These laws and regulations may apply but are not limited to: The Privacy Act of 1974; the Federal Information Security Management Act of 2002; the Computer Fraud and Abuse Act of 1986; the Health Insurance Portability and Accountability Act of 1996; the E–Government Act of 2002, the Clinger-Cohen Act of 1996; the Medicare Modernization Act of 2003, and the corresponding implementing regulations. OMB Circular A–130, Management of Federal Resources, Appendix III, Security of Federal Automated Information Resources also applies. Federal, HHS, and CMS policies and standards include but are not limited to: All pertinent National Institute of Standards and Technology publications; the HHS Information Systems Program Handbook and the CMS Information Security Handbook.

RETENTION AND DISPOSAL:

Records are maintained in a secure storage area with identifiers as long as needed for program research. Records will be disposed 3 years after research is completed.

SYSTEM MANAGER AND ADDRESS:

Director, Division of Health Systems Research, Research and Evaluations Group, Office of Research Development and Information.

NOTIFICATION PROCEDURE:

For purpose of access, the subject individual should write to the system manager who will require the system name, assigned card key number, and building/secure area, and for verification purposes, the subject individual's name (woman's maiden name, if applicable), and SSN. Furnishing the SSN is voluntary, but it may make searching for a record easier and prevent delay.

RECORD ACCESS PROCEDURE:

For purpose of access, use the same procedures outlined in Notification Procedures above. Requestors should also specify the record contents being sought. (These procedures are in accordance with department regulation 45 CFR 5b.5(a)(2)).

CONTESTING RECORDS PROCEDURES:

The subject individual should contact the system manager named above, and reasonably identify the records and specify the information to be contested. State the corrective action sought and the reasons for the correction with supporting justification. (These procedures are in accordance with department regulation 45 CFR 5b.7).

RECORDS SOURCE CATEGORIES:

Surveillance, Epidemiology, and End Results (SEER) program cancer registry records and Medicare enrollment and claims files.

SYSTEMS EXEMPTED FROM CERTAIN PROVISIONS OF THE ACT:

None.

[FR Doc. E6–19504 Filed 11–17–06; 8:45 am]

BILLING CODE 4120–03–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Privacy Act of 1974; Report of a Modified or Altered System of Records

AGENCY: Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS).

ACTION: Notice of a Modified or Altered System of Records (SOR).

SUMMARY: In accordance with the Privacy Act of 1974, we are proposing to modify or alter an existing SOR, ''National Claims History (NCH),'' System No. 09–70–0005, last published at 67 FR 57015 (September 6, 2002). We propose to assign a new CMS identification number to this system to simplify the obsolete and confusing numbering system originally designed to identify the Bureau, Office, or Center that maintained information in the Health Care Financing Administration systems of records. The new assigned identifying number for this system should read: System No. 09–70–0558.

We propose to modify existing routine use number one that permits disclosure to agency contractors and consultants to include disclosure to CMS grantees who perform a task for the agency. CMS grantees, charged with completing projects or activities that require CMS data to carry out that activity, are classified separate from CMS contractors and/or consultants. The modified routine use will remain as routine use number one. We will broaden the scope of routine uses number 8 and 9, authorizing disclosures to combat fraud and abuse in the Medicare and Medicaid programs to include combating ''waste'' which refers to specific beneficiary/recipient practices that result in unnecessary cost to all Federally-funded health benefit programs.

We will delete routine use number six authorizing disclosure to support constituent requests made to a congressional representative. If an authorization for the disclosure has been obtained from the data subject, then no routine use is needed. The Privacy Act allows for disclosures with the ''prior written consent'' of the data subject.

We are modifying the language in the remaining routine uses to provide a proper explanation as to the need for the routine use and to provide clarity to CMS's intention to disclose individual-specific information contained in this system. The routine uses will then be prioritized and reordered according to their usage. We will also take the opportunity to update any sections of the system that were affected by the recent reorganization or because of the impact of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108–173) provisions and to update language in the administrative sections to correspond with language used in other CMS SORs.

