purpose and user of the information) found in the Supporting statement by replacing "It is submitted at the time the applicant first requests a Medicare billing number" to "The CMS-855S is submitted to obtain Medicare billing privileges, when a change of information occurs, or in response to a request for revalidation."

- Replace the references found in B.1 (Need and Legal Basis) of the Summary Statement from bill titles (e.g., PPACA) or sections of bill to the amended section of the Social Security Act (Act). This change would facilitate the public's review of proposed information collections by allowing the public to review the amended Social Security Act, rather than searching for bill names or sections in bills and trying to piece together the changes that have been enacted to the Act. If adopted, CMS would need to replace the following sections of the Act in section B of the supporting statement for the CMS-855S. Specifically, CMS should replace the bullet "Social Security Act, section 6401 -…." and "The Patient Protection and Affordable Care Act, section 3109(a)" with the applicable amended section of the Act. Section 6401 refers to a section of PPACA, not a section in the Act.

- Correct the statement found in B.6 of the Summary Statement that from, "The information is collected on an as needed basis" to "The information is collected on an as needed basis or every three years for revalidation." CMS requires DMEPOS suppliers to complete a revalidation of their enrollment every 3 year.

- Delete the reference to "privileged or confidential commercial or financial information" in B.10 (Need and Legal Basis) of the Summary Statement or provide a list of the data elements that are considered "privileged or confidential commercial or financial information" on the CMS-855(A, I, B, R).

- Increase the hourly wage for administrative staff from $20 per hour to $30 per hour in section B.12 (Need and Legal Basis) of the Summary Statement.

Comments on the CMS-855 (A, B, I, R), OMB: 0938-0685)

I recommend that CMS withdraw this proposed information collection for the CMS-855(A, B, I, R), begin a new 60-day public comment period for this proposed information collection, and exclude these changes from any updates to Internet-based PECOS until OMB has approved a subsequent information for the following reasons, CMS:

- Did not update the CMS-855A and CMS-855B to include regulatory changes found in the following regulations:

  - Medicare, Medicaid, Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers, published on February 2, 2011

  - Hospital Inpatient Prospective Payment System published on August 16, 2010,

  - Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2011, and

  - Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2011; Changes in Certification Requirements for Home Health Agencies and Hospices; Final Rule.

- Did not publish regulations associated with section 6001 of the PPACA, but added two new attachments and definition for "immediate family member" into the CMS-855A. In order for CMS to establish a new definition on the CMS-855A, CMS should publish a proposed regulation and seek public comments on the definition for "immediate family member".

- Did not publish federal regulations that require Medicare providers and suppliers to comply with Section 511 of the Tax Increase Prevention and Reconciliation Act of 2005.

- Did not modify the Privacy Act Statement found in the CMS-855(A, I, B, R) to ensure consistency with the PECOS Systems of Records (09-70-0532), which was published in the Federal Register on October 13, 2006. Specifically, the PECOS System of Records document does not include the American Medical Association (AMA), State licensing boards, or commercial insurers, health maintenance organizations, multiple employer trust, and other health care groups as routine uses. As such, the AMA, State licensing board, commercial insurers, health maintenance organizations,

multiple employer trust, and other health care groups references found in the Privacy Act statement should be removed.

- Did not modify the PECOS Systems of Record document to reflect the types of information that could be published on the official CMS Internet site (see pages 53 and 56 of the CMS-855A.)

- Did not include the paperwork burden associated Medicare application fee and/or hardship waiver (see 42 CFR 424.514) or fingerprinting (see 42 CFR 424.518.) By excluding information regarding the application fee/hardship wavier process, CMS is delaying the processing of enrollment applications submitted by providers and suppliers.

- Did not modify the paperwork burden estimates for the CMS-855A, CMS-855B, CMS-855I, and CMS-855R to reflect the use of Internet-based PECOS by providers and suppliers.

- Did not include the paperwork burden associated providing the IRS-CP-575 or a copy of the IRS Determination Letter, if the provider or supplier is registered with the IRS as non-profit on the CMS-855A, CMS-855B, CMS-855I. These are new requirements.

- Delete or replace the statements found in the ADDITIONAL INFORMATION section of the CMS-855A, CMS-855B, CMS-855I and CMS-855R that states, "The information you provide on this application will not be shared. It is protected under …." with "The information you provide will only be disclosed according to the routine uses found in the Privacy Act Statement." As written the statement that "The information you provide on this application will not be shared." is incorrect or misleading.

- Did not include a summary of changes with 30-day proposed information collection found on the CMS web site for the CMS-855A, CMS-855B, CMS-855I, and CMS-855R and CMS' responses to comments received from the public in response to the 60-day proposed information collection.

- Did not update the paperwork burden estimates for the CMS-855A, CMS-855B, CMS-855I, and CMS-855R to reflect the actual application submission statistics using CY 2010 or CY 2011 workloads. Also, with the publication of "Medicare, Medicaid, Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers" on February 2, 2011, CMS stated that it would revalidate 87,000 providers and suppliers annually.

- Did not update the paperwork burden estimates for the CMS-855I and CMS-855B to reflect the paperwork burden associated with obtaining accreditation to furnish Advance Diagnostic Imaging (ADI) services to Medicare beneficiaries or completing the new sections for ADI within the CMS-855I and CMS-855B.

- May have incorporated changes to the 30 day information collection instrument that did not come from the public. (See Item 15 of the "Supporting Statement for Paperwork Reduction Act Submission" which states that there were no comments that altered the information collection estimate. CMS did not include any public comments for the CMS-855A, CMS-855B, CMS-855I, and CMS-855R and/or CMS responses on its PRA web site. Attachment 1 contains a list of

changes incorporated by CMS in the 30 day information collection instrument package that were not made as a result of public comment.

- Did not include information on the application fee its Medicare Provider Enrollment web site. Note: On February 2, 2011, CMS published a final regulation titled, "Medicare, Medicaid, Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers." CMS stated on page 5911 of this final rule that it would make information available about the Medicare application fee through our Web site, listservs, open door forums, and other communication methods." CMS did not include information regarding the application fee on its Medicare provider and supplier enrollment web site. Thus, newly enrolling providers and suppliers do not have any advance notice that an application fee is required.

- Did not provide the public with 60 days to review the changes proposed in this information collection. While CMS published the 60-day Notice in the Federal Register on March 11, 2011, CMS did not place the information collection for the CMS-855 (A, B, I, R) on CMS web site until April 18, 2011. In addition, while CMS published the 30-day Notice in Federal Register on May 20, 2011, CMS did not place the information collection for the CMS-855(A, B, I, R) on CMS web site until May 27, 2011. Accordingly, by limiting the public comment period associated with this information collection instrument during the 60-day and 30-day public comment periods, CMS violated the policies associated with the PRA and the Administration's goal of establishing a more transparency government.

Technical Comments and Recommendations on the CMS-855 (A, B, I, R)

If OMB decides to approve the revisions to the CMS-855A, CMS-855B, CMS-855I, and CMS-855R in lieu of the concerns discussed above, then I recommend that CMS:

- Revise the introductory paragraph of Section 2.H (Advanced Diagnostic Imaging) of the CMS-855B from, "This section must be completed by all Independent Diagnostic Testing Facilities (IDTF) that also furnish and will bill Medicare for ADI services. All IDTF suppliers furnishing ADI services MUST be accredited in each ADI modality checked below to qualify to bill Medicare for those services" to "Independent Diagnostic Testing Facilities (IDTF) and medical clinics/groups furnishing ADI services must complete this section. IDTFs and medical clinics/groups must be accredited for each ADI modality checked below to receive reimbursement for those services." **Note: In order to receive payments for ADI services, medical groups and clinics would need to complete the information found in Section 2.H of the CMS-855B regarding whether they are accredited for ADI services.**

- Replace the capitalized word, "Modality" in the introductory paragraph of Section 2.H (Advanced Diagnostic Imaging) of the CMS-855B from to the lower case, so that the word is spelled, "modality".

- Add the CMS web page that provides additional information about ADI accreditation to Section 2.L of the CMS-855B.

- Add the following information prior to the introductory paragraph of Section 2.H (Advanced Diagnostic Imaging) of the CMS-855B: "Section 135(a) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) amended section 1834(e) of the Social Security Act and required the Secretary to designate organizations to accredit suppliers, including but not limited to physicians, non-physician practitioners and Independent Diagnostic Testing Facilities, that furnish the technical component (TC) of advanced diagnostic imaging services. In order to furnish the TC of advanced diagnostic imaging services for Medicare beneficiaries, suppliers must be accredited by January 1, 2012."

- Revise the introductory paragraph of Section 2.L (Advanced Diagnostic Imaging) of the CMS-855I from, "This section must be completed by all individual practitioners that also furnish and bill Medicare for ADI services." to "Physicians furnishing ADI services to Medicare beneficiaries and billing for these services through their Type 1 (individual) or Type 2 (organization) NPI must complete this section. Physicians and non-physicians furnishing ADI services to Medicare beneficiaries through a reassignment of benefits can skip this section." The current introductory paragraph is not clear.

- Replace the capitalized word, "Modality" in the introductory paragraph of Section 2.L (Advanced Diagnostic Imaging) of the CMS-855I from to the lower case, so that the word is spelled, "modality".

