claims from physicians and suppliers. The Medicaid State Agencies, CHAMPUS/TriCare, Blue Cross/Blue Shield Plans, the Federal Employees Health Benefit Plan, and several private health plans also use it; it is the de facto standard ''professional'' claim form.

Medicare carriers 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., CHAMPUS/TriCare, Railroad Retirement Board (RRB), and Medicaid).

However, as the CMS–1500 displays data items required for other third-party payers in addition to Medicare, the form is considered too complex for use by beneficiaries when they file their own claims. Therefore, the CMS–1490S (Patient's Request for Medicare Payment) was explicitly developed for easy use by beneficiaries who file their own claims. The form can be obtained from any Social Security office or Medicare carrier. *Form Number:* CMS–1500(08/05), CMS–1490–S (OMB#: 0938–0999); *Frequency:* Reporting—On occasion; *Affected Public:* State, Local, or Tribal Government, Business or other-for-profit, Not-for-profit institutions; *Number of Respondents:* 1,448,346; *Total Annual Responses:* 988,005,045; *Total Annual Hours:* 21,418,336. (For policy questions regarding this collection contact Brian Reitz at 410–786–5001. For all other issues call 410–786–1326.)

2. *Type of Information Collection Request:* New collection; *Title of Information Collection:* Health Insurance Common Claims Form and Supporting Regulations at 42 CFR part 424, Subpart C; *Use:* The Form CMS–1500 answers the needs of many health insurers. It is the basic form prescribed by CMS for the Medicare program for claims from physicians and suppliers. The Medicaid State Agencies, CHAMPUS/TriCare, Blue Cross/Blue Shield Plans, the Federal Employees Health Benefit Plan, and several private health plans also use it; it is the de facto standard ''professional'' claim form.

Medicare carriers 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., CHAMPUS/TriCare, Railroad Retirement Board (RRB), and Medicaid).

However, as the CMS–1500 displays data items required for other third-party payers in addition to Medicare, the form is considered too complex for use by beneficiaries when they file their own claims. Therefore, the CMS–1490S (Patient's Request for Medicare Payment) was explicitly developed for easy use by beneficiaries who file their own claims. The form can be obtained from any Social Security office or Medicare carrier.

Most recently, the National Uniform Claim Committee (NUCC) has revised the CMS–1500. The NUCC began revision work on the 1500 Claim Form, version 02/12 in 2009. The goal of this work was to align the paper form with some of the changes in the electronic Health Care Claim: Professional (837), 005010X222 Technical Report Type 3 (5010) and 005010X222A1 Technical Report Type 3 (5010A1). During the revision work, consideration was given to different approaches to revising the form. The NUCC decided to proceed with making ''minor changes'' to the current form, which was defined as no physical changes to the existing form lines or underlying layout of the form. Once the CMS–1500 (02/12) has been approved, the CMS–1500 (08/05) will be discontinued after a form runoff period during which both the CMS–1500 (08/05) and the CMS–1500 (02/12) can be used. *Form Number:* CMS–1500(02/12), CMS–1490–S (OMB#: 0938–New); *Frequency:* Reporting—On occasion; *Affected Public:* State, Local, or Tribal Government, Business or other-for-profit, Not-for-profit institutions; *Number of Respondents:* 1,448,346; *Total Annual Responses:* 988,005,045; *Total Annual Hours:* 21,418,336. (For policy questions regarding this collection contact Brian Reitz at 410–786–5001. For all other issues call 410–786–1326.)

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 Email 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.

In commenting on the proposed information collections please reference the document identifier or OMB control number. To be assured consideration, comments and recommendations must be submitted in one of the following ways by July 30, 2012:

1. *Electronically.* You may submit 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) 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.

Dated: May 22, 2012.

Martique Jones,

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

[FR Doc. 2012–12810 Filed 5–25–12; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier CMS–10426, CMS–10421 and CMS–10415]

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:* End Stage Renal Disease (ESRD) System Access Request Form; *Use:* Within CMS, the Office of Clinical Standards and Quality is developing a new suite of systems to support the End Stage Renal Disease (ESRD) program. Due to the sensitivity of the data being collected and reported, CMS must ensure that only authorized personnel have access to data. Personnel are given access to the ESRD systems through the creation of user IDs and passwords within the QualityNet Identity Management System (QIMS); however, once within the system, the system determines the rights and privileges the personnel has over the data within the system.

The sole purpose the End Stage Renal Disease System (ESRD) System Access Request Form is to identify the individual's data access rights once within the ESRD system. This function and the associated data collection is currently being accomplished under ''Part B'' of the QualityNet Identity Management System Account Form (CMS–10267; OCN: 0938–1050). Once the ESRD System Access Form is approved, the QualityNet Identity Management System (QIMS) Account Form will be revised to remove Part B from the QIMS data collection. *Form Number:* CMS–10426 (OCN: 0938–New); *Frequency:* Yearly; *Affected Public:* Private Sector—Business or other for-profits. *Number of Respondents:* 25,000. *Number of Responses:* 25,000. *Total Annual Hours:* 6,250. (For policy questions regarding this collection contact Michelle Tucker at 410–786–0736. For all other issues call 410–786–1326.)

