DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS-1500/1490S, CMS-10221, CMS-10237, CMS-R-5, CMS-10224 and CMS-287-19]

Agency Information Collection Activities: Proposed Collection; Comment Request

AGENCY: Centers for Medicare & Medicaid Services, HHS.

ACTION: Notice.

SUMMARY: The Centers for Medicare & Medicaid Services (CMS) is announcing an opportunity for the public to comment on CMS' intention to collect information from the public. Under the Paperwork Reduction Act of 1995 (the PRA), federal agencies are required to publish notice in the *Federal Register* concerning each proposed collection of information (including each proposed extension or reinstatement of an existing collection of information) and to allow 60 days for public comment on the proposed action. Interested persons are invited to send comments regarding our burden estimates or any other aspect of this collection of information, including the necessity and utility of the proposed information collection for the proper performance of the agency's functions, the accuracy of the estimated burden, ways to enhance the quality, utility, and clarity of the information to be collected, and the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

DATES: Comments must be received by **[INSERT DATE 60 DAYS AFTER THE DATE OF PUBLICATION IN THE FEDERAL REGISTER]**.

ADDRESSES: When commenting, please reference the document identifier or OMB control number. To be assured consideration, comments and recommendations must be submitted in any one of the following ways:

1. *Electronically.* You may send your comments electronically to http://www.regulations.gov. Follow the instructions for "Comment or Submission" or "More Search Options" to find the information collection document(s) that are accepting comments.

2. *By regular mail.* You may mail written comments to the following address:

CMS, Office of Strategic Operations and Regulatory Affairs

Division of Regulations Development

Attention: Document Identifier/OMB Control Number _____

Room C4-26-05

7500 Security Boulevard

Baltimore, Maryland 21244-1850.

To obtain copies of a supporting statement and any related forms for the proposed collection(s) summarized in this notice, you may make your request using one of following:

1. Access CMS' Web Site address at Web Site address at https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing.html
2. E-mail your request, including your address, phone number, OMB number, and CMS document identifier, to Paperwork@cms.hhs.gov.
3. Call the Reports Clearance Office at (410) 786-1326.

FOR FURTHER INFORMATION CONTACT: William N. Parham at (410) 786-4669.

SUPPLEMENTARY INFORMATION:

Contents

This notice sets out a summary of the use and burden associated with the following information collections. More detailed information can be found in each collection's supporting statement and associated materials (see **ADDRESSES**).

CMS-1500/1490S Health Insurance Common Claims Form

CMS-10221 Independent Diagnostic Testing Facilities (IDTFs) Site Investigation Form Revisions

CMS-10237 Applications for Part C Medicare Advantage, 1876 Cost Plans, and Employer Group Waiver Plans to Provide Part C Benefits

CMS-R-5 Physician Certifications/Recertification's in Skilled Nursing Facilities Manual Instructions

CMS-10224 Healthcare Common Procedure Coding System (HCPCS) - Level II Code Modification Request Process

CMS-287-19 Home Office Cost Statement

Under the PRA (44 U.S.C. 3501-3520), federal agencies must obtain approval from the Office of Management and Budget (OMB) for each collection of information they conduct or sponsor. The term "collection of information" is defined in 44 U.S.C. 3502(3) and 5 CFR 1320.3(c) and includes agency requests or requirements that members of the public submit reports, keep records, or provide information to a third party. Section 3506(c)(2)(A) of the PRA requires federal agencies to publish a 60-day notice in the Federal Register concerning each proposed collection of information, including each proposed extension or reinstatement of an existing collection of information, before submitting the collection to OMB for approval. To comply with this requirement, CMS is publishing this notice.

Information Collection

1. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Health Insurance Common Claims Form and Supporting Regulations at 42 CFR Part 424, Subpart C (CMS-1500 and CMS-1490S); *Use:* The CMS-1500 and the CMS-1490S forms are used to deliver information to CMS in order for CMS to reimburse for

provided services. Medicare Administrative Contractors use the data collected on the CMS-1500 and the CMS-1490S to determine the proper amount of reimbursement for Part B medical and other health services (as listed in section 1861(s) of the Social Security Act) provided by physicians and suppliers to beneficiaries. The CMS-1500 is submitted by physicians/suppliers for all Part B Medicare. Serving as a common claim form, the CMS-1500 can be used by other third-party payers (commercial and nonprofit health insurers) and other Federal programs (e.g., TRICARE, RRB, and Medicaid). The CMS-1490S (Patient's Request for Medical Payment) was explicitly developed for easy use by beneficiaries who file their own claims. *Form Number*: CMS-1500/1490S (OMB control number: 0938-1197); *Frequency*: Yearly; *Affected Public:* State, Local, or Tribal Governments; *Number of Respondents:* 2,029,505; *Total Annual Responses:* 1,033,839,906; *Total Annual Hours:* 18,847,500. (For policy questions regarding this collection contact Charlene Parks at 410-786-8684.)

2. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Independent Diagnostic Testing Facilities (IDTFs) Site Investigation Form Revisions; *Use*: The data collection is used by Medicare contractors and/or their subcontractors on site visits to verify compliance with required IDTF performance standards. If a subcontractor is used, the subcontractor collects the information from the IDTF through an interview and forwards it to the Medicare contractor for evaluation. The collection and verification of this information defends and protects our beneficiaries from illegitimate IDTFs. These procedures also protect the Medicare Trust Fund against fraud. The data collected also ensures that the applicant has the necessary credentials to provide the health care services for which they intend to bill Medicare. *Form Number*: CMS-10221 (OMB control number: 0938-1029); *Frequency*: Occasionally; *Affected Public*: Private Sector (Business or other for-profit and Not-for-profit institutions); *Number of Respondents*: 727; *Total Annual Responses*: 727; *Total Annual Hours*: 1,454. (For policy questions regarding this collection contact Kimberly McPhillips at 410-786-5374.)

3. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Applications for Part C Medicare Advantage, 1876 Cost Plans, and Employer Group Waiver Plans to Provide Part C Benefits; *Use*: This information collection includes the process for organizations wishing to provide healthcare services under MA plans. These organizations must complete an application annually (if required), file a bid, and receive final approval from CMS. The MA application process has two options for applicants that include (1) request for new MA product or (2) request for expanding the service area of an existing product. CMS utilizes the application process as the means to review, assess and determine if applicants are compliant with the current requirements for participation in the MA program and to make a decision related to contract award. This collection process is the only mechanism for organizations to complete the required MA application process. The application process is open to all health plans that want to participate in the MA program. The application is distinct and separate from the bid process, and CMS issues a determination on the application prior to bid submissions, or before the first Monday in June.

Collection of this information is mandated by the Code of Federal Regulations, MMA, and CMS regulations at 42 CFR 422, subpart K, in "Application Procedures and Contracts for Medicare Advantage Organizations." In addition, the Medicare Improvement for Patients and Providers Act of 2008 (MIPPA) further amended titles XVII and XIX of the Social Security Act. *Form Number*: CMS-10237 (OMB control number: 0938-0935); *Frequency*: Occasionally; *Affected Public*: Private Sector (Business or other for-profit and Not-for-profit institutions); *Number of Respondents*: 435; *Total Annual Responses*: 435; *Total Annual Hours*: 6,754. (For policy questions regarding this collection contact Keith Penn-Jones at 410-786-3104.)

4. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Physician Certifications/Recertifications in Skilled Nursing Facilities Manual Instructions; *Use*: Section 1814(a) of the Social Security Act (the Act) requires

specific certifications in order for Medicare payments to be made for certain services. Before the enactment of the Omnibus Budget Reconciliation Act of 1989 (OBRA1989, Public Law 101-239), section 1814(a)(2) of the Act required that, in the case of post-hospital extended care services, a physician certify that the services are or were required to be given because the individual needs or needed, on a daily basis, skilled nursing care (provided directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitation services that, as a practical matter, can only be provided in a SNF on an inpatient basis. The physician certification requirements were included in the law to ensure that patients require a level of care that is covered by the Medicare program and because the physician is a key figure in determining the utilization of health services. In addition, it set forth qualification requirements that a nurse practitioner or clinical nurse specialist must meet in order to sign certification or recertification statements (these requirements were later revised in the Balanced Budget Act of 1997). Effective with items and services furnished on or after January 1, 2011, section 3108 of the Affordable Care Act added physician assistants to the existing authority for nurse practitioners and clinical nurse specialists. Regulations implementing this provision were promulgated in the calendar year (CY) 2011 Medicare Physician Fee Schedule (MPFS) final rule with comment period (75 FR 73387, 73602, 73626-27, November 29, 2010). The requirements at 42 CFR 424.20(a) and (b) concern the initial certification of a beneficiary's need for a SNF level of care, which must be made upon admission or as soon thereafter as is reasonable and practicable. The requirements at 42 CFR 424.20(c) and (d) concern recertification of a beneficiary's need for continued SNF level of care, and also require an estimate of the time the individual will need to remain in the SNF, plans for home treatment, and, if appropriate, whether continued services are needed for a condition that occurred after admission to the SNF and while still receiving treatment for the condition for which he or she had received inpatient hospital services. These sections require

recertification at specific intervals (the initial recertification must occur no later than the 14th day of SNF care, with subsequent recertification at least every 30 days thereafter) that posthospital SNF care is or was required because the individual needs or needed skilled care on a daily basis. The following CMS Internet-Only Manuals provide more detailed instructions regarding the required certification and recertification of covered post-hospital extended care services for a Medicare beneficiary: chapter 4, sections 40ff and 80 in the Medicare General Information, Eligibility, and Entitlement Manual (CMS Pub. 100-01), chapter 8, sections 40ff. in the Medicare Benefit Policy Manual (CMS Pub. 100-02), and chapter 6, section 6.3 in the Medicare Program Integrity Manual (CMS Pub. 100-08). *Form Number*: CMS-R-5 (OMB control number: 0938-0454); *Frequency*: Occasionally; *Affected Public*: Private Sector (Not-for-profit institutions); *Number of Respondents*: 2,746,550; *Total Annual Responses*: 2,746,550; *Total Annual Hours*: 615,149. (For policy questions regarding this collection contact Kia Sidbury at 410-786-7816.)