- Add the following information prior to the introductory paragraph of Section 2.L (Advanced Diagnostic Imaging) of the CMS-855I: "Section 135(a) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) amended section 1834(e) of the Social Security Act and required the Secretary to designate organizations to accredit suppliers, including but not limited to physicians, non-physician practitioners and Independent Diagnostic Testing Facilities, that furnish the technical component (TC) of advanced diagnostic imaging services. In order to furnish the TC of advanced diagnostic imaging services for Medicare beneficiaries, suppliers must be accredited by January 1, 2012."

- Add the CMS web page that provides additional information about ADI accreditation to Section 2.L of the CMS-855I.

- Include information into the CMS-855A and CMS-855B about the Medicare application fee and fingerprint process (Note: CMS established an application fee process for all providers and suppliers completing the CMS-855B except medical groups/clinics in a regulation published in the Federal Register on February 2, 2011. By not including information about the application fee in CMS-855A and CMS-855B, CMS is "hiding the ball on providers and suppliers and delaying application processing by its contractors.)
- Add information to Section 17 of the CMS-855A and CMS-855B to remind providers and suppliers, as applicable, to submit the Medicare application fee and hardship waiver process with the initial enrollment application or revalidation package;

- Add information to Section 17 of the CMS-855A to remind owners of a home health agency to submit their fingerprints and capitalization information with their initial enrollment application.

- Remove Advance Diagnostic Imaging (ADI) from Section 2 A of the CMS-855B since ADI is not a supplier type, but rather a type of service furnished in a physician's office, clinic or an independent diagnostic testing facility.

- Revise the bullet "Ensure that the legal business name shown in Section 2 matches the name on tax documentation" found on page 2 (Avoid Delays In Your Enrollment) of the CMS-855A and CMS-855B to "Ensure that the legal business name shown in Section 2 matches the name on tax documentation and the National Plan and Provider Enumeration System"

- Delete the supplier type "Part B Drug Vendor" from page 1 (Who Should Submit This Application" of the CMS-855B, or add "Part B Drug Vendor" to page 8 (Type of Supplier, in Section 2.A." Since CMS discontinued the Part B Drug Vendor program in prior to January 1, 2009, I recommend deleting the supplier type "Part B Drug Vendor" from page 1 (Who Should Submit This Application) of the CMS-855B.

- Delete the provider type "Indian Health Service Facility" from page 1 (Who Should Submit This Application" of the CMS-855A and delete the "Indian Health Services Facility" from page 10 (Type of Supplier, in Section 2.A.1)" Since an Indian Health Service Facility is place where services are being furnished, rather than eligible Part A facility (e.g., hospital, home health agency (see 42 CFR 400.202 for the definition of a provider), CMS should delete the reference to "Indian Health Service Facility" from pages 1 and 10 of the CMS-855A. Moreover, CMS can determine whether a provider is enrolling as a provider associated with the Indian Health Service based on the new question on page 11 which states, "Is this provider an Indian Health Facility enrolling with TrailBlazer Health Enterprises." It is also important to note that CMS does not include a reference to an "Indian Health Service Facility" as supplier type on from page 1 (Who Should Submit This Application" of the CMS-855B or page 10 (Type of Supplier, in Section 2.A)"

- Add "disregarded entity" and "government owned entity" to section 2.B.1 of the CMS-855A and CMS-855B.

- Add the first two paragraphs found on page 2 of the CMS-855B to the "Billing Number Information" found in the CMS-855A. This change will clarify which NPI should be submitted by a health care provider.

- Correct a spelling error "Proprietaryship" on page 8 of the CMS-855B.

- Delete the reference in Section 3 regarding misdemeanor conviction from items 2, 3, 4, 5 of the CMS-855A, CMS-855B, and CMS-855I because CMS does not have statutory or regulatory authority to deny or revoke Medicare billing privileges based on a misdemeanor conviction.
- Revise Section 3 of the CMS-855B to ensure consistency with provider enrollment changes adopted by CMS in federal regulations titled, "Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2011. This change is needed to clarify that air ambulance suppliers have a distinct responsibility to report that their FAA license has been revoked or suspended.

- Revise item 4 under "Exclusion, Revocation, or Suspensions" in Section 3 of the CMS-855A, CMS-855B, and CMS-855I to state, "Any Medicare payment suspension."

- Revise item 5 under "Exclusion, Revocation, or Suspensions" in Section 3 of the CMS-855A, CMS-855B, and CMS-855I to state, "Any Medicare revocation." It is not necessary to add, "of any Medicare billing number."

- Revise item 1 in section 3 of the CMS-855A, CMS-855B, and CMS-855I to delete the phrase, "that CMS has to be detrimental to the best interest of the program and its beneficiaries" since CMS or its contractor must make a qualitative judgment regarding whether physician or non-physician practitioner felony conviction is detrimental to the best interest of the Medicare program

- Delete the reference to the Medicare Identification Number in section 3 of the CMS-855A, CMS-855B, and CMS-855I (under Exclusions, Revocation, or Suspension") since providers and suppliers submit claims using a National Provider Identifier not a Medicare Identification Number.

- Revise item 2 in the section titled, "Obtaining Medicare Approval" on page 2 of the CMS-855A to state, "The fee-for-service contractor will review and conduct and initial assessment of the application and either recommend the application for approval to the CMS Regional Office or deny the application. This change is consistent with revisions made to the "Effective Date of Provider Agreements and Supplier Approvals" found in the Hospital Inpatient Prospective Payment System published on August 16, 2010.

- Revise the first sentence in item 3 in the section titled, "Obtaining Medicare Approval" on page 2 of the CMS-855A to state, "The State agency or approved accreditation organization conducts the Survey."

- Add a new item 4 in the section titled, "Obtaining Medicare Approval" on page 2 of the CMS-855A to state, "A CMS contractor conducts a second contractor review, as needed, to verify that a provider continues to meet the enrollment requirements prior to the issuance of a Medicare billing privileges." This change is consistent with revisions made to the "Effective Date of Provider Agreements and Supplier Approvals" found in the Hospital Inpatient Prospective Payment System published on August 16, 2010.

- Add a new bullet to page 4 (New Enrollees) of the CMS-855A and page 3 (New Enrollees) of the CMS-855B which states, "Enrolling a practice location which was deactivated due to 12 consecutive months of non-billing (see reactivation below."

- Delete the paragraph on Reactivation on page 4 (Existing Medicare New Enrollees) for the CMS-855A and page 3 (Existing Medicare New Enrollees) on the CMS-855B. A provider or supplier that is deactivated must initiate a new enrollment to re-enroll in the Medicare program.

- Add a new statement to the CMS-855A and CMS-855B Certification Statements to address the concept of nominee owners and responsible parties (see page 9 of this document for additional information about nominee owners and responsible parties.)

- Verify that the information found in the Privacy Act statement of the CMS-855A, CMS-855B, CMS-855I, and CMS-855R is consistent with PECOS Systems of Records document.

- Revise the first sentence in section 3 of the CMS-855A to add the word, "final" before adverse action. This change is consistent with the other forms and the term found in 424.502. regulatory definition for adverse verify that the information found in the Privacy Act statement of the CMS-855A, CMS-855B, CMS-855I, and CMS-855R is consistent with PECOS Systems of Records document.

- Change sentence "You are revalidating your Medicare enrollment" on page 7 of the CMS-855A, page 5 of the CMS-855B, and page 4 of the CMS-855I to "CMS or its contractor requested a revalidation." This change is consistent with information found earlier in the respective forms on revalidation (for example, on page 5 of the CMS-855A that the fee-for-service contractor will notify you when it is time for you to revalidate your enrollment information.) In addition, this change will create less confusion for the public and help CMS' contractors determine when a provider or supplier is actually revalidating its enrollment information rather than making a voluntary submission.

- Revise the check box on page 8 of the CMS-855B from "Ambulatory Surgical Center Clinic/Group Practice" to "Ambulatory Surgical Center".

- Replace the word, "local" with "designated" in the last sentence of page 9 of the CMS-855B. This is change is consistent with terminology that CMS uses on page 2 when referring to the designated Medicare fee-for-service contractor.

- Ensure that all accreditation information requests in consecutive order. In the CMS-855B, CMS request information for ASC accreditation in section 2F and ADI accreditation information in 2H. Section 2G collects information about the termination of Physician Assistants. To improve the readability of this form and reduce submission errors by suppliers, I recommend that all request for accreditation information be group together.

- Revise the title of Section 6B on the CMS-855B from "Final Adverse History" to "Final Adverse Action History". This change is consistent with the regulations found at 42 CFR 424.502.

- Revise the question on page 5 of the CMS-855I regarding "New Patient Status Information" from "Do you accept new patients" to "Are you accepting new Medicare patients"

- Revise the form name for the CMS-588 on page 14 of the CMS-855I from, "(Electronic Funds Transfer Authorized Agreement)" to "(Electronic Funds Transfer Authorization Agreement)." This change is consistent with the title of the CMS-588.

- Delete the check box found in Section 17 of the CMS-855B to remove "Complete Form(s) CMS-855R, Reassignment of Medicare Benefits, since the CMS-855R is only applicable to individual practitioners not organization entities.

- Clarify in Section 17 of the CMS-855B that the CMS-460 only applies to Multi-Specialty Clinics completing the CMS-855B.

- Clarify in Section 17 of the CMS-855B that the CMS-460 must be submitted by a Multi-Specialty Clinic at the time of initial enrollment or reactivation to establish the clinic as a participating practitioner in Medicare.