2. *Type of Information Collection Request:* New collection; *Title of Information Collection:* Fee-for-Service Recovery Audit Prepayment Review Demonstration and Prior Authorization Demonstration; *Use:* The Centers for Medicare & Medicaid Services (CMS) is requesting the Office of Management and Budget (OMB) approval of the collections required for two demonstrations of prepayment review and prior authorization. The first demonstration would allow Medicare Recovery Auditors to review claims on a pre-payment basis in certain States. The second demonstration would establish a prior authorization program for Power Mobility Device claims in certain States.

For the Recovery Audit Prepayment Review Demonstration, CMS and its agents will request additional documentation, including medical records, to support submitted claims. As discussed in more detail in Chapter 3 of the Program Integrity Manual, additional documentation includes any medical documentation, beyond what is included on the face of the claim that supports the item or service that is billed. For Medicare to consider coverage and payment for any item or service, the information submitted by the provider or supplier (e.g., claims) must be supported by the documentation in the patient's medical records. When conducting complex medical review, the contractor specifies documentation they require in accordance with Medicare's rules and policies. In addition, providers and suppliers may supply additional documentation not explicitly listed by the contractor. This supporting information may be requested by CMS and its agents on a routine basis in instances where diagnoses on a claim do not clearly indicate medical necessity, or if there is a suspicion of fraud.

For the Prior Authorization of Power Mobility Devices (PMDs) Demonstration, CMS will pilot prior authorization for Power Mobility Devices. Prior authorization will allow the applicable documentation that supports a claim to be submitted before the item is delivered. For prior authorization, relevant documentation for review is submitted before the item is delivered or the service is rendered. CMS will conduct this demonstration in California, Florida, Illinois, Michigan, New York, North Carolina and Texas based on beneficiary address as reported to the Social Security Administration and recorded in the Common Working File (CWF). For the demonstration, a prior authorization request can be completed by the (ordering) physician or treating practitioner and submitted to the appropriate DME MAC for an initial decision. The supplier may also submit the request on behalf of the physician or treating practitioner. The physician, treating practitioner or supplier who submits the request on behalf of the physician or treating practitioner, is referred to as the ''submitter.'' Under this demonstration, the submitter will submit to the DME MAC a request for prior authorization and all relevant documentation to support Medicare coverage of the PMD item.

CMS has decided to amend the requirement when subsequent prior authorization requests are submitted. Currently, CMS or its agents have up to 30 business days in which to conduct a review and communicate a decision. CMS now proposes to allow up to 20 business days to provide suppliers and the Medicare beneficiaries' quality services within reasonable time period to facilitate the delivery of necessary equipment which enhances mobility related activities of daily living and supports independence.

These demonstrations have been designed to develop and demonstrate improved methods for the investigation and prosecution of fraud in the provision of care or services under the health programs established by the Social Security Act. The information required under this information collection request is requested by Medicare contractors to determine proper payment or if there is a suspicion of fraud. For the RAC demonstration, Medicare contractors may request the information from providers or suppliers submitting claims for payment from the Medicare program when data analysis indicates aberrant billing patterns or other information which may present a vulnerability to the Medicare program. Under the prior authorization demonstration, for certain PMDs, with a history of aberrant billing patterns, this information is requested in advance to determine appropriate payment or if there is a suspicion of fraud. *Form Number:* CMS–10421 (OCN 0938—New); *Frequency:* Occasionally; *Affected Public:* State, Local or Tribal Governments; *Number of Respondents:* 479,750; *Total Annual Responses:* 479,750; *Total Annual Hours:* 243,060. (For policy questions regarding this collection contact Debbie Skinner at 410–786–7480. For all other issues call 410–786–1326.)

3. *Type of Information Collection Request:* New collection; *Title of Information Collection:* Generic Clearance for the Collection Customer Satisfaction Surveys; *Use:* This collection of information is necessary to enable the Agency to garner customer and stakeholder feedback in an efficient, timely manner, in accordance with our commitment to improving service delivery. The information collected from our customers and stakeholders will help ensure that users have an effective, efficient, and satisfying experience with the Agency's programs. This feedback will provide insights into customer or stakeholder perceptions, experiences and expectations, provide an early warning of issues with service, or focus attention on areas where communication, training or changes in operations might improve delivery of products or services. These collections will allow for ongoing, collaborative and actionable communications between the

Agency and its customers and stakeholders. It will also allow feedback to contribute directly to the improvement of program management.

