

two-year demonstration “to evaluate the feasibility and advisability of covering chiropractic services under Medicare”. The Demonstration aims to evaluate both the costs and the benefits of expanded coverage for chiropractic services. The evaluation will examine the achievements as well as the difficulties inherent in demonstration implementation. The study includes a descriptive evaluation of the program, a survey of a total of 2,000 beneficiaries using expanded services, analyses of medical claims to determine service utilization and expenditures, as well as the cost impact on the Medicare program. These data will allow the researchers to examine use, effectiveness, and satisfaction of Medicare beneficiaries with the chiropractic services they receive in relation to their demographic and clinical characteristics. The results will help CMS to understand the user’s experience with chiropractic services and with this Medicare demonstration.; *Form Number:* CMS-10187 (OMB#: 0938-New); *Frequency:* Reporting—Monthly; *Affected Public:* Individuals or Households; *Number of Respondents:* 2000; *Total Annual Responses:* 2000; *Total Annual Hours:* 667.

5. Type of Information Collection Request: Extension of a currently approved collection; **Title of Information Collection:** Conditions of Payment of Power Mobility Devices, including Power Wheelchairs and Power-Operated Vehicles (CMS-3017-IFC); **Use:** CMS-3017-IFC (Conditions for Payment of Power Mobility Devices, including Power Wheelchairs and Power-Operated Vehicles) provides further guidance with respect to the prescribing of and payment for Power Mobility Devices (PMDs). This rule defines the term power mobility devices (PMDs) as power wheelchairs and power operated vehicles (POVs or scooters). This rule conforms our regulations to section 302(a)(2)(E)(iv) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). The MMA mandated: (1) A face-to-face examination of the individual be conducted by a physician (as defined in section 1861(r)(1) of the Social Security Act (the Act)), a physician assistant, a nurse practitioner or a clinical nurse specialist (as those terms are defined in section 1861(aa)(5) of the Act; and (2) that payment may not be made for a power wheelchair unless the physician or treating practitioner has written a prescription for the item. With this information collection request, CMS is seeking approval for the collection requirements associated with

CMS-3017-IFC (70 FR 50940).; *Form Number:* CMS-10116 (OMB#: 0938-0971); *Frequency:* Recordkeeping and Reporting—On occasion; *Affected Public:* Business or other for-profit, Not-for-profit institutions, Federal government, State, Local, or Tribal governments; *Number of Respondents:* 17,000; *Total Annual Responses:* 37,400; *Total Annual Hours:* 37,400.

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS Web site address at <http://www.cms.hhs.gov/PaperworkReductionActof1995>, or E-mail your request, including your address, phone number, OMB number, and CMS document identifier, to Paperwork@cms.hhs.gov, or call the Reports Clearance Office on (410) 786-1326.

Written comments and recommendations for the proposed information collections must be mailed or faxed within 30 days of this notice directly to the OMB desk officer: OMB Human Resources and Housing Branch, Attention: Carolyn Lovett, New Executive Office Building, Room 10235, Washington, DC 20503. Fax Number: (202) 395-6974.

Dated: May 15, 2006.

Michelle Shortt,

*Director, Regulations Development Group,
Office of Strategic Operations and Regulatory Affairs.*

[FR Doc. E6-7944 Filed 5-25-06; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS-4117-FN]

Medicare Program; Approval of URAC for Deeming Authority for Medicare Advantage Health Maintenance Organizations and Local Preferred Provider Organizations

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final notice.

SUMMARY: This final notice announces the approval of URAC for deeming authority as a national accreditation organization for health maintenance organizations and local preferred provider organizations participating in the Medicare Advantage program, for a term of 6 years upon publication of this notice in the **Federal Register**. This notice describes the processes and criteria used in evaluating the

application. We did not receive any public comments during the public comment period, which ended on April 28, 2006.

FOR FURTHER INFORMATION CONTACT: Shaheen Halim, Ph.D., (410) 786-0641.

I. Background

Under the Medicare program, eligible beneficiaries may receive covered services through a managed care organization (MCO) that has a Medicare Advantage (MA) (formerly, Medicare+Choice) contract with the Centers for Medicare & Medicaid Services (CMS). The regulations specifying the Medicare requirements that must be met in order for an MCO to enter into an MA contract with CMS are located at 42 CFR part 422. These regulations implement Part C of Title XVIII of the Social Security Act (the Act), which specifies the services that an MCO must provide and the requirements that the organization must meet to be an MA contractor. Other relevant sections of the Act are Parts A and B of Title XVIII and Part A of Title XI pertaining to the provision of services by Medicare-certified providers and suppliers.

Generally, for an organization to enter into an MA contract, the organization must be licensed by the State as a risk-bearing organization as set forth in part 422 of our regulations. Additionally, the organization must file an application demonstrating that it meets other Medicare requirements in part 422 of our regulations. Following approval of the contract, we engage in routine monitoring and oversight audits of the MA organization to ensure continuing compliance. The monitoring and oversight audit process is comprehensive and uses a written protocol that itemizes the Medicare requirements the MA organization must meet.

As an alternative for meeting some Medicare requirements, an MA organization may be exempt from our monitoring of certain requirements in subsets listed in section 1852(e)(4)(B) of the Act as a result of an MA organization’s accreditation by a CMS-approved accrediting organization (AO). In essence, the Secretary “deems” that the Medicare requirements are met based on a determination that the AO’s standards are at least as stringent as Medicare requirements.

