Annually; *Affected Public:* State, Local or Tribal Government; *Number of Respondents:* 56; *Total Annual Responses:* 56; Total Annual Hours: 1,568.

4. *Type of Information Collection Request:* New Collection; *Title of Information Collection:* Rehabilitation Unit Criteria Work Sheet and Rehabilitation Hospital Criteria Work Sheet and Supporting Regulations at 42 CFR 488.26; *Form Number:* CMS–437A and CMS–437B (OMB#: 0938–NEW—NOTE: These instruments are currently approved under 0938–0358 but are being carved out into a separate collection as they are updated more frequently.); *Use:* The rehabilitation hospital and rehabilitation unit criteria work sheets are necessary to verify that these facilities/units comply and remain in compliance with the exclusion criteria for the Medicare prospective payment system; *Frequency:* Annually; *Affected Public:* Business or other-for-profit, Not-for-profit institutions, and State, Local, or Tribal Government; *Number of Respondents:* 1227; *Total Annual Responses:* 1227; Total Annual Hours: 306.75.

To obtain copies of the supporting statement and any related forms for these 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.

To be assured consideration, comments and recommendations for the proposed information collections must be received by the OMB Desk Officer at the address below, no later than 5 p.m. on February 27, 2006. OMB Human Resources and Housing Branch, Attention: Brenda Aguilar, CMS Desk Officer, New Executive Office Building, Room 10235, Washington, DC 20503.

Dated: January 12, 2006.

Michelle Shortt,

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

[FR Doc. 06–605 Filed 1–26–06; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10173]

Agency Information Collection Activities: Submission for OMB Review; Comment Request

Agency: Centers for Medicare & Medicaid Services, HHS.

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services, is publishing the following summary of proposed collections for public comment. Interested persons are invited to send comments regarding this burden estimate or any other aspect of this collection of information, including any of the following subjects: (1) The necessity and utility of the proposed information collection for the proper performance of the Agency's function; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

1. *Type of Information Collection Request:* New Collection; *Title of Information Collection:* Individuals Authorized Access to the CMS Computer Services; *Form Number:* CMS–10173 (OMB#: 0938–NEW); *Use:* The Centers for Medicare and Medicaid Services (CMS) is requesting the Office of Management and Budget (OMB) approval of the Individuals Authorized to Customer Service Application for Access to CMS Computer Systems. CMS has planned to provide a centralized user provisioning and administration service that supports the creation, deletion, and lifecycle management of enterprise identities. This service creates accounts, supports Role Based Access Control (RBAC), the form flow approval process and enterprise identity audit and recertification, and provides business application integration points. An application integration point allows business application owners to use the form flow process of the user provisioning service to approve or deny requests for access to business applications. The primary purpose of this system is to implement a unified framework for managing user information and access rights, for those individuals who apply for and are granted access across multiple CMS systems and business contexts. Information in this system will also be used to: (1) Support regulatory and policy functions performed within the Agency or by a contractor or consultant; (2) support constituent requests made to a Congressional representative; and (3) to support litigation involving the Agency related to this system.; *Frequency:* Other—As required; *Affected Public:* Business or other-for-profit, Individuals or Households, Not-for-profit institutions, Federal government, and State, local, or tribal government; *Number of Respondents:* 60,000,000; *Total Annual Responses:* 60,000,000; *Total Annual Hours:* 15,000,000.

To obtain copies of the supporting statement and any related forms for these 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.

To be assured consideration, comments and recommendations for the proposed information collections must be received by the OMB Desk Officer at the address below, no later than 5 p.m. on February 27, 2006. OMB Human Resources and Housing Branch, Attention: Carolyn Lovett, CMS Desk Officer, New Executive Office Building, Room 10235, Washington, DC 20503.

Dated: January 18, 2006.

Michelle Shortt,

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

[FR Doc. 06–717 Filed 1–26–06; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare and Medicaid Services

[CMS–2228–PN]

Medicare and Medicaid Programs; Application by the TÜV Healthcare Specialists for Deeming Authority for Hospitals

AGENCY: Centers for Medicare and Medicaid Services, HHS.

ACTION: Proposed notice.