- Clarify in Section 17 of the CMS-855I that the CMS-460 must be submitted by physician at the time of initial enrollment or reactivation to establish the clinic as a participating practitioner in Medicare.

- Delete the reference to the CMS-460 in Section 17 of the CMS-855R because a physician reassigning his or her payments to a clinic/group practice will be participating or non-participating based on the participation status of the clinic or group.

- Standardize the statements found in the section 15 (Certification Statement) for the CMS-855A, CMS-855B, and CMS-855I. The statements found in section 15 of each Medicare application should be in a consistent order, and to the extent practical, contain the same information.

- Add a new check box to "Mandatory For Selected Provider/Supplier Types" section found in the section 15 (Certification Statement) of the CMS-855B the following, "Copy(s) of all documentation verifying the state licenses or certifications of the laboratory director or non-physician practitioner personnel of an independent clinical laboratory."

- Change the sentence "You are revalidating your Medicare enrollment" in section 1A of the CMS-855A, CMS-855B, and CMS-855I to "The Medicare contractor requested a revalidation." This change will create less confusion for the public and help the NSC determine when a provider or supplier is actually revalidating its enrollment information rather than making a voluntary submission.

- Change the "Reason for Submission" section 1A of the CMS-855A, CMS-855B, and CMS-855I from "You are a new enrollee in Medicare" to "You are a new enrollee or you are voluntarily updating your enrollment information with Medicare for the first time in more than 5 years." Since there are thousands of providers and suppliers enrolled in Medicare, but who have not submitted the CMS-855 form in more than 5 years, I believe that this change will clarify why the application is being submitted.

- Revise section 15, item 5 of CMS-855I from "Neither I, no any managing employee list in this application, is currently …" to "I am not currently …" Since the CMS-855I does not collect information about a managing employee, this statement seems to be incorrect.

- Delete the word "Convictions" from the title found in Section 3 of the CMS-855A, CMS-855B, and CMS-855I. Since a conviction is only one type of Final Adverse Action, the word conviction should be removed from the title of section 3.

- Add the statement "The address must be a specific street address as recorded by the United States Postal Service. A practice location must be the physical location where you furnish services. This address cannot be P.O. Box." to from section 4A of the CMS-855A, CMS-855B, and CMS-855I. The statement above is similar to the language found in section 4A of the CMS-855S.

- Add a new Certification Statement on page 11 of the CMS-855I that that states, "I certify that the signature below is mine and that I have not authorized another individual to sign this application on my behalf. I understand and certify that if I do not sign this application that CMS will return this application to me and that the Medicare contractor will not preserve my application date." This change would reduce the likelihood of office staff signing the enrollment application on behalf a physician or non-physician practitioner.

- Remove the list of Independent Diagnostic Testing Facility (IDTF) performance standards found on pages 39 and 40 of the CMS-855B and refer IDTFs to a CMS' web site to obtain a list of the performance standards that apply to them. This change reduces the number of pages contained the CMS-855B and is consistent with CMS' decision to remove the DMEPOS supplier standards from page 36 the CMS-855S (Note: CMS replaced the list of DMEPOS supplier standards on page 36 of the CMS-855 by referring DMEPOS suppliers to a CMS' web site.) Alternatively, add the list of DMEPOS supplier standards back to the CMS-855S. This recommendation will ensure consistency throughout the Medicare enrollment applications.

- Align the meaning of provider enrollment terms found under "Enrolled Medicare Suppliers" on page 3 with the "Reason for Application Submission" on pages 4 and 5 of the CMS-855B, so that information is presented in the following manner in both sections:1. New Enrollee, 2.Reactivation, 3.Change of Ownership, 4.Changing Your Medicare Information, 5. Enrolling in another fee-for-service contractor's justification, 6. Revalidation, 7. Voluntarily Termination

- Explain what is meant by the check box "enrolling in another fee-for-service contractor's jurisdiction" found page 4 on page 3 of the CMS-855B.

- Align the meaning of provider enrollment terms found under "Enrolled Medicare Suppliers" on page 4 and 5 with the "Reason for Application Submission" on pages 6 and 7 of the CMS-855A, so that information is presented in the following manner in both sections: 1. New Enrollee, 2.Reactivation, 3.Change of Ownership, 4. Acquisition or Merger, 5. Consolidation, 6.Changing Your Medicare Information, 7. Revalidation, 8. Voluntarily Termination

- Replace the explanation for the term "Reactivation" on page 4 of the CMS-855A and page 3 of the CMS-855B with the explanation for the term, "Reactivation" found on page 4 of the CMS-855S. The definition found in the CMS-855S is clearer and more meaningful than the explanations found in the CMS-855A and CMS-855B.

- Delete the word, "hospital" found in the explanation for "Change of Ownership" on page 3 of the CMS-855B. A "hospital" is not a supplier who would complete the CMS-855B.

- Delete the word, “hospital” from the “Change of Ownership” check box found on page 6 of the CMS-855B. A “hospital” is not a supplier who would complete the CMS-855B.

- Replace the explanation for “Change of Ownership” on page 3 of the CMS-855B with the explanation of “Change of Ownership” on page 4 of the CMS-855A. The information on the CMS-855A is clearer.

- Correct and modify the explanation for “Change of Ownership” on page 4 and “Change of Information” on page 5 of the CMS-855A to reflect changes adopted by CMS in Federal Regulations published n November 17, 2010 and titled, “Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2011; Changes in Certification Requirements for Home Health Agencies and Hospices; Final Rule. In the aforementioned Final Rule, CMS established a definition for Change in Majority Ownership for Home Health Agencies (see 42 CFR 424.502) and established prohibitions on the sale or transfer of billing privileges for home health agencies in 42 CFR 424.550.

- Replace the term, “Adverse Legal Action/Convictions” on page 8 (section 1.B) of the CMS-855A with “Final Adverse Action”. This change would ensure consistency with Section 3 of the CMS-855A and Federal Regulations found at 42 CFR 424.502. Moreover, a conviction is a type of “Adverse Legal Action.”

- Delete the word, “Convictions” from the check box titled, “Final Adverse Action/Convictions” on page 6 (section 1.B) of the CMS-855B and page 4 (section 1.B) of the CMS-855I. This change would ensure consistency with Section 3 of the CMS-855B and CMS-855I. Moreover, a “conviction” is considered a “Final Adverse Action.”

- Replace the term, “Final Adverse Legal History” with “Final Adverse Action” on page 32 (section 5.B) of the CMS-855A. Replace the term, “Final Adverse Legal Action” with “Final Adverse Action” in the table on page 32 (section 5.B) of the CMS-855A. This change would ensure consistency with Section 3 of the CMS-855A and Federal Regulations found at 42 CFR 424.502.

- Replace the term, “Final Adverse Legal History” with “Final Adverse Action” on page 23 (section 5.B) of the CMS-855B. This change would ensure consistency with Section 3 of the CMS-855A and Federal Regulations found at 42 CFR 424.502.

- Replace the term, “Adverse Legal History” with “Final Adverse Action” on page 33 (section 6.B) of the CMS-855A and page 25 of the CMS-855B. This change would ensure consistency with Section 3 of the CMS-855A and Federal Regulations found at 42 CFR 424.502.

- Remove the paragraph regarding “Non-Profit, Charitable or Religious Organization from page 24 of the CMS-855B and add this information to Section 17 of the CMS-855B because CMS is requesting supporting documentation (e.g., the 501(c)(3)).

- Delete the sentence on page 21 of the CMS-855B that states, “Each non-profit organization should submit a copy of a 501(c)(3) document verifying its non-profit status.”

- Clarify Section B.1 to of the Supporting Statement for the Medicare enrollment application with the OMB control number 0938-0685 to indicate that Section 6401 of PPACA modified Section 1866 of the Social Security Act.

- Add information to Section 2.D of the CMS-855A to capture information about providers who meet the Conditions of Participation for their provider type via the State survey process, including the date of that the State survey was completed.

- Correct the regulatory citation for reassignment on page 1 of the CMS-885R referring to 42 CFR 424.520(b). The regulatory citation is incorrect.

- Add a closing parenthetical after the words "…eligible supplier." on page 3 of the CMS-855R.

- Delete the reference to "health care delivery system" on page 6 of the CMS-855R. Since the fee-for-service program does not have "health care delivery system" as a supplier type, this reference is inappropriate.

- Add the "Penalties for Falsifying Information" in Section 14 of the CMS-855B and CMS-855I to the CMS-885R.

- Delete or clarify the statement, "The signatures below acknowledge that you will abide by all laws and regulations pertaining to the reassignments of benefits" because this statement is vague and not enforceable. CMS could clarify this statement by citing the specific statutory or regulatory authority that is applicable to reassignments.

- Revise the paper work burden estimate for the CMS-855R from 15 minutes to 30 minutes. Since the paperwork burden includes the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection, it seems that the burden estimate should be increased from 15 minutes to 30 minutes.

- Correct the web site address on page 3 (Mail Your Application) to remove the "hhs" from the web site address. According to the CMS web site, the correct address for CMS is "cms.gov", not "cms.hhs.gov"

- Correct the regulatory citations found on page 1 (Currently enrolled in Medicare and neeed to make changes in your enrollment data) of the CMS-885B. The correct citation of ITDFs is 42 CFR 410.33(g)(2), not 42 CFR 410.33. The correct citation for multi-specialty clinics is 42 CFR 424.516(d). The correct citation for all other suppliers, except DMEPOS suppliers is 42 CFR 424.516(e).