The primary purpose of this modified system is to collect and maintain billing and utilization data on Medicare beneficiaries enrolled in hospital insurance (Part A) or medical insurance (Part B) of the Medicare program for statistical and research purposes related to evaluating and studying the operation and effectiveness of the Medicare program. The information retrieved from this system of records will also be disclosed to: (1) Support regulatory, reimbursement, and policy functions performed within the agency or by a contractor, consultant, or grantee; (2) assist another Federal or state agency, agency of a state government, an agency established by state law, or its fiscal agent; (3)support providers and suppliers of services for administration of Title XVIII; (4) assist third parties where the contact is expected to have information relating to the individual's capacity to manage his or her own affairs; (5) assist QIOs; (6) process individual insurance claims by other insurers; (7) facilitate research on the quality and effectiveness of care provided, as well as payment-related projects; (8) support litigation involving the agency; and (9) combat fraud, waste, and abuse in Federally-funded health benefits programs. We have provided background information about the modified system in the **SUPPLEMENTARY INFORMATION** section below. Although the Privacy Act requires only that CMS provide an opportunity for interested persons to comment on the modified or altered routine uses, CMS invites comments on all portions of this notice. See ''Effective Dates'' section for comment period.

DATES: *Effective Dates:* CMS filed a modified or altered system report with the Chair of the House Committee on Government Reform and Oversight, the Chair of the Senate Committee on Homeland Security & Governmental Affairs, and the Administrator, Office of Information and Regulatory Affairs, Office of Management and Budget (OMB) on November 14, 2006. To ensure that all parties have adequate time in which to comment, the modified system, including routine uses, will become effective 30 days from the publication of the notice, or 40 days from the date it was submitted to OMB and Congress, whichever is later, unless CMS receives comments that require alterations to this notice.

ADDRESSES: The public should address comments to: CMS Privacy Officer, Division of Privacy Compliance, Enterprise Architecture and Strategy Group, Office of Information Services, CMS, Room N2–04–27, 7500 Security Boulevard, Baltimore, MD 21244–1850. Comments received will be available for review at this location, by appointment, during regular business hours, Monday through Friday from 9 a.m.—3 p.m., eastern time zone.

FOR FURTHER INFORMATION CONTACT: John Evangelist, Director, Division of Integrated Data Program Management, Enterprise Databases Group, Office of Information Services, CMS, Mail Stop N2–17–07, 7500 Security Boulevard, Baltimore, MD 21244–1850. He can also be reached by telephone at 410–786–2885, or via e-mail at *John.Evangelist@cms.hhs.gov*.

SUPPLEMENTARY INFORMATION:

I. Description of the Modified or Altered System of Records

A. Statutory and Regulatory Basis for SOR

Authority for maintenance of the system is given under §§ 1874 (a) and 1875 of the Social Security Act (the Act) and Title 42 United States Code (U.S.C.) section 1395kk(a) and 1395ll.

B. Collection and Maintenance of Data in the System

NCH contains billing and utilization information on Medicare beneficiaries enrolled in hospital insurance (Part A) or medical insurance (Part B) of the Medicare program. Information maintained in this system includes, but is not limited to Medicare billing and utilization data, name, health insurance claim number, ethnicity, gender, date of birth, state and county code, zip code, as well as the basis for the beneficiary's Medicare entitlement. The system also contains provider characteristics, assigned provider number (facility, referring/servicing physician), admission date, service dates, diagnosis and procedural codes, total charges, Medicare payment amount, and beneficiary's liability.

II. Agency Policies, Procedures, and Restrictions on Routine Uses

A. Agency Policies, Procedures, and Restrictions on the Routine Use

The Privacy Act permits us to disclose information without an individual's consent if the information is to be used for a purpose that is compatible with the purpose(s) for which the information was collected. Any such disclosure of data is known as a ''routine use.'' The government will only release NCH information that can be associated with an individual as provided for under ''Section III. Proposed Routine Use Disclosures of Data in the System.'' Both identifiable and non-identifiable data may be disclosed under a routine use.