SUMMARY: This proposed notice acknowledges the receipt of an application from the TÜV Healthcare

Specialists for deeming authority for hospitals that wish to participate in the Medicare and Medicaid programs. Section 1865(b)(3)(A) of the Social Security Act requires that within 60 days of receipt of an organization's complete application, we publish a notice that identifies the national accrediting body making the request, describes the nature of the request, and provides at least a 30-day public comment period.

DATES: We will consider comments if we receive them at the appropriate address, as provided below, no later than 5 p.m. on February 27, 2006.

ADDRESSES: In commenting, please refer to file code CMS–2228–PN. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (no duplicates, please):

1. *Electronically.* You may submit electronic comments on specific issues in this regulation to *http://www.cms.hhs.gov/regulations/eRulemaking.* Click on the link ''Submit electronic comments on CMS regulations with an open comment period.) (Attachments should be in Microsoft Word, WordPerfect, or Excel; however, we prefer Microsoft Word.)

2. *By regular mail.* You may mail written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–2228–PN, P.O. Box 8018, Baltimore, MD 21244–8018.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–2228-PN, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to one of the following addresses. If you intend to deliver your comments to the Baltimore address, please call Yolanda Hayes at telephone number (410) 786–7195 in advance to schedule your arrival with one of our staff members. Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201; or 7500 Security Boulevard, Baltimore, MD 21244–1850.

(Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, *see* the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Amber Wolfe, (410) 786–6773.

SUPPLEMENTARY INFORMATION:

Submitting Comments: We welcome comments from the public on all issues set forth in this proposed notice to assist us in fully considering issues and developing policies. You can assist us by referencing the file code CMS–2228–PN.

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: *http://www.cms.hhs.gov/regulations/eRulemaking.* Click on the link ''Electronic Comments on CMS Regulations'' on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

I. Background

Under the Medicare program, eligible beneficiaries may receive covered services in a hospital provided certain requirements are met. The regulations specifying the Medicare conditions of participation (CoPs) for hospitals are located in 42 CFR part 482. These conditions implement section 1861(e) of the Social Security Act (the Act), which specifies services covered as hospital care and the requirements that a hospital must meet in order to participate in the Medicare program. Regulations concerning provider agreements are at 42 CFR part 489, and those pertaining to activities relating to the survey and certification of facilities are at 42 CFR part 488.

Generally, in order to enter into an agreement with CMS, a hospital must first be certified by a State survey agency as complying with the CoPs set forth in part 482 of our regulations. Thereafter, the hospital is subject to regular surveys by a State survey agency to determine whether it continues to meet these requirements. There is an alternative, however, to surveys by State agencies.

Section 1865(b)(1) of the Act provides that, if a provider entity demonstrates through accreditation by an approved national accreditation organization that all applicable Medicare conditions are met or exceeded, we will ''deem'' those provider entities as having met the requirements.

If an accreditation organization is recognized by the Secretary as having standards for accreditation that meet or exceed Medicare requirements, any provider entity accredited by the national accrediting body's approved program would be deemed to meet the Medicare conditions. A national accreditation organization applying for approval of deeming authority under part 488, subpart A must provide us with reasonable assurance that the accreditation organization requires the accredited provider entities to meet requirements that are at least as stringent as the Medicare CoPs. Accreditation by an accreditation organization is voluntary and is not required for Medicare participation.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the American Osteopathic Association (AOA) are currently the only approved national accreditation organizations for hospitals.

II. Approval of Deeming Organizations

Section 1865(b)(2) of the Act and our regulations at § 488.8(a) require that our findings concerning review and approval of a national accrediting organization's requirements consider, among other factors, the applying accreditation organization's requirements for accreditation; survey procedures; resources for conducting required surveys; capacity to furnish information for use in enforcement activities; monitoring procedures for provider entities found not in compliance with the conditions or

requirements; and ability to provide us with the necessary data for validation.

Section 1865(b)(3)(A) of the Act further requires that we publish, within 60 days of receipt of an organization's complete application, a notice identifying the national accreditation body making the request, describing the nature of the request, and providing at least a 30-day public comment period. We have 210 days from our receipt of a completed application to publish approval or denial of the application.

The purpose of this proposed notice is to inform the public of our consideration of the TÜV Healthcare Specialists' (TÜVHS') request to become a national accreditation organization for hospitals. This notice also solicits public comment on the ability of TÜVHS requirements to meet or exceed the Medicare CoPs for hospitals.

