Supporting Statement for Paperwork Reduction Act Submission
Appointment of Representative and Supporting Regulations in 42 CFR 405.910
(CMS-1696, OMB 0938-0950)

Background

The Centers for Medicare and Medicaid Services (CMS) requests approval of a revision of an information collection package associated with regulations that permit individuals or entities to appoint representatives to exercise their rights to appeal an initial determination. We are proposing several changes that have no impact on our requirements or burden estimates. The CMS Office of Communications (OC) streamlined all sections of the form, updating the layout and wording using plain language to comport with research and current practices. These changes do not impact or change the information being collected, or the currently approved per response estimates, but the total burden estimates have been updated with more recent annual response data. Our currently approved per response estimates are unchanged.

In conjunction with statutory changes to the appeals process under BIPA and MMA (Benefits Improvement and Protections Act of 2000, and the Medicare Modernization Act of 2003, respectively), the requirements for appointing representatives for claims and appeals processed under 42 CFR Part 405 Subpart I were codified into regulation at 42 CFR 405.910. In summary, section 405.910 states an individual or entity may appoint a representative to act on their behalf in exercising their rights relative to an initial claim determination or an appeal. The appointment of representation must be in writing and must include all the required elements specified in 405.910(c). The burden associated with this requirement is the time and effort of the individual or entity to prepare an appointment of representation containing all the required information of this section. To reduce some of the burden associated with this requirement, we developed a standardized form that the individual/entity may opt (but is not required) to use.

The changes made to this form were completed by the CMS OC to promote plain language in order to increase accessibility and reduce health disparities. OC supplied the following information on how their design and language decisions used in this form are research-based:

> *The Office of Communications recommendations are soundly based on research-based best practices in plain language and information design. Along with decades of research in cognitive science and behavioral economics, we draw from a wealth of research data specific to CMS programs. We've been conducting consumer research with the patients, caregivers, providers and partners who interact with CMS programs for more than 20 years, and we use feedback from this research to make sure our information and products are clear and easy to use. Consumer testing is ongoing, and we iteratively refine language and design standards as our audiences and their information needs evolve. We work to apply the same research-based standards across all products and channels to make sure our language, messaging and branding are consistent.*

We are proposing several changes that have no impact on our information collection requirements or burden estimates. OC streamlined all the sections of the form and updated the layout and wording using plain language. The OC changes do not impact or change the information being collected. However, we are adjusting our total burden estimate based on more recent annual response data.

A. Justification

1. Need and Legal Basis

The authority for collecting this information is under 42 CFR 405.910(a) of the Medicare claims appeal procedures.

An appointment of representative must:

- be in writing;
- be signed and dated by both the individual having legal party standing to the claim or appeal and the individual agreeing to be the representative;
- provide a statement appointing the representative to act on behalf of the party, and in the case of a beneficiary, authorize the adjudicator to release personally identifiable health information;
- include a written explanation of the purpose and scope of the representation;
- contain the party's and appointed representative's name, phone number, and address;
- provide the beneficiary's Medicare number (either the health insurance claim number, or the Medicare beneficiary identifier), if applicable. When the represented party is not a beneficiary, a unique identifier (such as the National Provider Identifier or plan number) is requested;
- include the appointed representative's professional status or relationship to the party; and
- be filed with the entity processing the party's initial determination or appeal.

2. Information Users

This form would be completed by Medicare beneficiaries, providers and suppliers (typically their billing clerk, or billing company), and any party who wish to appoint a representative to assist them with their initial Medicare claims determinations and filing appeals on Medicare claims.

The information supplied on the form is reviewed by Medicare claims and appeals adjudicators. The adjudicators make determinations whether the form was completed accurately, and if the form is correct and accepted, the form is appended to the claim or appeal that it was filed with.

3. Use of Information Technology

This instrument can be completed manually (print the form and complete it using pen and ink), or electronically (type the information into the form and digitally sign). After completion, this instrument may be submitted (along with other corresponding appeal or claim request) in hard copy through the postal mail, or electronically through a contractor or appeal adjudicator portal. Due to containing Personally Identifiable Information and Protected Health Information (PHI), any electronic submission must be through a secure connection.

4. Duplication of Efforts

The CMS-1696 does not duplicate any existing information collection.