We will only collect the minimum personal data necessary to achieve the purpose of NCH. CMS has the following policies and procedures concerning disclosures of information that will be maintained in the system. Disclosure of information from this system will be approved only to the extent necessary to accomplish the purpose of the disclosure and only after CMS:

1. Determines that the use or disclosure is consistent with the reason that the data is being collected, *e.g.*, to collect and maintain billing and utilization data on Medicare beneficiaries enrolled in hospital insurance (Part A) or medical insurance (Part B) of the Medicare program for statistical and research purposes related to evaluating and studying the operation and effectiveness of the Medicare program.

2. Determines that:

a. The purpose for which the disclosure is to be made can only be accomplished if the record is provided in individually identifiable form;

b. The purpose for which the disclosure is to be made is of sufficient importance to warrant the effect and/or risk on the privacy of the individual that additional exposure of the record might bring; and

c. There is a strong probability that the proposed use of the data would in fact accomplish the stated purpose(s).

3. Requires the information recipient to:

a. Establish administrative, technical, and physical safeguards to prevent unauthorized use of disclosure of the record;

b. Remove or destroy at the earliest time all patient-identifiable information; and

c. Agree to not use or disclose the information for any purpose other than the stated purpose under which the information was disclosed.

4. Determines that the data are valid and reliable.

III. Proposed Routine Use Disclosures of Data in the System

A. The Privacy Act allows us to disclose information without an individual's consent if the information is to be used for a purpose that is compatible with the purpose(s) for which the information was collected. Any such compatible use of data is known as a ''routine use.'' The proposed routine uses in this system meet the compatibility requirement of the Privacy Act. We are proposing to establish the following routine use disclosures of information maintained in the system:

1. To support Agency contractors, consultants, or grantees who have been contracted by the Agency to assist in accomplishment of a CMS function relating to the purposes for this system and who need to have access to the records in order to assist CMS.

We contemplate disclosing this information under this routine use only in situations in which CMS may enter into a contractual or similar agreement with a third party to assist in accomplishing a CMS function relating to purposes for this system.

CMS occasionally contracts out certain of its functions when doing so would contribute to effective and efficient operations. CMS must be able to give a contractor, consultant or grantee whatever information is necessary for the contractor, consultant or grantee to fulfill its duties. In these situations, safeguards are provided in the contract prohibiting the contractor, consultant or grantee from using or disclosing the information for any purpose other than that described in the contract and requires the contractor, consultant or grantee to return or destroy all information at the completion of the contract.

2. To assist another Federal and/or state agency, agency of a state government, an agency established by state law, or its fiscal agent to:

a. Contribute to the accuracy of CMS' proper payment of Medicare benefits,

b. Enable such agency to administer a Federal health benefits program, or as necessary to enable such agency to fulfill a requirement of a Federal statute or regulation that implements a health benefits program funded in whole or in part with Federal funds, and/or

c. Assist Federal/state Medicaid programs within the state.

Other Federal or state agencies in their administration of a Federal health program may require NCH information in order to support evaluations and monitoring of Medicare claims information of beneficiaries, including proper reimbursement for services provided.

The Internal Revenue Service may require NCH data for the application of tax penalties against employers and employee organizations that contribute to Employer Group Health Plan or Large Group Health Plans that are not in compliance with 42 U.S.C. 1395y(b).

In addition, state agencies in their administration of a Federal health program may require NCH information for the purpose of determining, evaluating and/or assessing cost, effectiveness, and/or the quality of health care services provided in the state.

The Railroad Retirement Board requires NCH information to enable them to assist in the implementation and maintenance of the Medicare program. The Social Security Administration requires NCH data to enable them to assist in the implementation and maintenance of the Medicare program.

Disclosure under this routine use shall be used by state Medicaid agencies pursuant to agreements with HHS for determining Medicaid and Medicaid eligibility, for quality control studies, for determining eligibility of recipients of assistance under Titles IV, XVIII, and XIX of the Act, and for the administration of the Medicaid program. Data will be released to the state only on those individuals who are patients under the services of a Medicaid program within the state or who are residents of that state.

We also contemplate disclosing information under this routine use in situations in which state auditing agencies require NCH information for auditing state Medicaid eligibility considerations. CMS may enter into an agreement with state auditing agencies to assist in accomplishing functions relating to purposes for this system.