III. Evaluation of Deeming Authority Request

On December 2, 2005, the TÜV Healthcare Specialists (TÜVHS) submitted all the necessary materials to enable us to make a determination concerning its request for approval as a deeming organization for hospitals. Under section 1865(b)(2) of the Act and our regulations at § 488.8 (Federal review of accreditation organizations), our review and evaluation of TÜVHS will be conducted in accordance with, but not necessarily limited to, the following factors:

- The equivalency of TÜVHS' standards for hospitals as compared with our comparable hospital CoPs.
- TÜVHS' survey process to determine the following:

—The composition of the survey team, surveyor qualifications, and the ability of the organization to provide continuing surveyor training.

—The comparability of TÜVHS' processes to those of State agencies, including survey frequency, and the ability to investigate and respond appropriately to complaints against accredited facilities.

—TÜVHS' processes and procedures for monitoring providers or suppliers found out of compliance with TÜVHS' program requirements. These monitoring procedures are used only when TÜVHS identifies noncompliance. If noncompliance is identified through validation reviews, the survey agency monitors corrections as specified at § 488.7(d).

—TÜVHS' capacity to report deficiencies to the surveyed facilities and respond to the facility's plan of correction in a timely manner.

—TÜVHS' capacity to provide us with electronic data in ASCII comparable code, and reports necessary for effective validation and assessment of the organization's survey process.

—The adequacy of TÜVHS' staff and other resources, and its financial viability.

—TÜVHS' capacity to adequately fund required surveys.

—TÜVHS' policies with respect to whether surveys are announced or unannounced.

—TÜVHS' agreement to provide us with a copy of the most current ac creditation survey together with any other information related to the survey as we may require (including corrective action plans).

IV. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 35).

V. Response to Public Comments and Notice Upon Completion of Evaluation

Because of the large number of comments we normally receive on **Federal Register** documents published for comment, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this proposed notice.

Upon completion of our evaluation, including evaluation of comments received as a result of this proposed notice, we will publish a final notice in the **Federal Register** responding to the public comments and announcing the result of our evaluation.

VI. Executive Order 12866 Statement

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

Authority: Section 1865 of the Social Security Act (42 U.S.C. 1395bb).

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program; No. 93.773 Medicare—Hospital Insurance Program; and No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: January 20, 2006.

Mark B. McClellan,

Administrator, Centers for Medicare and Medicaid Services.

[FR Doc. 06–748 Filed 1–26–06; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare and Medicaid Services

[CMS–3144–FN]

0938–ZA49

Medicare Program; Approval of Adjustment in Payment Amounts for New Technology Intraocular Lenses Furnished by Ambulatory Surgical Centers

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

ACTION: Final notice.

SUMMARY: In this final notice we respond to public comments on our September 30, 2005 notice with comment period and announce our decision concerning an application submitted by Advanced Medical Optics (AMO) to adjust the Medicare payment amounts for certain intraocular lenses (IOLs) on the basis that they are new technology intraocular lenses (NTIOLs).

This is the third of three statutorily required **Federal Register** documents. On May 27, 2005, we published a notice in the **Federal Register** entitled ''Medicare Program; Calendar Year 2005 Review of the Appropriateness of Payment Amounts for New Technology Intraocular Lenses (NTIOLs) Furnished by Ambulatory Surgical Centers (ASCs)'' (70 FR 30731) that solicited interested parties to submit requests for review of the appropriateness of the payment amount for an IOL furnished by an ambulatory surgical center. On September 30, 2005, we published a notice with comment period entitled ''Medicare Program; Calendar Year 2005 Review of the Appropriateness of Payment Amounts for New Technology Intraocular Lenses (NTIOLs) Furnished by Ambulatory Surgical Centers (ASCs)'' (70 FR 57297) acknowledging timely receipt of one application. In this final notice, we announce our decision to approve the NTIOL application submitted by Advanced Medical Optics (AMO) for Tecnis® (model numbers Z9000, Z9001, and Z9003).

EFFECTIVE DATE: This notice is effective on February 27, 2006.

FOR FURTHER INFORMATION CONTACT: Michael Lyman, (410) 786–6938.

SUPPLEMENTARY INFORMATION:

I. Background

On October 31, 1994, the Social Security Act Amendments of 1994 (SSAA 1994) (Pub. L. 103–432) were enacted. Section 141(b)(1) of SSAA 1994 required us to develop and implement