- Clarify whether a "Mass immunization roster biller" should complete the CMS-855I or the CMS-855B. This supplier type is shown on page 1 and section 2 of the CMS-855I and CMS-855B. It

appears that CMS delete the supplier type of "Mass immunization roster biller" from the CMS-855I since the CMS-855I is designed for individual practitioners, not supplier organizations.

- Delete the paragraph that refers to final adverse actions on page 8 of the CMS-855I. This paragraph seems is misplaced.

- Move the request for supporting documentation for CLIA Number and/or FDA/Radiology Certification Number from page 15 of the CMS-855I to Section 17 of the CMS-855I.

I would like to recommend the following technical comments and recommendations regarding the "Supporting Statement for Paperwork Reduction Act Submission" for the CMS-855(A, B, I, R). I recommend that CMS:

- Delete the reference to section 3109 of PPACA from section B.1 of the Supporting Statement for the Medicare enrollment application with the OMB control number 0938-0685. The reference to section 3109 of PPACA refers to pharmacies enrolling in the Medicare program using the CMS-855S.

- Correct the statement found in B.2 (Purpose and user of the information) found in the Supporting statement by replacing "The CMS-855 is submitted at the time the applicant first request a Medicare billing number" to " The CMS-855 is submitted prior to the applicants first request for Medicare billing privileges, when a change of information occurs, including a change of ownership, or in response to a MAC request for revalidation."

- Correct the statement found in B2 (Improved Information Techniques) that states, "Access to the data maintained in PECOS is limited to CMS and Medicare contractor employees responsible for provider enrollment activities" to "Access to the data maintained in PECOS is limited to CMS and Medicare contractor employees responsible for provider enrollment activities and the routine uses described in the Privacy Statement."

- Replace the references found in B.1 (Need and Legal Basis) of the Summary Statement from bill titles (e.g., PPACA) or sections of bill to the amended section of the Social Security Act (Act). This change would facilitate the public's review of proposed information collections by allowing the public to review the amended Social Security Act, rather than searching for bill names or sections in bills and trying to piece together the changes that have been enacted to the Act. If adopted, CMS would need to replace the following sections of the Act in section B of the supporting statement for the CMS-855(A, B, I, R). Specifically, CMS should replace the bullet "Social Security Act, section 6401 -…." with the applicable amend section of the Act. Section 6401 refers to a section of PPACA, not a section in the Act.

- Delete the statement from section A.1 of the Supporting Statement that refers to section 6001 of PPACA since CMS did not publish final regulations implementing section 6001 of PPACA.

- Replace the statement in section B.3 of the Supporting Statement which states, "PECOS began housing provider/supplier information 2004 in compliance with Government Paperwork Elimination

Act. However, until CMS adopts an electronic signature standard, providers/suppliers will be required to submit a hard copy signature page of the applicable CMS-855 with an original signature" with "CMS began storing CMS-855 data in PECOS in 2003. However, until CMS adopts an electronic signature standard for Internet-based PECOS enrollment applications, providers/suppliers will be required to submit a hard copy signature page with the their enrollment submission. "

- Correct the statement found in B.5 of the Summary Statement that states, "In addition, these business have always been required to provide CMS with substantially the same information in order to enroll in the Medicare Program and for CMS to successfully process their claims" to "In addition, these business have been required to provide CMS with substantially the same information in order to enroll in the Medicare Program and for CMS to successfully process their claims."

- Correct the statement found in B.6 of the Summary Statement that from, "The information is collected on an as needed basis" to "The information is collected on an as needed basis or every five years." CMS requires providers and suppliers to complete a revalidation of their enrollment every 5 year. In a Federal Regulation published on February 2, 2011, CMS stated that they would conduct 87,000 revalidations per year.

- Correct the statement found in B.10 of the Summary Statement that from, "The information is collected on an as needed basis" to "The information is collected on an as needed basis or every five years."

- Delete the reference to "privileged or confidential commercial or financial information" in B.10 (Need and Legal Basis) of the Summary Statement or provide a list of the data elements that are considered "privileged or confidential commercial or financial information" on the CMS-855(A, I, B, R).

- Increase the hourly wage for administrative staff from $20 per hour to $30 per hour in section B.12 (Need and Legal Basis) of the Summary Statement.

- Replace the estimate of 10,000 providers (CMS-855A) and 85,000 suppliers (CMS-855B and CMS-855I) used to create the increase in paperwork burden for the CMS-855(A, B, I, R) with a realistic number of providers and suppliers subject to this proposed information collection. Since providers and suppliers that complete and submit the CMS-855(A, B, I, R) are subject to the changes found in this proposed information collection when they submit an new enrollment, change of information, change of ownership, or revalidation, the paperwork burden associated with this proposed information collection seems low. In addition, as noted above, CMS stated that they would conduct 87,000 revalidations annually in a final rule published on February 2, 2011. Thus, the number of respondents affected by this proposed information collection essentially only accounts for the number of revalidations estimated by CMS. Ideally, CMS would use current enrollment data (i.e., CY 2010 or CY 2011), plus the number of annual revalidations, to estimate the number of respondents subject to the increase in paperwork burden.

- Adjust the paperwork burden estimate found on the CMS-855(A, B, I, R) found in the paperwork burden box to account for the increase in paperwork burden.

Office of Management and Budget
Office of Information and Regulatory Affairs
Attention: CMS Desk Officer
Fax: (202) 395-6974
e-mail: OIRA_submission@omb.eop.gov

Document Identifier: CMS-855(O), CMS-855(S) and CMS-855(A, B, I, R))

I am submitting 18 pages comments and recommendations to the Centers for Medicare & Medicaid Services (CMS) information collection package titled, "CMS-855O, Medicare Enrollment Application for Eligible Ordering and Referring Physicians and Non-Physician Practitioners;" CMS-855S, Medicare Enrollment Application for Durable Medial Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), OMB: 0938-1056; and the CMS-855 (A, B, I, R), OMB: 0938-0685". This submission is in response to the 30-day Paperwork Reduction Act (PRA) information collection request published in Federal Register on May 20, 2011.

Comments on PRA package: CMS-855(O)

I recommend that CMS withdraw and rescind the CMS-855O information collection instrument, begin a new 60 day public comment period, and exclude these changes from any updates to Internet-based Provider Enrollment, Chain and Ownership System (PECOS) until Office of Management and Budget (OMB) approves a subsequent information collection. CMS:

- Does not have statutory or regulatory authority to create an information collection that allows a physician or non-physician practitioner to enroll in the Medicare program for a purpose other than receiving Medicare billing privileges (see 42 CFR 424.500 and 42 CFR 424.505). Moreover, as the May 20, 2011 Federal Register Notice states, "Therefore, if an ordering or referring physician does not participate in the Medicare program, but orders and refers his/her patients to a Medicare provider or supplier for the given ordered or referred service is automatically rejected by the MAC." Thus, if a physician or non-physician practitioner does not participate in Medicare, they must enroll in the Medicare program to participate.

  On May 5, 2010, CMS published Medicare and Medicaid Programs; Changes in Provider and Supplier Enrollment, Ordering and Referring, and Documentation Requirements; and 424.507(a)(iii) states that, "The physician or eligible professional who ordered or referred must have an approved enrollment record or valid opt-out record in the Provider Enrollment, Chain and Ownership System." On February 2, 2011, CMS published a final regulation titled, "Medicare, Medicaid, Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers" and while this final regulation cited the non-existent CMS-855O, CMS did not seek comment on allowing a physician or non-physician practitioner to enroll in the Medicare program for a purpose other than receiving Medicare billing privileges.

- Incorrectly stated in the May 20, 2011 Federal Register Notice that a "The ordering and referring field of the CMS1500 claims submission form requires an ordering or referring physician to have a Medicare Identification Number." With the implementation of the National Provider Identifier on May 23, 2008, certain providers (e.g., home health agencies) and suppliers (e.g., DMEPOS suppliers, independent clinical laboratories, and independent diagnostic testing facilities) are required to include the National Provider Identifier, not a Medicare Identification Number, of an eligible physician or non-physician practitioner in the ordering and referring field of the paper and electronic claim submission forms.

- Incorrectly stated in the May 20, 2011 Federal Register Notice that a MAC automatically rejects a service furnished by a physician that does not participate in the Medicare program. To date, CMS has not implemented a process whereby a MAC, carrier or fiscal intermediary automatically rejects a claim from a physician that is not enrolled in the Medicare program. In fact, the CMS Medicare Provider and Supplier Enrollment web site states, "At this time CMS has not turned on the automated edits that would deny claims for services that were ordered or referred by a physician or other eligible professional simply for lack of an approved file in PECOS. CMS is working diligently to resolve backlog and other systems issues and will provide ample advance notice to the provider and beneficiary communities before CMS begins any such automatic denials. While there are some rumors that the edits will be turned on in January, we want to reiterate that CMS has not announced any date (January 3 or otherwise) as to when ordering/referring edits will be turned on."

- Violated the PRA by modifying the CMS-855I (OMB approval number 0938-0685) and allowing physicians to submit a modified CMS-855I for the sole purpose of ordering and referring (see download titled, "Special Enrollment Fact Sheet for Physicians and with Infrequent Reimbursements" on CMS' Medicare Provider and Supplier Enrollment web site.) **Note**: According to the OMB web site: In complying with the PRA, agencies must ensure that they have OMB approval to implement new or revise existing information collections, prior to their use. Whenever an agency implements a new information collection, or revises an existing collection, without obtaining OMB's approval to do so, it is considered a violation of the PRA.