3. To support providers and suppliers of services directly or through fiscal intermediaries or carriers for the administration of Title XVIII of the Act.

Providers and suppliers of services require NCH information in order to establish the validity of evidence or to verify the accuracy of information presented by the individual, as it concerns the individual's entitlement to benefits under the Medicare program, including proper reimbursement for services provided.

4. To assist third party contact in situations where the party to be contacted has, or is expected to have information relating to the individual's capacity to manage his or her affairs or to his or her eligibility for, or an entitlement to, benefits under the Medicare program and;

a. The individual is unable to provide the information being sought (an individual is considered to be unable to provide certain types of information when any of the following conditions exists: the individual is confined to a mental institution, a court of competent jurisdiction has appointed a guardian to manage the affairs of that individual, a court of competent jurisdiction has declared the individual to be mentally incompetent, or the individual's attending physician has certified that the individual is not sufficiently mentally competent to manage his or her own affairs or to provide the information being sought, the individual cannot read or write, cannot afford the cost of obtaining the information, a language barrier exist, or the custodian of the information will not, as a matter of policy, provide it to the individual), or

b. The data are needed to establish the validity of evidence or to verify the accuracy of information presented by the individual, and it concerns one or more of the following: the individual's entitlement to benefits under the Medicare program, the amount of reimbursement, and in cases in which the evidence is being reviewed as a result of suspected fraud and abuse, program integrity, quality appraisal, or evaluation and measurement of activities.

Third parties contacts require NCH information in order to provide support for the individual's entitlement to benefits under the Medicare program; to establish the validity of evidence or to verify the accuracy of information presented by the individual, and assist in the monitoring of Medicare claims information of beneficiaries, including proper reimbursement of services provided.

5. To support Quality Improvement Organizations (QIO) in order to assist the QIO to perform Title XI and Title XVIII functions relating to assessing and improving quality of care.

The QIO will work to implement quality improvement programs, provide consultation to CMS, its contractors, and to state agencies. The QIO will assist state agencies in related monitoring and enforcement efforts, assist CMS and intermediaries in program integrity assessment, and prepare summary information for release to CMS.

6. To assist insurance companies, underwriters, third party administrators (TPA), employers, self-insurers, group health plans, health maintenance organizations (HMO), health and welfare benefit funds, managed care organizations, other supplemental insurers, non-coordinating insurers, multiple employer trusts, other groups providing protection against medical expenses of their enrollees without the beneficiary's authorization, and any entity having knowledge of the occurrence of any event affecting: (a) An individual's right to any such benefit or payment, or (b) the initial right to any such benefit or payment, for the purpose of coordination of benefits with the Medicare program and implementation of the Medicare Secondary Payer (MSP) provision at 42 U.S.C. 1395y (b). Information to be disclosed shall be limited to Medicare utilization data necessary to perform that specific function. In order to receive the information, they must agree to:

a. Certify that the individual about whom the information is being provided is one of its insured or employees, or is insured and/or employed by another entity for whom they serve as a TPA;

b. Utilize the information solely for the purpose of processing the individual's insurance claims; and

c. Safeguard the confidentiality of the data and prevent unauthorized access.

Other insurers may require NCH information in order to support evaluations and monitoring of Medicare claims information of beneficiaries, including proper reimbursement for services provided.

7. To assist an individual or organization for a research project or in support of an evaluation project related to the prevention of disease or disability, the restoration or maintenance of health, or payment related projects.

The NCH data will provide for research or in support of evaluation projects, a broader, national perspective of the status of Medicare beneficiaries. CMS anticipates that many researchers will have legitimate requests to use these data in projects that could ultimately improve the care provided to Medicare beneficiaries and the policy that governs the care.

8. To support the Department of Justice (DOJ), court or adjudicatory body when:

a. The agency or any component thereof, or

b. Any employee of the agency in his or her official capacity, or

c. Any employee of the agency in his or her individual capacity where the DOJ has agreed to represent the employee, or

d. The United States Government is a party to litigation or has an interest in such litigation, and by careful review, CMS determines that the records are both relevant and necessary to the litigation and that the use of such records by the DOJ, court or adjudicatory body is compatible with the purpose for which the agency collected the records.