5. Small Businesses

This collection does not have a significant economic impact on a substantial number of small entities.

6. Less Frequent Collection

This form is submitted on an as needed basis; therefore, we cannot conduct this collection less frequently. If this data is not collected, under current regulations, individuals or entities would not be able to appoint representatives to assist them in exercising their right to file a claim or an appeal of a claim determination.

7. Special Circumstances

This information collection is in accordance with the guidelines in 5 CFR 1320.6. There are no special circumstances that would require an information collection to be conducted in a manner that requires respondents to:

- Report information to the agency more often than quarterly;
- Prepare a written response to a collection of information in fewer than 30 days after receipt of it;
- Submit more than an original and two copies of any document;
- Retain records, other than health, medical, government contract, grant-in-aid, or tax records for more than three years;

- Collect data in connection with a statistical survey that is not designed to produce valid and reliable results that can be generalized to the universe of study,
- Use a statistical data classification that has not been reviewed and approved by OMB;
- Include a pledge of confidentiality that is not supported by authority established in statute or regulation that is not supported by disclosure and data security policies that are consistent with the pledge, or which unnecessarily impedes sharing of data with other agencies for compatible confidential use; or
- Submit proprietary trade secret, or other confidential information unless the agency can demonstrate that it has instituted procedures to protect the information's confidentiality to the extent permitted by law.

8. Federal Register/Outside Consultation

The 60-day Federal Register Notice published in the Federal Register on TBD (89 FR).

9. Payments/Gifts to Respondents

We do not plan to provide any payment or gifts to respondents.

10. Confidentiality

Beneficiaries who choose to appoint a representative are required by regulation (42 CFR 405.910(c)(5)) to provide their Medicare number on the AOR form or a similar conforming written instrument. The form is not collected as a standalone file or record but is submitted along with an appeal that the party is seeking assistance with, so any personal identifying information on the form is not collected separately and is not retrieved through the use of a unique identifier separately from the appeal. Contractors collect and maintain the claims and appeal information for CMS under the provisions of the Privacy Act.

11. Sensitive Questions

Users of this form must supply certain information as required by regulation, in order to identify the parties involved and to supply adjudicators with contact information to furnish responses. In particular, users must:

- provide the party's and appointed representative's name, phone number, and address;
- provide the beneficiary's Medicare Number (either the health insurance claim number, or the Medicare beneficiary identifier), if applicable. When the represented party is not a beneficiary, a unique identifier (such as the National Provider Identifier or plan number) is required;

- include the appointed representative's professional status or relationship to the party.

12. Burden Estimates (Hours & Wages)

CMS estimates the burden for the Appointment of Representative (AOR) form because we do not collect data on the use of appointed representatives. The cost to alter systems to collect the data would be prohibitive, and there is no use for the data other than for this collection. Therefore, our estimates are derived from comments received during past notice and comment on this collection package and other anecdotal information.

We believe that when parties appoint representatives, they generally do so at the start of the appeals process. For calendar year (CY) 2023, 2,132,080 requests for first level appeals were received (this figure is obtained from the CROWD [Contractor Reporting of Operational & Workload Data] system used by contractors to report workload statistics to CMS). We estimate that in 10% of all appeals (213,208) appellants will appoint a representative.

Since we have developed the optional standardized form, we estimate that it should take approximately 15 minutes to supply the information needed to comply with the requirements for a valid Appointment of Representative.

Wage Estimates

To derive average costs, we used data from the U.S. Bureau of Labor Statistics' May 2022 (released April 2023) National Occupational Employment and Wage Estimates for all salary estimates in the table below (www.bls.gov/oes/current/oes_nat.htm).

The following table presents the median hourly wage, the cost of fringe benefits and overhead, and the adjusted hourly wage.

Estimated Hourly Wages

Occupation Title	Occupation Code	Median Hourly Wage ($/hr)	Fringe Benefits and Overhead ($/hr)	Adjusted Hourly Wage ($/hr)
Billing and Posting Clerks	43-3021	20.58	20.58	41.16

Except where noted, we are adjusting our employee hourly wage estimates by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly from employer to employer, and because methods of estimating these costs vary widely from study to study. Nonetheless, there is no practical

alternative and we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

Individuals: We believe that the burden will be addressed under All Occupations (occupation code 00-0000 also from the May 2022 National Occupational Employment and Wage Estimates table cited earlier) at the median hourly rate of $22.26/hr since the group of individual respondents varies widely from working and nonworking individuals and by respondent age, location, years of employment, and educational attainment, etc.