- Did not modify the PECOS Systems of Records (09-70-0532), which was published in the Federal Register on October 13, 2006, to include the CMS-855O.

- Did not include the use of Internet-based PECOS by physicians and non-physician practitioners in the CMS-855O paperwork burden estimates.

Technical Comments and Recommendations

If OMB decides to approve the revisions to the CMS-855O in lieu of the concerns cited above, then I recommend that CMS:

- Clarify that physicians and non-physician practitioners submit their type 1 National Provider Identifier (NPI) on page 2 and 3 of the CMS-855O. A type 1 NPI is associated with an individual practitioner.

- Revise the sentence under D.1 on page 5 of the CMS-855O to remove the reference "all Federal" in the sentence, "A physician must meet all Federal and State requirements for the type of specialty(s) checked." There are no Federal requirements for physician licensure or specialty designation.

- Revise page 6 (item 1 under Convictions) of the CMS-855O from "The provider, supplier, or owner of the provider or supplier…" to state, "The physician or non-physician practitioner was…" Since the CMS-855 only applies to physicians and non-physician practitioners the form as written is incorrect.

- Delete item 2 and item 3 under "Convictions" from page 6 since CMS does not have statutory or regulatory authority to deny or revoke Medicare billing privileges based on a misdemeanor conviction.

- Revise item 4 and 5 under Convictions from page 6 to delete the term, "or misdemeanor" from the CMS-855O since CMS does not have statutory or regulatory authority to deny or revoke Medicare billing privileges based on misdemeanor conviction.

- Revise item 1 under Convictions on page 6 to delete the phrase, "that CMS has to be detrimental to the best interest of the program and its beneficiaries." Since CMS must make a qualitative judgment regarding whether physician or non-physician practitioner felony conviction is detrimental to the best interest of the Medicare program, a physician or non-physician practitioner should report all felony convictions.

- Delete the reference to the Medicare Identification Number in items 4 and 5 (under Exclusions, Revocation, or Suspension) on page 6 since providers and suppliers submit claims using a National Provider Identifier not a Medicare Identification Number.

- Replace the term, "Medicare law" with "Title XVIII of the Social Security Act (Act)" on page 11 (Certification Statement). Statutory provisions regarding Medicare are found in the Social Security Act.

- Delete the words, "will not knowingly present" in item 6 on page 11 (Certification Statement) since the physician is only ordering or referring the service. Thus, the revised item 6 would read, "I will cause to be presented a false or fraudulent claim for payment by Medicare."

- Remove item 3 from section 15 of the CMS-855O because non-enrolled physicians and non-physician practitioners do not have a statutory or regulatory responsibility to report changes to CMS or its contractor.

- Add Section 1866 of the Social Security Act to the first paragraph found on page 13 of the CMS-855O. On page 13 of the CMS-855O, CMS does not include Section 1866(j)(1)(C) of Social Security Act in the Privacy Act Statement, but contains this statutory citation in the "Supporting Statement for Paperwork Reduction Act Submission".

I would like to recommend the following technical comments and recommendations regarding the "Supporting Statement for Paperwork Reduction Act Submission." I recommend that CMS:

- Review and consider removing the reference to Section 1842(r) of Social Security Act. With the implementation of the National Provider Identifier, this citation may no longer be relevant. If CMS adopts this change, then I recommend that CMS update the Privacy Statement found in the CMS-855O.

- Review and consider removing the reference to Section 1842(u) of Social Security Act since this citation is not relevant to this information collection. If CMS adopts this change, then I recommend that CMS update the Privacy Statement found in the CMS-855O.

- Remove the Social Security Act citations regarding Advanced Diagnostic Imaging Services, Independent Diagnostic Testing Facilities, PPACA, the Tax Increase Prevention and Reconciliation Act of 2005 since these statutory citations are not relevant to this information collection.

- Use the CMS-855I in lieu of the CMS-855O. In item 4 (Duplication and Similar Information) of the Justification section found in "Supporting Statement for Paperwork Reduction Act Submission," CMS states that there is no duplicative information instrument or process. This is not correct. The CMS-855I contains the same information found in this information collection instrument (e.g., the CMS-855O).

- Remove the sentence that states, "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" since this information collection does not have privileged or confidential commercial or financial information.

- Delete the word "Convictions" from the title found in Section 3 of the CMS-855O. Since a conviction is only one type of Final Adverse Action, the word conviction should be removed from the title of section 3.

- Add a new Certification Statement on page 11 that that states, "I further certify that I signature below is mine and that I have not authorized another individual to sign this application on my behalf. I further understand and certify that if I do not sign this application that CMS will return this application to me." This change would reduce the likelihood of office staff signing the enrollment application on behalf a physician or non-physician practitioner.

Comments on PRA package: CMS-855S, Medicare Enrollment Application for Durable Medial Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), OMB: 0938-1056.

I am submitting comments to the CMS information collection package titled, "CMS-855S, Medicare Enrollment Application for Durable Medial Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)." I recommend that CMS rescind and withdraw this information collection instrument for the CMS-855S, begin a new 60 day public comment period for this information collection, and exclude these changes from any updates to Internet-based PECOS until OMB has approved a subsequent information collection for the following reasons. CMS:

- Did not update the CMS-855S to reflect regulatory changes found in the final regulation titled, "Medicare, Medicaid, Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers."

- Did not include changes found in section 3109 of the Patient Protection and Affordable Care Act into this information collection instrument.

- Did not include the paperwork burden associated with the Medicare application fee and/or hardship waiver (see 42 CFR 424.514) or fingerprinting (see 42 CFR 424.518) into this information collection. Moreover, by excluding information regarding the application fee/hardship wavier process, CMS is delaying the processing of enrollment applications submitted by DMEPOS suppliers.

- Did not include the paperwork burden associated to confirm that a provider or supplier is a "Disregarded Entity". This is new requirement found in section 17 of the CMS-855A and CMS-855B.

- Did not include the paperwork burden associated providing the IRS-CP-575 or a copy of the IRS Determination Letter, if the provider or supplier is registered with the IRS as non-profit on the CMS-855S. These are new requirements.

- Did not modify the paperwork burden estimates for this information collection instrument to reflect the use of Internet-based PECOS by DMEPOS suppliers. CMS states that it made Internet-based PECOS available to DEMPOS supplies in October 2010.

- Did not update the paperwork burden estimates for the CMS-855S to reflect the actual application submission statistics using CY 2010 or CY 2011 workloads (initial, changes, revalidations).

- Did not include a summary of changes with 30-day information collection instrument for the CMS-855S on the CMS PRA Listing web site.

- Did not modify the Privacy Act Statement found on page 37 in the CMS-855S to ensure consistency with the PECOS Systems of Records (09-70-0532). Specifically, the PECOS System of Records document does not include the American Medical Association (AMA), State licensing boards, or commercial insurers, health maintenance organizations, multiple employer trust, and other health care groups as routine uses. As such, the AMA, State licensing board, commercial insurers, health maintenance organizations, multiple employer trust, and other health care groups references found in the Privacy Act statement should be removed.

Technical Comments and Recommendations

If OMB decides to approve the revisions to the CMS-855S in lieu of the concerns cited above, then I recommend that CMS:

- Include information into the CMS-855S that provides DMEPOS suppliers information about the Medicare application fee and fingerprint processes (Note: CMS established an application fee process for all DMEPOS suppliers in a final regulation published in the Federal Register on February 2, 2011. By not including information about the application fee in CMS-855S, CMS is "hiding the ball on DMEPOS suppliers" and delaying application processing by the NSC.)

- Delete the bullet "Report the NPI and provide a copy of the NPI notification from the NPI enumerator" found on page 2 (Avoid Delays In Your Enrollment) of the CMS-855S. CMS does not require any other provider or supplier to submit their NPI notification with their enrollment application.

- Delete the check box "Copy of the National Provider Identifier notification that you received from the National Plan and Provider Enumeration System (NPPES) in Section 17 (Supporting Documents) of the CMS-855S. This requirement is no longer necessary and eliminating this requirement will reduce the paperwork burden on DMEPOS suppliers.

- Add a new bullet to page 2 (Avoid Delays In Your Enrollment) of the CMS-855S which states, "Ensure that the legal business name shown in Section 2 matches the name on tax documentation and the National Plan and Provider Enumeration System."

- Add a new bullets to page 2 (Obtaining Medicare Approval) of the CMS-855S which state:

  - "Prior to submitting an enrollment application (CMS-855S or Internet-based PECOS application), obtain a surety bond and/or accreditation, if necessary.
  - "Submit your Medicare application fee or hardship wavier with your initial enrollment application or revalidation submission"

- Add information to page 12 of the CMS-855 to explain when a pharmacy DMEPOS supplier is exempt from accreditation requirements.

- Add a new bullet to page 4 (New Enrollees) of the CMS-855S which states: "Enrolling a practice location which was deactivated due to 12 consecutive months of non-billing (see reactivation below).

- Delete the paragraph on Reactivation on page 4 (Existing Medicare New Enrollees). A DMEPOS supplier that is deactivated must initiate a new enrollment to re-enroll in the Medicare program.