Collecting voluntary customer feedback is the least burdensome, most effective way for the Agency to determine whether or not its public Web sites are useful to and used by its customers. Generic clearance is needed to ensure that the Agency can continuously improve its Web sites though regular surveys developed from these pre-defined questions. Surveying the Agency Web sites on a regular, ongoing basis will help ensure that users have an effective, efficient, and satisfying experience on any of the Web sites, maximizing the impact of the information and resulting in optimum benefit for the public. The surveys will ensure that this communication channel meets customer and partner priorities, builds the Agency's brands, and contributes to the Agency's health and human services impact goals. *Form Number:* CMS–10415 (OCN 0938—New); *Frequency:* Occasionally; *Affected Public:* Individuals and Households, Business or other for-profits and Not-for-profit institutions, State, Local or Tribal Governments; *Number of Respondents:* 1,000,000; *Total Annual Responses:* 1,000,000; *Total Annual Hours:* 67,000. (For policy questions regarding this collection contact John Booth at 410–786–6577. For all other issues call 410–786–1326.)

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 Email 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 June 28, 2012. OMB, Office of Information and Regulatory Affairs, Attention: CMS Desk Officer, Fax Number: (202) 395–6974, Email: *OIRA_submission@omb.eop.gov*.

Dated: May 22, 2012.

Martique Jones,

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

[FR Doc. 2012–12811 Filed 5–25–12; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services (CMS)

[CMS–2382–N]

Medicaid Program; Announcement of Requirements and Registration for CMS Provider Screening Innovator Challenge

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

ACTION: Notice.

SUMMARY: The Centers for Medicare & Medicaid Services (CMS), is announcing the launch of the ''CMS Provider Screening Innovator Challenge.'' This Challenge is sponsored by CMS and is presented as part of the Partnership for Program Integrity Innovation program, and will be administered by the National Aeronautic and Space Administration's (NASA) Federal Center of Excellence for Collaborative Innovation. This Challenge addresses our goals of improving our abilities to streamline operations, screen providers, and reduce fraud and abuse. Specifically, the challenge is an innovation competition to develop a multi-State, multi-program provider screening software application which would be capable of risk scoring, credentialing validation, identity authentication, and sanction checks, while lowering burden on providers and reducing administrative and infrastructure expenses for States and Federal programs. More information pertaining to the Medicaid and CHIP programs can be found at *www.medicaid.gov.*

DATES: Important dates concerning the Challenge include the following:

Challenge Competition Begin: 6:00 p.m., e.d.t., May 30, 2012.

Challenge Competition End: To be determined, but expected to be completed by October/November 2012 timeframe.

FOR FURTHER INFORMATION CONTACT: John ''Chip'' Garner, 410–786–3012.

SUPPLEMENTARY INFORMATION:

Subject of Challenge Competition

Entrants are asked to develop artifacts and components of software applications that can be integrated into an open source solution that can deliver a reliable, scalable, and cost-effective provider-screening capability for multiple States (or for the nation).

We expect the winning entry to exhibit the following characteristics:

1. Reduced processing and transaction time for submitting and receiving queries to authoritative data sources regarding provider credentials and sanctions.

2. Reductions in time needed by providers to submit information and resolve discrepancies.

3. Administrative/infrastructure savings from a multi-tenant provider screening solution.

4. Improved availability of key provider data relevant for program participation and oversight.

5. Improved timeliness and accuracy in provider participation, oversight, and enrollment decisions.

6. Improved ability to implement sections 1902(a)(39) and 1902(a)(77) of the Social Security Act, as amended by the Patient Protection and Affordable Care Act (Pub. L. 111–148 and 111–152) subsections 6401(b) and (c) (Provider Screening and Other Enrollment Requirements Under Medicare, Medicaid, and CHIP), and section 6501 (Termination of Provider Participation Under Medicaid if Terminated by Medicare or Other State Plan).

7. Assist in better driving alignment of the Medicaid Information Technology Architecture (MITA) 3.0 framework to the Information and Technology Architecture levels. More information pertaining to MITA can be found at the following Web site: *www.medicaid.gov/Medicaid-CHIP–Program-Information/By-Topics/Data-and-Systems/Medicaid-Information-Technology-Architecture-MITA.html.*

General Eligibility Rules for Participating in the Competition

To be eligible to win a prize under this Challenge, an individual or entity must comply with all the requirements under this section.

An individual or entity shall not be deemed ineligible solely because the individual or entity used Federal facilities or consulted with Federal employees during a competition if such facilities and employees are made available to all individuals and entities participating in the competition on an equitable basis.

A Federal entity or Federal employee acting within the scope of his or her employment is not eligible to participate. A Federal employee seeking to participate in this competition outside the scope of his/her employment should consult his/her ethics official prior to developing the submission. Employees of CMS, the Challenge judges, and employees of any other company or individual involved with the design, production, execution, or distribution of the Challenge, along with such employees' or judges' immediate families (spouse, parents and