

Supporting Statement for Paperwork Reduction Act Submissions

CMS-855I Medicare Enrollment Application for Physician and Non-Physician Practitioners Package Revision CMS-855I/OMB Control Number: 0938-XXXX)

A. BACKGROUND

The primary function of the CMS-855I Medicare enrollment application for physicians and non-physician practitioners is to gather information from an individual provider or supplier that tells us who he/she is, whether he/she meets certain qualifications to be a Medicare health care provider or supplier, where he/she practices or renders services, and other information necessary to establish correct claims payments.

There are two principal facets of this submission:

- 1. Request for Individual OMB Control Number for the CMS-855I** - On November 16, 2016, in accordance with the Paperwork Reduction Act, OMB approved a reinstatement without change of a previously approved collection of the Medicare enrollment applications (specifically, the CMS-855A, CMS-855B, and CMS-855I Medicare enrollment application bundle, OMB control number 0938-0685, ICR reference number 201611-0938-009). This was necessary in order to allow the CMS-855A, CMS-855B and CMS-855I to remain active. That collection expires on August 31, 2019. While the CMS-855I enrollment form is included in that collection, CMS is revising the CMS-855 Medicare Enrollment Applications Package (OMB No. 0938-0685) to remove the CMS-855I application from its collection and is requesting a new OMB control number specific to the CMS-855I. The CMS-855I application under OMB control number 0938-0685 will be removed from the Medicare application bundle collection during its next resubmission cycle. There will be no duplication of CMS-855I Medicare application form as this revision with its new OMB control number will replace the CMS-855I with OMB control number 0938-0685, making this revision the only active CMS-855I application. The CMS-855I with the bundled OMB control number of 0938-0685 will be removed from the cms.gov forms website upon OMB approval of this revision of the CMS-855I. CMS has found that the regulations governing the enrollment requirements for physicians and non-physician practitioners occur at intervals separate from the other provider and supplier types reimbursed by Medicare. Consequently, CMS may need to revise and submit the CMS-855I enrollment application for OMB approval at intervals separate from the other enrollment applications under OMB No. 0938-0685 which currently includes the CMS-855A, CMS-855B, and CMS-855I enrollment applications. The ability to revise the CMS-855I separately from the other CMS-855 enrollment applications will lessen the burden on both CMS and OMB as well as the public during the Federal Register notice period, as only one subset of providers/suppliers will be effected by CMS-855I revisions. CMS intends to maintain the continuity of the CMS-855 enrollment applications by using the same formats and lay-out of the current CMS-855 enrollment applications, regardless of the separation of the CMS-855I from the

collective enrollment application package.

- 2. Corrections to the content of the CMS-855I** - The goal of evaluating and revising the CMS-855I enrollment application is to simplify and clarify the information collection without jeopardizing our need to collect specific information. In addition, periodically new congressional legislation or regulations require CMS to update the Medicare Provider Enrollment Applications (CMS-855s). The majority of these changes are minor in nature for the purposes of provider/supplier enrollment, such as instruction clarification for the physician and/or non-physician practitioner, adding new specialty codes for the physicians and non-physician practitioners to choose from, questions with “Yes/No” check boxes, spelling and formatting corrections, removal of duplicate fields, and indicating which addresses the physicians and non-physician practitioners wish to use for different types of correspondence. This revision also includes a re-sequencing and re-numbering of the sections and sub-sections of the application to create a more logical flow of the data to make it easier for the physician and/or non-physician practitioner to complete (for example, by putting most address information in one section). Other minor editorial and clerical corrections were made to better simplify and clarify the current data collection and some of the instructions for the providers/suppliers completing this application in response to comments received during the revision of the current version of this application.

In this revision of the CMS-855I, other main revisions include NPI information and a list of commonly used acronyms being added to the instruction pages. All information previously collected for Advanced Diagnostic Imaging, the Clinical Laboratory Improvement Amendments (CLIA) number and the Food and Drug Administration (FDA) radiology certification number reporting was removed to lessen provider burden. CMS can derive this information from other sources. Electronic storage information was added as some physician/non-physician practitioners no longer store paper records. CMS expanded the instructions for individual and group affiliations to simplify individual and group reassignment/affiliation reporting. The contact person section was made optional to reduce the reporting burden for physicians/non-physician practitioners. Additionally, some obsolete questions were removed.