- Revise the check box regarding "reactivation" on page 5 to state, "You are **reactivating** your Medicare Billing Privileges"

- Since CMS does not have statutory or regulatory authority to deny or revoke Medicare billing privileges based on a misdemeanor conviction, I recommend that CMS delete this reference in from items 2, 3, 4, 5 in Section 3 of the CMS-855S

- Revise item 1 in section 3 to delete the phrase, "that CMS has to be detrimental to the best interest of the program and its beneficiaries." This phrase requires the DMEPOS supplier to qualitative

judgment regarding whether physician or non-physician practitioner felony conviction is detrimental to the best interest of the Medicare program. CMS or its contractor should make this qualitative determination.

- Delete the reference to the Medicare Identification Number in section 3 of the CMS-855S (under Exclusions, Revocation, or Suspension"). CMS requires DMEPOS suppliers submit claims using the National Provider Identifier not a Medicare Identification Number.

- Replace that the term, "Medicare law" with "Title XVIII of the Social Security Act (Act)" in the section 15 (Certification Statement).

- Add "disregarded entity" and "government owned entity" to page 12 (Organizational Structure) of the CMS-855S.

- Add "Expiration Date of Current Surety Bond (mm/dd/yyyy)" to Section 12 C on page 26 of the CMS-855S.

- Add the first two paragraphs found on page 2 of the CMS-855B to the "Billing Number Information" found in the CMS-855S. This change will clarify which NPI should be submitted by a health care provider.

- Add information to the "Billing Number Information" section of the CMS-855S to state that DMEPOS suppliers must have a separate NPI for each practice location unless the supplier is a sole proprietorship.

- Delete the word, "Convictions" from the check box titled, "Final Adverse Action/Convictions" on page 6 (section 1.B) of the CMS-855S. This change would ensure consistency with Section 3 of the CMS-855S. Moreover, a "conviction" is considered a "Final Adverse Action."

- Add a new statement to the CMS-855S Certification Statement to address the concept of nominee owners and responsible parties. The Internal Revenue Service (IRS) has become aware that nominee individuals are being listed as principal officers, general partners, grantors, owners, and trustors in the Employer Identification Number (EIN) application process. A nominee is not one of these people. Rather, nominees are temporarily authorized to act on behalf of entities during the formation process. The use of nominees in the EIN application process prevents the IRS from gathering appropriate information on entity ownership, and has been found to facilitate tax non-compliance by entities and their owners.

  A "nominee" is someone who is given limited authority to act on behalf of an entity, usually for a limited period of time, and usually during the formation of the entity. The "principal officer, general partner," etc., as defined by the IRS, is the true "responsible party" for the entity, instead of a nominee. The "responsible party" is the individual or entity that controls, manages, or directs the entity and the disposition of the entity's funds and assets, unlike a nominee, who is given little or no authority over the entity's assets.

The IRS does not authorize the use of nominees to obtain EINs. All EIN applications (mail, fax, phone, electronic) must disclose the name and Taxpayer Identification Number (SSN, ITIN, or EIN) of the true principal officer, general partner, grantor, owner or trustor. This individual or entity, which the IRS will call the "responsible party," controls, manages, or directs the applicant entity and the disposition of its funds and assets.

The IRS defines a "nominee owner as follows:

For entities with shares or interests traded on a public exchange, or which are registered with the Securities and Exchange Commission, "responsible party" is (a) the principal officer, if the business is a corporation, (b) a general partner, if a partnership, (c) the owner of an entity that is disregarded as separate from its owner (disregarded entities owned by a corporation enter the corporation's name and EIN), or (d) a grantor, owner, or trustor if a trust.

For all other entities, "responsible party" is the person who has a level of control over, or entitlement to, the funds or assets in the entity that, as a practical matter, enables the individual, directly or indirectly, to control, manage or direct the entity and the disposition of its funds and assets. The ability to fund the entity or the entitlement to the property of the entity alone, however, without any corresponding authority to control, manage, or direct the entity (such as in the case of a minor child beneficiary), does not cause the individual to be a responsible party.

- Align the meaning of provider enrollment terms found under "Existing Medicare DMEPOS Suppliers" on page 4 with the "Reason for Application Submission" on pages 5 and 6 of the CMS-855S so that the information is presented in the following manner:

    - New Enrollee
    - Adding a New Business Location
    - Changing Your Medicare Information
    - Reactivation
    - Voluntarily Termination
    - Revalidation

- Change term "reenrollment" on page 4 and 5 of the CMS-855S to "revalidation". This change is consistent with Federal Regulations published by CMS on February 2, 2011 where CMS changed the term "reenrollment" to "revalidation" for suppliers of DMEPOS.

- Replace the word, "reenroll" found in the explanation for "Revalidation" on page 4 of the CMS-855S with word, "revalidate".

- Change the sentence "You are revalidating your Medicare enrollment" on page 5 of the CMS-855S to "CMS or the NSC requested a revalidation." This change will create less confusion for the public and help the NSC determine when a provider or supplier is actually revalidating its enrollment information rather than making a voluntary submission.

- Delete the word "Convictions" from the title found in Section 3 of the CMS-855S. Since a conviction is only one type of Final Adverse Action, the word conviction should be removed from the title of section 3.

- Revise and consolidate the information found on page 1 and 4 of the CMS-855S regarding who should submit the CMS-855S. By revising and consolidating the information found on page 1 and 4 of the CMS-855S, CMS will remove at least a half-page of text from this document.

- Delete or replace the statements found on page 3 (ADDITIONAL INFORMATION) of the CMS-855S that states, "The information you provide on this application will not be shared. It is protected under …." with "The information you provide will only be disclosed according to the routine uses found in the Privacy Act Statement of this form." As written, the statement that "The information you provide on this application will not be shared." is incorrect or misleading.

- Delete the word "always" in item A.5 (Small Business) of the Supporting Statement Justification for CMS-855S. The word "always" is incorrect since CMS begin to use the CMS-855 family of forms until the mid-1990s.

- Delete the last bullet on page 6 of CMS-855S Supporting Statement. The last bullet states, "As a courtesy, Medicare produces the "Medicare Physician and Healthcare Provider Directory". Beneficiary feedback has asked that Medicare indicate if the Physicians are accepting new patients in this directory." While beneficiaries may have asked CMS to collect this information in CMS-855I, it is doubtful that beneficiaries asking CMS to indicate if a physician is accepting new patients in the CMS-855S.

Comments on PRA package: CMS-855 (A, B, I, R), OMB: 0938-0685)

I am submitting comments to the CMS information collection package titled, "CMS-855(A, B, I, R)."

I recommend that CMS rescind and withdraw this paperwork reduction act package for the CMS-855(A, B, I, R), begin a new 60 day public comment period for this information collection, and exclude these changes from any updates to Internet-based PECOS until OMB has approved a subsequent information for the following reasons. CMS:

- Did not update the CMS-855A and CMS-855B to reflect regulatory changes found in the following regulations:

    - Medicare, Medicaid, Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers,

    - Hospital Inpatient Prospective Payment System published on August 16, 2010,

    - Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2011, and

- Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2011; Changes in Certification Requirements for Home Health Agencies and Hospices; Final Rule.

- Did not publish regulations associated with section 6001 of the PPACA, but added two new attachments and definition for "immediate family member" into the CMS-855A. In order for CMS to establish a new definition on the CMS-855A, CMS should proposed a regulation and request comments.

- Did not publish federal regulations that require Medicare providers and suppliers to comply with Section 511 of the Tax Increase Prevention and Reconciliation Act of 2005.

- Did not modify the Privacy Act Statement found in the CMS-855(A, I, B, R) to ensure consistency with the PECOS Systems of Records (09-70-0532), which was published in the Federal Register on October 13, 2006. Specifically, the PECOS System of Records document does not include the American Medical Association (AMA), State licensing boards, or commercial insurers, health maintenance organizations, multiple employer trust, and other health care groups as routine uses. As such, the AMA, State licensing board, commercial insurers, health maintenance organizations, multiple employer trust, and other health care groups references found in the Privacy Act statement should be removed.

- Did not modify the PECOS Systems of Record Document to reflect the types of information that could be published on the official CMS Internet site (see pages 53 and 56 of the CMS-855A.)

- Did not include the paperwork burden associated Medicare application fee and/or hardship waiver (see 42 CFR 424.514) or fingerprinting (see 42 CFR 424.518.) By excluding information regarding the application fee/hardship wavier process, CMS is delaying the processing of enrollment applications submitted by providers and suppliers.

- Did not modify the paperwork burden estimates for the CMS-855A, CMS-855B, CMS-855I, and CMS-855R to reflect the use of Internet-based PECOS by providers and suppliers.

- Did not include the paperwork burden associated providing the IRS-CP-575 or a copy of the IRS Determination Letter, if the provider or supplier is registered with the IRS as non-profit on the CMS-855A, CMS-855B, CMS-855I. These are new requirements.

- Delete or replace the statements found in the ADDITIONAL INFORMATION section of the CMS-855A, CMS-855B, CMS-855I and CMS-855R that states, "The information you provide on this application will not be shared. It is protected under …." with "The information you provide will only be disclosed according to the routine uses found in the Privacy Act Statement." As written the statement that "The information you provide on this application will not be shared." is incorrect or misleading.

- Did not include a summary of changes with 30-day information collection instrument found on the CMS web site for the CMS-855A, CMS-855B, CMS-855I, and CMS-855R.

- Did not update the burden estimates for the CMS-855A, CMS-855B, CMS-855I, and CMS-855R to reflect the actual application submission statistics using CY 2010 or CY 2011 workloads. Also, with the publication of "Medicare, Medicaid, Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers" on February 2, 2011, CMS stated that it would revalidate 87,000 providers and suppliers annually.