Whenever CMS is involved in litigation, and occasionally when another party is involved in litigation and CMS' policies or operations could be affected by the outcome of the litigation, CMS would be able to disclose information to the DOJ, court or adjudicatory body involved.

9. To assist a CMS contractor (including, but not necessarily limited to, fiscal intermediaries and carriers) that assists in the administration of a CMS-administered health benefits program, or to a grantee of a CMS-administered grant program, when disclosure is deemed reasonably necessary by CMS to prevent, deter, discover, detect, investigate, examine, prosecute, sue with respect to, defend against, correct, remedy, or otherwise combat fraud, waste, or abuse in such program.

We contemplate disclosing information under this routine use only in situations in which CMS may enter into a contractual, grantee, cooperative agreement or consultant relationship with a third party to assist in accomplishing CMS functions relating to the purpose of combating fraud and abuse. CMS occasionally contracts out certain of its functions or makes grants or cooperative agreements when doing so would contribute to effective and efficient operations. CMS must be able to give a contractor, grantee, consultant or other legal agent whatever information is necessary for the agent to fulfill its duties. In these situations, safeguards are provided in the contract prohibiting the agent from using or disclosing the information for any purpose other than that described in the contract and requiring the agent to return or destroy all information.

10. To assist another Federal agency or to an instrumentality of any governmental jurisdiction within or under the control of the United States (including any State or local governmental agency), that administers, or that has the authority to investigate potential fraud, waste, or abuse in, a health benefits program funded in whole or in part by Federal funds, when disclosure is deemed reasonably necessary by CMS to prevent, deter, discover, detect, investigate, examine, prosecute, sue with respect to, defend against, correct, remedy, or otherwise combat fraud, waste, or abuse in such programs.

Other agencies may require NCH information for the purpose of combating fraud, waste, and abuse in such federally-funded programs.

B. Additional Provisions Affecting Routine Use Disclosures

To the extent this system contains Protected Health Information (PHI) as defined by HHS regulation ''Standards for Privacy of Individually Identifiable Health Information'' (45 CFR parts 160 and 164, subparts A and E) 65 FR 82462 (12–28–00). Disclosures of such PHI that are otherwise authorized by these routine uses may only be made if, and as, permitted or required by the ''Standards for Privacy of Individually Identifiable Health Information.'' (See 45 CFR 164–512 (a)(1)).

In addition, our policy will be to prohibit release even of data not directly identifiable, except pursuant to one of the routine uses or if required by law, if we determine there is a possibility that an individual can be identified through implicit deduction based on small cell sizes (instances where the patient population is so small that individuals could, because of the small size, use this information to deduce the identity of the beneficiary).

IV. Safeguards

CMS has safeguards in place for authorized users and monitors such users to ensure against unauthorized use. Personnel having access to the system have been trained in the Privacy Act and information security requirements. Employees who maintain records in this system are instructed not to release data until the intended recipient agrees to implement appropriate management, operational and technical safeguards sufficient to protect the confidentiality, integrity and availability of the information and information systems and to prevent unauthorized access.

This system will conform to all applicable Federal laws and regulations and Federal, HHS, and CMS policies and standards as they relate to information security and data privacy. These laws and regulations may apply but are not limited to: The Privacy Act of 1974; the Federal Information Security Management Act of 2002; the Computer Fraud and Abuse Act of 1986; the Health Insurance Portability and Accountability Act of 1996; the E-Government Act of 2002, the Clinger-Cohen Act of 1996; the Medicare Modernization Act of 2003, and the corresponding implementing regulations. OMB Circular A–130, Management of Federal Resources, Appendix III, Security of Federal Automated Information Resources also applies. Federal, HHS, and CMS policies and standards include but are not limited to: All pertinent National Institute of Standards and Technology publications; the HHS Information Systems Program Handbook and the CMS Information Security Handbook.