JUSTIFICATION

1. Need and Legal Basis

Various sections of the Social Security Act (Act), the United States Code (U.S.C.), Internal Revenue Service Code (Code) and the Code of Federal Regulations (CFR) require providers and suppliers to furnish information concerning the amounts due and the identification of individuals or entities that furnish medical services to beneficiaries before payment can be made.

- C.F.R. section 424.500 state the requirements for enrollment, periodic resubmission and certification of enrollment information for revalidation, and timely reporting of updates and changes to enrollment information. These requirements apply to all providers and suppliers

except for physicians and practitioners who have entered into a private contract with a beneficiary as described in part 405, subpart D of this chapter. Providers and suppliers must meet and maintain these enrollment requirements to bill either the Medicare program or its beneficiaries for Medicare covered services or supplies.

- Sections 1814(a), 1815(a), and 1833(e) of the Act require the submission of information necessary to determine the amounts due to a provider or other person.
- Section 1842(r) of the Act requires us to establish a system for furnishing a unique identifier for each physician who furnishes services for which payment may be made. In order to do so, we need to collect information unique to that provider or supplier.
- Section 1866(j)(1)(C) of the Act requires us to consult with providers and suppliers of services before making changes in provider enrollment forms.
- The Balanced Budget Act of 1997 (BBA) (Public Law 105-33) section 4313, amended sections 1124(a)(1) and 1124A of the Act to require disclosure of both the Employer Identification Number (EIN) and Social Security Number (SSN) of each provider or supplier, each person with ownership or control interest in the provider or supplier, as well as any managing employees. The Secretary of Health and Human Services (the Secretary) signed and sent to the Congress a “Report to Congress on Steps Taken to Assure Confidentiality of Social Security Account Numbers as Required by the Balanced Budget Act” on January 26, 1999, with mandatory collection of SSNs and EINs effective on or about April 26, 1999.
- Section 31001(I) of the Debt Collection Improvement Act of 1996 (DCIA) (Public Law 104-134) amended 31 U.S.C. 7701 by adding paragraph (c) to require that any person or entity doing business with the Federal Government provide their Tax Identification Number (TIN).
- Section 1866(b)(2)(D) and 1842(h)(8) of the Act require denial of enrollment (directly or indirectly) of persons convicted of a felony for a period not less than 10 years from the date of conviction.
- 42 C.F.R. section 424.502, defines enrollment and enrollment related terms.
- Sections 1102 and 1871 of the Act, which provide general authority for the Secretary to prescribe regulations for the efficient administration of the Medicare program
- The Internal Revenue (IRS) Code, section 3402 requires us to collect additional information about the proprietary/non-profit structure of a Medicare provider/supplier to allow exclusion of non-profit organization from the mandatory 3% tax withholding.
- The IRS section 501(c) requires each Medicare provider/supplier to report information about its proprietary/non-profit structure to the IRS for tax withholding determination.
- Section 1866(i)(2)(A) of the Act requires the Secretary, in consultation with the Department of Health and Human Services' Office of the Inspector General, to establish procedures under which screening is conducted with respect to providers of medical or other items or services and suppliers under Medicare, Medicaid, and CHIP.
- Section 1866(i)(2)(B) of the Act requires the Secretary to determine the level of screening to be conducted according to the risk of fraud, waste, and abuse with respect to the category of provider or supplier.
- Section 1848(k)(3)(B) defines covered professional services and eligible professionals.
- Section 3004(b)(1) of the Public Health Service Act (PHSA) requires the Secretary to adopt an initial set of standards, implementation guidance, and certification criteria and associated standards and implementation specifications will be used to test and certify complete EHRs and EHR modules in order to make it possible for eligible professionals and eligible hospitals to adopt and implement Certified EHR Technology.