- May have incorporated changes to the 30 day information collection instrument that did not come from the public. (See Item 15 of the "Supporting Statement for Paperwork Reduction Act Submission" which states that there were no comments that altered the information collection estimate. CMS did not include any public comments for the CMS-855A, CMS-855B, CMS-855I, and CMS-855R and/or CMS responses on its PRA web site. Attachment 1 contains a list of changes incorporated by CMS in the 30 day information collection instrument package that were not made as a result of public comment.

- Did not include information on the application fee its Medicare Provider Enrollment web site. Note: On February 2, 2011, CMS published a final regulation titled, "Medicare, Medicaid, Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers." CMS stated on page 5911 of this final rule that it would make information available about the Medicare application fee through our Web site, listservs, open door forums, and other communication methods." CMS did not include information regarding the application fee on its Medicare provider and supplier enrollment web site. Thus, newly enrolling providers and suppliers do not have any advance notice that an application fee is required.

- Did not provide the public with 60 days to review the changes proposed in this information collection. While CMS published the 60-day Notice in the Federal Register on March 11, 2011, CMS did not place the information collection for the CMS-855 (A, B, I, R) on CMS web site until April 18, 2011. In addition, while CMS published the 30-day Notice in Federal Register on May 20, 2011, CMS did not place the information collection for the CMS-855(A, B, I, R) on CMS web site until May 27, 2011. Accordingly, by limiting the public comment period associated with this information collection instrument during the 60-day and 30-day public comment periods, CMS violated the policies associated with the PRA and the Administration's goal of establishing a more transparency government.

Technical Comments and Recommendations

If OMB decides to approve the revisions to the CMS-855A, CMS-855B, CMS-855I, and CMS-855R in lieu of the concerns cited above, then I recommend that CMS:

- Include information into the CMS-855A and CMS-855B about the Medicare application fee and fingerprint process (Note: CMS established an application fee process for all providers and suppliers completing the CMS-855B except medical groups/clinics in a regulation published in the Federal Register on February 2, 2011. By not including information about the application fee in CMS-855A

and CMS-855B, CMS is "hiding the ball on providers and suppliers and delaying application processing by its contractors.)

- Add information to Section 17 of the CMS-855A and CMS-855B to remind providers and suppliers, as applicable, to submit the Medicare application fee and hardship waiver process with the initial enrollment application or revalidation package;

- Add information to Section 17 of the CMS-855A to remind owners of a home health agency to submit their fingerprints and capitalization information with their initial enrollment application.

- Remove Advance Diagnostic Imaging (ADI) from Section 2 A of the CMS-855B since ADI is not a supplier type, but rather a type of service furnished in a physician's office, clinic or an independent diagnostic testing facility.

- Revise the bullet "Ensure that the legal business name shown in Section 2 matches the name on tax documentation" found on page 2 (Avoid Delays In Your Enrollment) of the CMS-855A and CMS-855B to "Ensure that the legal business name shown in Section 2 matches the name on tax documentation and the National Plan and Provider Enumeration System"

- Delete the supplier type "Part B Drug Vendor" from page 1 (Who Should Submit This Application" of the CMS-855B, or add "Part B Drug Vendor" to page 8 (Type of Supplier, in Section 2.A." Since CMS discontinued the Part B Drug Vendor program in prior to January 1, 2009, I recommend deleting the supplier type "Part B Drug Vendor" from page 1 (Who Should Submit This Application) of the CMS-855B.

- Delete the provider type "Indian Health Service Facility" from page 1 (Who Should Submit This Application" of the CMS-855A and delete the "Indian Health Services Facility" from page 10 (Type of Supplier, in Section 2.A.1)" Since an Indian Health Service Facility is place where services are being furnished, rather than eligible Part A facility (e.g., hospital, home health agency (see 42 CFR 400.202 for the definition of a provider), CMS should delete the reference to "Indian Health Service Facility" from pages 1 and 10 of the CMS-855A. Moreover, CMS can determine whether a provider is enrolling as a provider associated with the Indian Health Service based on the new question on page 11 which states, "Is this provider an Indian Health Facility enrolling with TrailBlazer Health Enterprises." It is also important to note that CMS does not include a reference to an "Indian Health Service Facility" as supplier type on from page 1 (Who Should Submit This Application" of the CMS-855B or page 10 (Type of Supplier, in Section 2.A)"

- Add "disregarded entity" and "government owned entity" to section 2.B.1 of the CMS-855A and CMS-855B.

- Add the first two paragraphs found on page 2 of the CMS-855B to the "Billing Number Information" found in the CMS-855A. This change will clarify which NPI should be submitted by a health care provider.

- Correct a spelling error "Proprietaryship" on page 8 of the CMS-855B.

- Delete the reference in Section 3 regarding misdemeanor conviction from items 2, 3, 4, 5 of the CMS-855A, CMS-855B, and CMS-855I because CMS does not have statutory or regulatory authority to deny or revoke Medicare billing privileges based on a misdemeanor conviction.

- Revise Section 3 of the CMS-855B to ensure consistency with provider enrollment changes adopted by CMS in federal regulations titled, "Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2011. This change is needed to clarify that air ambulance suppliers have a distinct responsibility to report that their FAA license has been revoked or suspended.

- Revise item 4 under "Exclusion, Revocation, or Suspensions" in Section 3 of the CMS-855A, CMS-855B, and CMS-855I to state, "Any Medicare payment suspension."

- Revise item 5 under "Exclusion, Revocation, or Suspensions" in Section 3 of the CMS-855A, CMS-855B, and CMS-855I to state, "Any Medicare revocation." It is not necessary to add, "of any Medicare billing number."

- Revise item 1 in section 3 of the CMS-855A, CMS-855B, and CMS-855I to delete the phrase, "that CMS has to be detrimental to the best interest of the program and its beneficiaries" since CMS or its contractor must make a qualitative judgment regarding whether physician or non-physician practitioner felony conviction is detrimental to the best interest of the Medicare program

- Delete the reference to the Medicare Identification Number in section 3 of the CMS-855A, CMS-855B, and CMS-855I (under Exclusions, Revocation, or Suspension") since providers and suppliers submit claims using a National Provider Identifier not a Medicare Identification Number.

- Add information for individual physicians to indicate that they do not have a practice location, but rather "conduct house calls to Medicare beneficiaries."

- Revise item 2 in the section titled, "Obtaining Medicare Approval" on page 2 of the CMS-855A to state, "The fee-for-service contractor will review and conduct and initial assessment of the application and either recommend the application for approval to the CMS Regional Office or deny the application. This change is consistent with revisions made to the "Effective Date of Provider Agreements and Supplier Approvals" found in the Hospital Inpatient Prospective Payment System published on August 16, 2010.

- Revise the first sentence in item 3 in the section titled, "Obtaining Medicare Approval" on page 2 of the CMS-855A to state, "The State agency or approved accreditation organization conducts the Survey."

- Add a new item 4 in the section titled, "Obtaining Medicare Approval" on page 2 of the CMS-855A to state, "A CMS contractor conducts a second contractor review, as needed, to verify that a provider continues to meet the enrollment requirements prior to the issuance of a Medicare billing privileges." This change is consistent with revisions made to the "Effective Date of Provider Agreements and Supplier Approvals" found in the Hospital Inpatient Prospective Payment System published on August 16, 2010.

- Add a new bullet to page 4 (New Enrollees) of the CMS-855A and page 3 (New Enrollees) of the CMS-855B which states, "Enrolling a practice location which was deactivated due to 12 consecutive months of non-billing (see reactivation below."

- Delete the paragraph on Reactivation on page 4 (Existing Medicare New Enrollees) for the CMS-855A and page 3 (Existing Medicare New Enrollees) on the CMS-855B. A provider or supplier that is deactivated must initiate a new enrollment to re-enroll in the Medicare program.

- Add a new statement to the CMS-855A and CMS-855B Certification Statements to address the concept of nominee owners and responsible parties (see page 9 of this document for additional information about nominee owners and responsible parties.)

- Verify that the information found in the Privacy Act statement of the CMS-855A, CMS-855B, CMS-855I, and CMS-855R is consistent with PECOS Systems of Records document.

- Revise the first sentence in section 3 of the CMS-855A to add the word, "final" before adverse action. This change is consistent with the other forms and the term found in 424.502. regulatory definition for adverse verify that the information found in the Privacy Act statement of the CMS-855A, CMS-855B, CMS-855I, and CMS-855R is consistent with PECOS Systems of Records document.

- Change sentence "You are revalidating your Medicare enrollment" on page 7 of the CMS-855A, page 5 of the CMS-855B, and page 4 of the CMS-855I to "CMS or its contractor requested a revalidation." This change is consistent with information found earlier in the respective forms on revalidation (for example, on page 5 of the CMS-855A that the fee-for-service contractor will notify you when it is time for you to revalidate your enrollment information.) In addition, this change will create less confusion for the public and help CMS' contractors determine when a provider or supplier is actually revalidating its enrollment information rather than making a voluntary submission.

- Revise the check box on page 8 of the CMS-855B from "Ambulatory Surgical Center Clinic/Group Practice" to "Ambulatory Surgical Center".

- Replace the word, "local" with "designated" in the last sentence of page 9 of the CMS-855B. This is change is consistent with terminology that CMS uses on page 2 when referring to the designated Medicare fee-for-service contractor.