V. Effects of the Modified System of Records on Individual Rights

CMS proposes to modify this system in accordance with the principles and requirements of the Privacy Act and will collect, use, and disseminate information only as prescribed therein. Data in this system will be subject to the authorized releases in accordance with the routine uses identified in this system of records.

CMS will take precautionary measures to minimize the risks of unauthorized access to the records and the potential harm to individual privacy or other personal or property rights of patients whose data are maintained in the system. CMS will collect only that information necessary to perform the system's functions. In addition, CMS will make disclosure from the proposed system only with consent of the subject individual, or his/her legal representative, or in accordance with an applicable exception provision of the Privacy Act. CMS, therefore, does not anticipate an unfavorable effect on individual privacy as a result of information relating to individuals.

Dated: November 8, 2006.

John R. Dyer,

Chief Operating Officer, Centers for Medicare & Medicaid Services.

SYSTEM NO. 09–70–0558

SYSTEM NAME:

''National Claims History (NCH),'' HHS/CMS/OIS.

SECURITY CLASSIFICATION:

Level Three Privacy Act Sensitive Data.

SYSTEM LOCATION:

The Centers for Medicare & Medicaid Services (CMS) Data Center, 7500 Security Boulevard, North Building, First Floor, Baltimore, MD 21244–1850 and at various contractor sites and at CMS Regional Offices.

CATEGORIES OF INDIVIDUALS COVERED BY THE SYSTEM:

NCH contains billing and utilization information on Medicare beneficiaries enrolled in hospital insurance (Part A) or medical insurance (Part B) of the Medicare program.

CATEGORIES OF RECORDS IN THE SYSTEM:

Information maintained in this system includes, but is not limited to Medicare billing and utilization data, name, health insurance claim number, ethnicity, gender, date of birth, state and county code, zip code, as well as the basis for the beneficiary's Medicare entitlement. The system also contains provider characteristics, assigned provider number (facility, referring/servicing physician), admission date, service dates, diagnosis and procedural codes, total charges, Medicare payment amount, and beneficiary's liability.

AUTHORITY FOR MAINTENANCE OF THE SYSTEM:

Authority for maintenance of the system is given under §§ 1874(a) and 1875 of the Social Security Act (the Act) and Title 42 United States Code (U.S.C.) section 1395kk(a) and 1395ll.

PURPOSE(S) OF THE SYSTEM:

The primary purpose of this modified system is to collect and maintain billing and utilization data on Medicare beneficiaries enrolled in hospital insurance (Part A) or medical insurance (Part B) of the Medicare program for statistical and research purposes related to evaluating and studying the operation and effectiveness of the Medicare program. The information retrieved from this system of records will also be disclosed to: (1) Support regulatory, reimbursement, and policy functions performed within the agency or by a contractor, consultant, or grantee; (2) assist another Federal or state agency, agency of a state government, an agency established by state law, or its fiscal agent; (3) support providers and suppliers of services for administration of Title XVIII; (4) assist third parties where the contact is expected to have information relating to the individual's capacity to manage his or her own affairs; (5) assist QIOs; (6) process individual insurance claims by other insurers; (7) facilitate research on the quality and effectiveness of care provided, as well as payment-related projects; (8) support litigation involving the agency; and (9) combat fraud, waste, and abuse in federally-funded health benefits programs.

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OR USERS AND THE PURPOSES OF SUCH USES:

A. The Privacy Act allows us to disclose information without an individual's consent if the information is to be used for a purpose that is compatible with the purpose(s) for which the information was collected. Any such compatible use of data is known as a ''routine use.'' The proposed routine uses in this system meet the compatibility requirement of the Privacy Act. We are proposing to establish the following routine use disclosures of information maintained in the system:

1. To support Agency contractors, consultants, or grantees who have been contracted by the Agency to assist in accomplishment of a CMS function relating to the purposes for this system and who need to have access to the records in order to assist CMS.

2. To assist another Federal and/or state agency, agency of a state government, an agency established by state law, or its fiscal agent to:

a. Contribute to the accuracy of CMS' proper payment of Medicare benefits,

b. Enable such agency to administer a Federal health benefits program, or as necessary to enable such agency to fulfill a requirement of a Federal statute or regulation that implements a health benefits program funded in whole or in part with Federal funds, and/or

c. Assist Federal/state Medicaid programs within the state.