5. *Type of Information Collection Request*: Revision of a currently approved collection; *Title of Information Collection*: Healthcare Common Procedure Coding System (HCPCS) - Level II Code Modification Request Process; *Use*: In October 2003, the Secretary of Health and Human Services (HHS) delegated authority under the Health Insurance Portability and Accountability Act (HIPAA) legislation to Centers for Medicare and Medicaid Services (CMS) to maintain and distribute HCPCS Level II Codes. As stated in 42 CFR Sec. 414.40 (a) CMS establishes uniform national definitions of services, codes to represent services, and payment modifiers to the codes. The HCPCS code set has been maintained and distributed via modifications of codes, modifiers and descriptions, as a direct result of data received from applicants. Thus, information collected in the application is significant to codeset maintenance. The HCPCS code set maintenance is an ongoing process, as changes are implemented and updated annually; therefore, the process requires continual

collection of information from applicants on an annual basis. As new technology evolves and new devices, drugs and supplies are introduced to the market, applicants submit applications to CMS requesting modifications to the HCPCS Level II codeset. Applications have been received prior to HIPAA implementation and must continue to be collected to ensure quality decision-making. The HIPAA of 1996 required CMS to adopt standards for coding systems that are used for reporting health care transactions. The regulation that CMS published on August 17, 2000 (45 CFR 162.10002) to implement the HIPAA requirement for standardized coding systems established the HCPCS Level II codes as the standardized coding system for describing and identifying health care equipment and supplies in health care transactions. HCPCS Level II was selected as the standardized coding system because of its wide acceptance among both public and private insurers. Public and private insurers were required to be in compliance with the August 2000 regulation by October 1, 2002. Modifications to the HCPCS are initiated via application form submitted by any interested stakeholder. These applications have been received on an on-going basis with an annual deadline for each cycle. The purpose of the data provided is to educate the decision-making body about products and services for which a modification is requested so that an informed decision can be reached in response to the recommended coding. *Form Number*: CMS-10224 (OMB control number: 0938-1042); *Frequency*: Annually; *Affected Public*: Private Sector (Business or other for-profit and Not-for-profit institutions); *Number of Respondents*: 100; *Total Annual Responses*: 100; *Total Annual Hours*: 1,100. (For policy questions regarding this collection contact Kimberlee Combs Miller at 410-786-6707.)

6. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Home Office Cost Statement; *Use*: Home offices of chain organizations vary greatly in size, number of locations, staff, mode of operations, and services

furnished to the facilities in the chain. The home office of a chain is not in itself certified by Medicare. The relationship of the home office is that of a related organization to participating providers (See 42 CFR 413.17). When a provider claims costs on its cost report that are allocated from a home office, the Home Office Cost Statement constitutes the documentary support required of the provider to be reimbursed for home office costs in the provider's cost report. Each contractor servicing a provider in a chain must be furnished with a detailed Home Office Cost Statement as a basis for reimbursing the provider for cost allocations from a home office or chain organization. Home offices usually furnish central management and administrative services, e.g., centralized accounting, purchasing, personnel services, management direction and control, and other services. To the extent that the home office furnishes services related to patient care to a provider, the reasonable costs of such services are included in the provider's cost report and are reimbursable as part of the provider's costs. If the home office of the chain provides no services related to patient care, the costs of the home office may not be recognized in determining the allowable costs of the providers in the chain. Under the authority of sections 1815(a) and 1833(e) of the Social Security Act (42 USC 1395g), CMS requires that providers of services participating in the Medicare program submit information to determine costs for health care services rendered to Medicare beneficiaries. CMS requires that providers follow reasonable cost principles under 1861(v)(1)(A) of the Act when completing the Medicare cost report. Under the regulations at 42 CFR 413.20 and 413.24, CMS defines adequate cost data and requires cost reports from providers on an annual basis. Providers receiving Medicare reimbursement must provide adequate cost data based on financial and statistical records, which can be verified by qualified auditors. The Form CMS-287-19 home office cost statement is needed to determine a provider's reasonable cost incurred in furnishing medical services to Medicare beneficiaries and reimbursement due to or from a provider. *Form Number*: CMS-287-

19 (OMB control number: 0938-0202); *Frequency*: Annually; *Affected Public*: Private Sector (Business or other for-profit and Not-for-profit institutions); *Number of Respondents*: 1,507; *Total Annual Responses*: 1,507; *Total Annual Hours*: 702,262. (For policy questions regarding this collection contact Yaakov Feinstein at 410-786-3137.)

Dated: September 6, 2019

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William N. Parham, III,

Director,

Paperwork Reduction Staff,

Office of Strategic Operations and Regulatory Affairs.

4120-01-U-P

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