- Section 508 of the Rehabilitation Act of 1973, as incorporated with the Americans with Disabilities Act of 2005 requires all Federal electronic and information technology to be accessible to people with disabilities, including employees and members of the public.

The CMS-855 applications collect this information, including the information necessary to uniquely identify and enumerate the provider/supplier. Additional information necessary to ensure that providers and suppliers meet all applicable Medicare requirements and to process claims accurately and timely and are also collected on the CMS-855 applications.

2. Purpose and users of the information

The CMS-855I is submitted by an applicant to initially apply for a Medicare billing number, to revalidate Medicare enrollment, reactivate Medicare enrollment, enroll as an individual practitioner if the individual is currently enrolled as an ordering/certifying provider, enroll with another MAC in a different geographic location, to report a change to current Medicare enrollment information, and to voluntarily terminate the individual's Medicare enrollment, as applicable. It is used by new applicants as well as individuals already enrolled in Medicare but need to submit the form for a reason other than initial enrollment into the Medicare program. Physicians, non-physician practitioners, and eligible professionals complete this form for the submittal reasons above.

The application is used by Medicare contractors to collect data to ensure that the applicant has the necessary credentials to provide the health care services for which they intend to bill Medicare, including information that allows the Medicare contractor to correctly price, process and pay the applicant's claims. This application collects information to ensure that only legitimate physicians, non-physician practitioners, and other eligible professionals are enrolled in the Medicare program. It is meant to be the first line defense to protect our beneficiaries from illegitimate providers and to protect the Medicare Trust Fund against fraud. It also gathers information that allows Medicare contractors to ensure that the provider/supplier is not sanctioned from the Medicare and/or Medicaid program(s), or debarred, suspended or excluded from any other Federal agency or program. This is sole instrument implemented for this purpose.

3. Improved Information Techniques

This collection lends itself to electronic collection methods and is currently available through the CMS website. The Provider Enrollment, Chain and Ownership System (PECOS) is a secure, intelligent and interactive national data storage system maintained and housed within the CMS Data Center with limited user access through strict CMS systems access protocols. Access to the data maintained in PECOS is limited to CMS and Medicare contractor employees responsible for provider/supplier enrollment activities. PECOS is an electronic Medicare enrollment system through which providers and suppliers can: submit Medicare enrollment applications, view and print enrollment information, update enrollment information, complete the enrollment

revalidation process, voluntarily withdraw from the Medicare program, and track the status of a submitted Medicare enrollment application. The data stored in PECOS mirrors the data collected on the CMS-855s (Medicare Enrollment Applications) and is maintained indefinitely as both historical and current information. CMS also supports an Internet-based provider/supplier CMS-855 enrollment platform which allows the provider/supplier to complete an online CMS-855 enrollment application and transmit it to the Medicare contractor database for processing. Then the data is transferred from the Medicare contractor processing database into PECOS by the Medicare contractor. CMS also has the ability to allow suppliers to upload supporting documentation (required for enrollment) electronically. CMS has also adopted an electronic signature standard; however, practitioners will have the choice to e-sign via the CMS website or to submit a hard copy of the CMS-855I certification page with an original signature. Periodically, CMS will require adjustment to the format of the CMS-855 form (either paper, electronic or both) for clarity or to improve form design. These adjustments do not alter the current OMB data collection approval. Currently, approximately 36% of individual provider/suppliers use the electronic method of enrolling in the Medicare program via the PECOS system.

4. Duplication and Similar Information

There is no duplicative information collection instrument or process.

5. Small Business

This form will affect small businesses; however, these businesses have always been required to provide CMS with the same information in order to enroll in the Medicare program to submit information for CMS to ensure the providers are legitimate and to collect information to successfully process their Medicare claims.