3. To support providers and suppliers of services directly or through fiscal intermediaries or carriers for the administration of Title XVIII of the Act.

4. To assist third party contact in situations where the party to be contacted has, or is expected to have information relating to the individual's capacity to manage his or her affairs or to his or her eligibility for, or an entitlement to, benefits under the Medicare program and;

a. The individual is unable to provide the information being sought (an individual is considered to be unable to provide certain types of information when any of the following conditions exists: the individual is confined to a mental institution, a court of competent jurisdiction has appointed a guardian to manage the affairs of that individual, a court of competent jurisdiction has declared the individual to be mentally incompetent, or the individual's attending physician has certified that the individual is not sufficiently mentally competent to manage his or her own affairs or to provide the information being sought, the individual cannot read or write, cannot afford the cost of obtaining the information, a language barrier exist, or the custodian of the information will not, as a matter of policy, provide it to the individual), or

b. The data are needed to establish the validity of evidence or to verify the accuracy of information presented by the individual, and it concerns one or more of the following: The individual's entitlement to benefits under the Medicare program, the amount of reimbursement, and in cases in which the evidence is being reviewed as a result of suspected fraud and abuse, program integrity, quality appraisal, or evaluation and measurement of activities.

5. To support Quality Improvement Organizations (QIO) in order to assist the QIO to perform Title XI and Title XVIII functions relating to assessing and improving quality of care.

6. To facilitate insurance companies, underwriters, third party administrators (TPA), employers, self-insurers, group health plans, health maintenance organizations (HMO), health and welfare benefit funds, managed care organizations, other supplemental insurers, non-coordinating insurers, multiple employer trusts, other groups providing protection against medical expenses of their enrollees without the beneficiary's authorization, and any entity having knowledge of the occurrence of any event affecting: (a) An individual's right to any such benefit or payment, or (b) the initial right to any such benefit or payment, for the purpose of coordination of benefits with the Medicare program and implementation of the Medicare Secondary Payer (MSP) provision at 42 U.S.C. 1395y (b). Information to be disclosed shall be limited to Medicare utilization data necessary to perform that specific function. In order to receive the information, they must agree to:

a. Certify that the individual about whom the information is being provided is one of its insured or employees, or is insured and/or employed by another entity for whom they serve as a TPA;

b. Utilize the information solely for the purpose of processing the individual's insurance claims; and

c. Safeguard the confidentiality of the data and prevent unauthorized access.

7. To assist an individual or organization for a research project or in support of an evaluation project related to the prevention of disease or disability, the restoration or maintenance of health, or payment related projects.

8. To support the Department of Justice (DOJ), court or adjudicatory body when:

a. The agency or any component thereof, or

b. Any employee of the agency in his or her official capacity, or

c. Any employee of the agency in his or her individual capacity where the DOJ has agreed to represent the employee, or

d. The United States Government is a party to litigation or has an interest in such litigation, and by careful review, CMS determines that the records are both relevant and necessary to the litigation and that the use of such records by the DOJ, court or adjudicatory body is compatible with the purpose for which the agency collected the records.

9. To assist a CMS contractor (including, but not necessarily limited to, fiscal intermediaries and carriers) that assists in the administration of a CMS-administered health benefits program, or to a grantee of a CMS-administered grant program, when disclosure is deemed reasonably necessary by CMS to prevent, deter, discover, detect, investigate, examine, prosecute, sue with respect to, defend against, correct, remedy, or otherwise combat fraud, waste, or abuse in such program.

10. To assist another Federal agency or to an instrumentality of any governmental jurisdiction within or under the control of the United States (including any State or local governmental agency), that administers, or that has the authority to investigate potential fraud, waste, or abuse in, a health benefits program funded in whole or in part by Federal funds, when disclosure is deemed reasonably necessary by CMS to prevent, deter, discover, detect, investigate, examine, prosecute, sue with respect to, defend against, correct, remedy, or otherwise combat fraud, waste, or abuse in such programs.