Unlike our private sector adjustment to the respondent hourly wage (see above), we are not adjusting this figure for fringe benefits and overhead since the individuals' activities would occur outside the scope of their employment.

Requirements/Burden Estimates

Providers/Suppliers

We estimate that 90% of all AOR forms will be completed by providers or suppliers. As noted previously, providers and suppliers are likely to use a billing service to file claims and appeals. We estimate 191,887 AORs (213,208 x 0.90) completed by providers or suppliers annually.

In aggregate we estimate a burden of 47,972 hours (191,887 providers or supplier appointments x 0.25 hr) at a cost of $1,974,527.52 (47,972 hrs x $41.16/hr).

Beneficiaries

The remaining 10% of the AOR forms filled out would be completed by beneficiaries. We estimate that 21,321 AORs (213,208 x 0.10) will be completed by beneficiaries annually.

In aggregate, we estimate a burden of 5,330 hours (21,321 beneficiaries x 0.25 hr) at a cost of $118,645.80 (5,330 hours x $22.26/hr).

Burden Survey

Respondent Type	Respondents	Responses	Time per Response (hr)	Total Time (hr)	Labor Rate ($/hr)	Total Cost ($)
Providers/Suppliers	191,887	191,887	0.25	47,972	41.16	1,974,527.52
Beneficiaries	21,321	21,321	0.25	5,330	22.26	118,645.80
TOTAL	**213,208**	213,208	**0.25**	53,302	**varies**	**2,093,173.32**

Collection of Information Instruments and Instruction/Guidance Documents

- Appointment of Representative (English)

  Revised with changes.

- Appointment of Representative (Spanish)

Revised with changes.

13. Capital Costs

There are no capital costs associated with this collection.

14. Cost to Federal Government

.

The cost to the Federal government is on a triennial basis (more frequently if required by OMB) and is associated with the preparation and release of the updated notice and supplemental documents (e.g., form instructions and alternate versions). This includes the time it takes the employee to complete the PRA process, coordinate with other CMS components for language and accessibility, and posting the documents to CMS.gov. Because the notices are publicly available on cms.gov and medicare.gov, printing and mailing is done by request by 1-800-MEDICARE and are calculated separately from this collection.

The analysis and preparation of the PRA package and the subsequent release of documents is performed by a CMS employee. The average salary of the employee who would be completing this task, which includes the locality pay adjustment for the area of Washington-Baltimore-Arlington, is listed in the table below. *See* OPM 2023 General Schedule (GS) Locality Pay Tables, https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/pdf/2023/DCB_h.pdf. We estimate that on average it takes a CMS employee 20 hours to perform these activities and the triennial cost to the Federal government to be $1,324.00.

Employee	**Hourly Wage**	**Number of Hours**	**Triennial Cost to Government**
GS-13, step 8	$66.20	20	$1324.00
			TOTAL: $1324.00

15. Changes to Burden

As stated earlier in this document, we are proposing several changes that have no impact on our information collection requirements or burden estimates. OC streamlined all the sections of the form and updated the layout and wording using plain language. The OC changes do not impact or change the information being collected. However, we are adjusting our total burden estimate based on more recent annual response data.

The burden is computed based on relevant available data for Medicare appeals, and those figures are updated annually. Current appeals data indicates that the number of first level appeals has decreased since 2021. While the total time to complete the form has not changed, the hourly burden estimates have decreased and is being adjusted in this iteration for all respondents due to a fewer number of appeals being filed. Overall, the number of appeals using this collection has decreased by 57,336 (prior amount 270,544 minus current amount 213,208) which translates to a decrease of 14,335 burden hours (prior amount 67,637 minus current amount 53,302).

16. Publication/Tabulation Dates

The standardized form will be published on the Internet on the CMS.gov forms page, however, no aggregate or individual data will be tabulated from them.

17. Expiration Date

The expiration date appears at the bottom of the form.

18. Certification Statement

There are no exceptions to the certification statement.

B. Collection of Information Employing Statistical Methods

The use of statistical methods does not apply for purposes of this form.