- Ensure that all accreditation information requests in consecutive order. In the CMS-855B, CMS request information for ASC accreditation in section 2F and ADI accreditation information in 2H. Section 2G collects information about the termination of Physician Assistants. To improve the readability of this form and reduce submission errors by suppliers, I recommend that all request for accreditation information be group together.

- Revise the title of Section 6B on the CMS-855B from "Final Adverse History" to "Final Adverse Action History". This change is consistent with the regulations found at 42 CFR 424.502.

- Revise the question on page 5 of the CMS-855I regarding "New Patient Status Information" from "Do you accept new patients" to "Are you accepting new Medicare patients"

- Revise the form name for the CMS-588 on page 14 of the CMS-855I from, "(Electronic Funds Transfer Authorized Agreement)" to "(Electronic Funds Transfer Authorization Agreement)." This change is consistent with the title of the CMS-588.

- Delete the check box found in Section 17 of the CMS-855B to remove "Complete Form(s) CMS-855R, Reassignment of Medicare Benefits, since the CMS-855R is only applicable to individual practitioners not organization entities.

- Clarify in Section 17 of the CMS-855B that the CMS-460 only applies to Multi-Specialty Clinics completing the CMS-855B.

- Clarify in Section 17 of the CMS-855B that the CMS-460 must be submitted by a Multi-Specialty Clinic at the time of initial enrollment or reactivation to establish the clinic as a participating practitioner in Medicare.

- Clarify in Section 17 of the CMS-855I that the CMS-460 must be submitted by physician at the time of initial enrollment or reactivation to establish the clinic as a participating practitioner in Medicare.

- Delete the reference to the CMS-460 in Section 17 of the CMS-855R because a physician reassigning his or her payments to a clinic/group practice will be participating or non-participating based on the participation status of the clinic or group.

- Standardize the statements found in the section 15 (Certification Statement) for the CMS-855A, CMS-855B, and CMS-855I. The statements found in section 15 of each Medicare application should be in a consistent order, and to the extent practical, contain the same information.

- Add a new check box to "Mandatory For Selected Provider/Supplier Types" section found in the section 15 (Certification Statement) of the CMS-855B the following, "Copy(s) of all documentation verifying the state licenses or certifications of the laboratory director or non-physician practitioner personnel of an independent clinical laboratory."

- Change the sentence "You are revalidating your Medicare enrollment" in section 1A of the CMS-855A, CMS-855B, and CMS-855I to "The Medicare contractor requested a revalidation." This change will create less confusion for the public and help the NSC determine when a provider or supplier is actually revalidating its enrollment information rather than making a voluntary submission.

- Change the "Reason for Submission" section 1A of the CMS-855A, CMS-855B, and CMS-855I from "You are a new enrollee in Medicare" to "You are a new enrollee or you are voluntarily

updating your enrollment information with Medicare for the first time in more than 5 years." Since there are thousands of providers and suppliers enrolled in Medicare, but who have not submitted the CMS-855 form in more than 5 years, I believe that this change will clarify why the application is being submitted.

- Revise section 15, item 5 of CMS-855I from "Neither I, no any managing employee list in this application, is currently …" to "I am not currently …" Since the CMS-855I does not collect information about a managing employee, this statement seems to be incorrect.

- Delete the word "Convictions" from the title found in Section 3 of the CMS-855A, CMS-855B, and CMS-855I. Since a conviction is only one type of Final Adverse Action, the word conviction should be removed from the title of section 3.

- Add the statement "The address must be a specific street address as recorded by the United States Postal Service. A practice location must be the physical location where you furnish services. This address cannot be P.O. Box." to from section 4A of the CMS-855A, CMS-855B, and CMS-855I. The statement above is similar to the language found in section 4A of the CMS-855S.

- Add a new Certification Statement on page 11 of the CMS-855I that that states, "I certify that the signature below is mine and that I have not authorized another individual to sign this application on my behalf. I understand and certify that if I do not sign this application that CMS will return this application to me and that the Medicare contractor will not preserve my application date." This change would reduce the likelihood of office staff signing the enrollment application on behalf a physician or non-physician practitioner.

- Remove the list of Independent Diagnostic Testing Facility (IDTF) performance standards found on pages 39 and 40 of the CMS-855B and refer IDTFs to a CMS' web site to obtain a list of the performance standards that apply to them. This change reduces the number of pages contained the CMS-855B and is consistent with CMS' decision to remove the DMEPOS supplier standards from page 36 the CMS-855S (Note: CMS replaced the list of DMEPOS supplier standards on page 36 of the CMS-855 by referring DMEPOS suppliers to a CMS' web site.) Alternatively, add the list of DMEPOS supplier standards back to the CMS-855S. This recommendation will ensure consistency throughout the Medicare enrollment applications.

- Align the meaning of provider enrollment terms found under "Enrolled Medicare Suppliers" on page 3 with the "Reason for Application Submission" on pages 4 and 5 of the CMS-855B, so that information is presented in the following manner in both sections:

    - New Enrollee
    - Reactivation
    - Change of Ownership
    - Changing Your Medicare Information
    - Enrolling in another fee-for-service contractor's justification
    - Revalidation
    - Voluntarily Termination

- Explain what is meant by the check box "enrolling in another fee-for-service contractor's jurisdiction" found page 4 on page 3 of the CMS-855B.

- Align the meaning of provider enrollment terms found under "Enrolled Medicare Suppliers" on page 4 and 5 with the "Reason for Application Submission" on pages 6 and 7 of the CMS-855A, so that information is presented in the following manner in both sections:

    - New Enrollee
    - Reactivation
    - Change of Ownership
    - Acquisition or Merger
    - Consolidation
    - Changing Your Medicare Information
    - Revalidation
    - Voluntarily Termination

- Replace the explanation for the term "Reactivation" on page 4 of the CMS-855A and page 3 of the CMS-855B with the explanation for the term, "Reactivation" found on page 4 of the CMS-855S. The definition found in the CMS-855S is clearer and more meaningful than the explanations found in the CMS-855A and CMS-855B.

- Delete the word, "hospital" found in the explanation for "Change of Ownership" on page 3 of the CMS-855B. A "hospital" is not a supplier who would complete the CMS-855B.

- Delete the word, "hospital" from the "Change of Ownership" check box found on page 6 of the CMS-855B. A "hospital" is not a supplier who would complete the CMS-855B.

- Replace the explanation for "Change of Ownership" on page 3 of the CMS-855B with the explanation of "Change of Ownership" on page 4 of the CMS-855A. The information on the CMS-855A is clearer.

- Correct and modify the explanation for "Change of Ownership" on page 4 and "Change of Information" on page 5 of the CMS-855A to reflect changes adopted by CMS in Federal Regulations published n November 17, 2010 and titled, "Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2011; Changes in Certification Requirements for Home Health Agencies and Hospices; Final Rule. In the aforementioned Final Rule, CMS established a definition for Change in Majority Ownership for Home Health Agencies (see 42 CFR 424.502) and established prohibitions on the sale or transfer of billing privileges for home health agencies in 42 CFR 424.550.

- Replace the term, "Adverse Legal Action/Convictions" on page 8 (section 1.B) of the CMS-855A with "Final Adverse Action". This change would ensure consistency with Section 3 of the CMS-855A and Federal Regulations found at 42 CFR 424.502. Moreover, a conviction is a type of "Adverse Legal Action."

- Delete the word, “Convictions” from the check box titled, “Final Adverse Action/Convictions” on page 6 (section 1.B) of the CMS-855B and page 4 (section 1.B) of the CMS-855I. This change would ensure consistency with Section 3 of the CMS-855B and CMS-855I. Moreover, a “conviction” is considered a “Final Adverse Action.”

- Replace the term, “Final Adverse Legal History” with “Final Adverse Action” on page 32 (section 5.B) of the CMS-855A. Replace the term, “Final Adverse Legal Action” with “Final Adverse Action” in the table on page 32 (section 5.B) of the CMS-855A. This change would ensure consistency with Section 3 of the CMS-855A and Federal Regulations found at 42 CFR 424.502.

- Replace the term, “Final Adverse Legal History” with “Final Adverse Action” on page 23 (section 5.B) of the CMS-855B. This change would ensure consistency with Section 3 of the CMS-855A and Federal Regulations found at 42 CFR 424.502.

- Replace the term, “Adverse Legal History” with “Final Adverse Action” on page 33 (section 6.B) of the CMS-855A and page 25 of the CMS-855B. This change would ensure consistency with Section 3 of the CMS-855A and Federal Regulations found at 42 CFR 424.502.

- Remove the paragraph regarding “Non-Profit, Charitable or Religious Organization from page 24 of the CMS-855B and add this information to Section 17 of the CMS-855B because CMS is requesting supporting documentation (e.g., the 501(c)(3)).

- Delete the sentence on page 21 of the CMS-855B that states, “Each non-profit organization should submit a copy of a 501(c)(3) document verifying its non-profit status.”

- Delete the reference to section 3109 of PPACA from section B.1 of the Supporting Statement for the Medicare enrollment application with the OMB control number 0938-0685. The reference to section 3109 of PPACA refers to pharmacies enrolling in the Medicare program using the CMS-855S.

- Clarify Section B.1 to of the Supporting Statement for the Medicare enrollment application with the OMB control number 0938-0685 to indicate that Section 6401 of PPACA modified Section 1866 of the Social Security Act.