B. *Additional Provisions Affecting Routine Use Disclosures.* To the extent this system contains Protected Health Information (PHI) as defined by HHS regulation ''Standards for Privacy of Individually Identifiable Health Information'' (45 CFR parts 160 and 164, subparts A and E) 65 FR 82462 (12–28–00). Disclosures of such PHI that are otherwise authorized by these routine uses may only be made if, and as, permitted or required by the ''Standards for Privacy of Individually Identifiable Health Information.'' (See 45 CFR 164–512(a)(1)).

In addition, our policy will be to prohibit release even of data not directly identifiable, except pursuant to one of the routine uses or if required by law, if we determine there is a possibility that an individual can be identified through implicit deduction based on small cell sizes (instances where the patient population is so small that individuals could, because of the small size, use this information to deduce the identity of the beneficiary).

POLICIES AND PRACTICES FOR STORING, RETRIEVING, ACCESSING, RETAINING, AND DISPOSING OF RECORDS IN THE SYSTEM:

STORAGE:

All records are stored on both magnetic storage media and in a DB2 relational database management environment (DASD data storage media).

RETRIEVABILITY:

Information in this system is retrieved by HICN, provider number (facility, physician, supplier Ids), service dates, type of bill, Medicare status code, diagnosis, procedural codes, and beneficiary state code.

SAFEGUARDS:

CMS has safeguards in place for authorized users and monitors such users to ensure against unauthorized use. Personnel having access to the system have been trained in the Privacy Act and information security requirements. Employees who maintain records in this system are instructed not to release data until the intended recipient agrees to implement appropriate management, operational and technical safeguards sufficient to protect the confidentiality, integrity and availability of the information and information systems and to prevent unauthorized access.

This system will conform to all applicable Federal laws and regulations and Federal, HHS, and CMS policies and standards as they relate to information security and data privacy. These laws and regulations may apply but are not limited to: The Privacy Act of 1974; the Federal Information Security Management Act of 2002; the Computer Fraud and Abuse Act of 1986; the Health Insurance Portability and Accountability Act of 1996; the E-Government Act of 2002, the Clinger-Cohen Act of 1996; the Medicare Modernization Act of 2003, and the corresponding implementing regulations. OMB Circular A–130, Management of Federal Resources, Appendix III, Security of Federal Automated Information Resources also applies. Federal, HHS, and CMS policies and standards include but are not limited to: All pertinent National Institute of Standards and Technology publications; the HHS Information Systems Program Handbook and the CMS Information Security Handbook.

RETENTION AND DISPOSAL:

Records will be retained and disposed of in accordance with the National Archives and Records Administration guidelines. Records are housed in both active and archival files. All claims-related records are encompassed by the document preservation order and will be retained until notification is received from DOJ.

SYSTEM MANAGER(S) AND ADDRESS:

Director, Division of Integrated Data Program Management, Enterprise Databases Group, Office of Information Services, CMS, Mail Stop N2–17–07, 7500 Security Boulevard, Baltimore, MD 21244–1850.

NOTIFICATION PROCEDURE:

For purpose of notification, the subject individual should write to the system manager who will require the system name, and the retrieval selection criteria (e.g., HIC, facility ID, physician/supplier number, service dates, type of bill, etc.).

RECORD ACCESS PROCEDURE:

For purpose of access, use the same procedures outlined in Notification Procedures above. Requestors should also reasonably specify the record contents being sought. (These procedures are in accordance with Department regulation 45 CFR 5b.5(a)(2).)

CONTESTING RECORDS PROCEDURES:

The subject individual should contact the system manager named above, and reasonably identify the record and specify the information to be contested. State the corrective action sought and the reasons for the correction with supporting justification. (These procedures are in accordance with Department regulation 45 CFR 5b.7.)

RECORDS SOURCE CATEGORIES:

Fee-for-Service (FFS) billing and utilization information contained in this records system is obtained from the Common Working File.

SYSTEMS EXEMPTED FROM CERTAIN PROVISIONS OF THE ACT:

None.

[FR Doc. E6–19505 Filed 11–17–06; 8:45 am]

BILLING CODE 4120–03–P