An organization that applies for MA deeming authority is generally recognized by the industry as an entity that accredits MCOs that are licensed as a health maintenance organization (HMO) or a preferred provider organization (PPO). As we specify at

§ 422.157(b)(2) of our regulations, the term for which an AO may be approved by us may not exceed 6 years. For continuing approval, the AO must re-apply to us.

II. Deeming Application Approval Process

Section 1852(e)(4)(C) of the Act requires that within 210 days of receipt of an application, the Secretary shall determine whether the applicant meets criteria specified in section 1865(b)(2) of the Act. Under these criteria, the Secretary will consider for a national accreditation body, its requirements for accreditation, its survey procedures, its ability to provide adequate resources for conducting activities, its monitoring procedures for provider entities found out of compliance with the conditions or requirements, and its ability to provide the Secretary with necessary data for validation.

Section 1865(b)(3)(A) of the Act further requires that we publish a notice identifying receipt of an organization's application identifying the national accreditation body making the request, and providing at least a 30-day public comment period. We must publish a finding of approval or denial of the application within 210 days from the receipt of the completed application.

III. Provisions of the Proposed Notice

On March 24, 2006, we published a proposed notice in the **Federal Register** (71 FR 14922) announcing URAC's October 12, 2005 application for deeming authority for MA HMOs and local PPOs in the following six areas:

- Quality improvement.
- Antidiscrimination.
- Access to services.
- Confidentiality and accuracy of enrollee records.
- Information on advance directives.
- Provider participation rules.

In the proposed notice, we described our evaluation criteria. Under § 422.158(a), this includes but is not limited to, the following:

- The equivalency of URAC's requirements for HMOs and PPOs to our comparable MA organization requirements.
- URAC's survey process, to determine the following:
 - + The frequency of surveys.
 - + The types of forms, guidelines, and instructions used by surveyors.
 - + Descriptions of the accreditation decision making process, deficiency notification and monitoring process, and compliance enforcement process.
- Detailed information about individuals who perform accreditation surveys including—

- + Size and composition of the survey team;
- + Education and experience requirements for the surveyors;
- + In-service training required for surveyor personnel;
- + Surveyor performance evaluation systems; and
- + Conflict of interest policies relating to individuals in the survey and accreditation decision process.

- Descriptions of the organization's—
 - + Data management and analysis system;

- + Policies and procedures for investigating and responding to complaints against accredited organizations;
- + Types and categories of accreditation offered and MA organizations currently accredited within those types and categories.

In accordance with § 422.158(b) of our regulations, the applicant must provide documentation relating to—

- Its ability to provide data in a CMS compatible format;
 - The adequacy of personnel and other resources necessary to perform the required surveys and other activities; and
 - Assurances that it will comply with ongoing responsibility requirements specified in § 422.157(c) of our regulations. We also must have an opportunity to observe the applicant using the accreditation processes under which it intends to deem compliance. Those observational site visits allow us to verify that the information presented in the application is correct and to make a determination on the application.
- In accordance with section 1865(b)(3)(A) of the Act, the proposed notice solicited public comment on the ability of URAC's accreditation program to meet or exceed the Medicare requirements for which it seeks authority to deem. We did not receive any public comments in response to the proposed notice.

IV. Evaluation of Application for Deeming Authority

Following the receipt of URAC's application for deeming authority on October 12, 2005, for MA organizations that are licensed as either HMOs or PPOs, we began our review and evaluation under § 422.158(a) of the regulations. Our review and evaluation included, but was not limited to, the information and criteria provided in sections II and III of this final notice. Additionally, we observed on-site application of URAC's accreditation processes twice at two separate managed care organizations. Following these two observational opportunities,

we determined that URAC's criteria and methods of evaluating MA plans meet or exceed ours. We grant approval of URAC's application for deeming authority for MA HMOs and local PPOs for a term of 6 years beginning upon publication of this final notice.

V. Executive Order 12866 Statement

In accordance with the provisions of Executive Order 12866, this regulation was not reviewed by the Office of Management and Budget.

Authority: Sections 1852 and 1865 of the Social Security Act (42 U.S.C. 1395w–22 and 1395bb).

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: May 17, 2006.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicare Services.

[FR Doc. E6–8135 Filed 5–25–06; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1324–N]

Medicare Program; Public Meeting in Calendar Year 2006 for New Clinical Laboratory Tests for Payment Determinations

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Notice.

SUMMARY: This notice announces a public meeting to discuss payment determinations for specific new Physicians' Current Procedural Terminology (CPT) codes for clinical laboratory tests. The meeting provides a forum for interested parties to make oral presentations and submit written comments on the new codes that will be included in Medicare's Clinical Laboratory Fee Schedule for calendar year 2007, which will be effective on January 1, 2007. Discussion is directed toward technical issues relating to payment determinations for a specified list of new clinical laboratory codes. The development of the codes for clinical laboratory tests is performed by the CPT Editorial Panel and will not be discussed at the public meeting.

DATES: The public meeting announced in this notice is scheduled for Monday, July 17, 2006 from 10 a.m. to 3 p.m.