6. Less Frequent Collections

This information is collected on an as needed basis. The information provided on these forms is necessary for enrollment in the Medicare program. It is essential to collect this information the first time a provider/supplier enrolls with a Medicare contractor so that CMS' contractors can uniquely identify the provider/supplier, ensure the provider's/supplier's eligibility and legitimacy, to determine if the provider/supplier meets all statutory and regulatory requirements and are properly credentialed in their specialty (if applicable), and to collect relevant information to process the provider's/supplier's claims in a timely and accurate manner.

In addition, to ensure uniform data submissions, CMS requires that all changes to previously submitted enrollment data be reported via this enrollment application.

7. Special Circumstances

There are no special circumstances associated with this collection.

8. *Federal Register Notice/Outside Consultation*

A 60-day Notice will publish in the Federal Register on_____.
No outside consultation was sought.

9. *Payment/Gift to Respondents*

No payments and/or gifts will be provided to respondents.

10. *Confidentiality*

CMS will comply with all Privacy Act, Freedom of Information laws and regulations that apply to this collection. Privileged or confidential commercial or financial information is protected from public disclosure by Federal law 5 U.S.C. 522(b)(4) and Executive Order 12600.

11. *Sensitive Questions*

There are no sensitive questions associated with this collection.

12. *Burden Estimate (hours and cost)*

A. Burden Estimate (hours)

HOURS ASSOCIATED WITH COMPLETING THE CMS-855I ENROLLMENT APPLICATION

For this proposed revision of the CMS-855I, CMS has recalculated the estimated burden hours. CMS believes this recalculation is necessary because this data collection tool has not been revised since 2011. In addition, the number of affected users, actual data collected and the collection methods have changed significantly. CMS believes these new burden hours accurately reflects the current burden for the purposes of this application when completing this proposed revision of the CMS-855I. CMS is basing the new burden amounts on data compiled from PECOS and the Medicare Administrative Contractors (MACs). The new estimates for completing the CMS-855I Medicare enrollment application form for the seven submission reasons shown in the burden tables (initial enrollment, revalidation, reactivation, currently enrolled as an ordering/certifying provider and wish to enroll as an individual practitioner, enrolling with another MAC, reporting a change of Medicare enrollment information, and voluntary termination of Medicare enrollment) are taken directly from the actual applications

processed for calendar year 2016. The new figures of processed applications are exact and therefore more accurate than the prior estimates.

The hour burden to the respondents is calculated based on the following assumptions:

- MACs currently process approximately 513,872 CMS-855I applications per year.
- Completion of the CMS-855I hour burden depends on the reason for submittal and respondent.
- Hour burden of the respondents is calculated as follows based on the following assumption:
 - The CMS-855I will likely be completed by administrative staff (BLS category = medical secretaries),
 - The record keeping burden is included in the time determined for completion by administrative staff,
 - Approximately 66.6% of CMS-855I applications are reviewed and signed by the enrolling or enrolled physician, and
 - Approximately 33.3% of CMS-855I applications are reviewed and signed by the enrolling or enrolled non-physician practitioner.

CMS estimates the new total burden hour for this information collection to be approximately 513,872 hours. These figures are calculated based on why a respondent must complete and submit this enrollment application (CMS-855I), which also determines the time it takes for completion and submission, and if the respondent is a physician or a non-physician practitioner. The figures are reflected in the Tables below and in the calculations in Part II of the 83 Worksheets.

B. Burden Estimate (costs)

COST ASSOCIATED WITH COMPLETING THE CMS-855I ENROLLMENT APPLICATION

For this proposed revision of the CMS-855I, CMS has recalculated the estimated burden cost. CMS believes this recalculation is necessary because this data collection tool has not been revised since 2011. In addition, the number of affected users, actual data collected and the collection methods have changed significantly. CMS believes this new burden cost accurately reflects the current burden for the purposes of this application when completing this proposed revision of the CMS-855I. CMS is basing the new burden amounts on data compiled from PECOS and the Medicare Administrative Contractors (MACs). The new estimates for completing the CMS-855I Medicare enrollment application form for the seven submission reasons shown in the burden tables (initial enrollment, revalidation, reactivation, currently enrolled as an ordering/certifying provider and wish to enroll as an individual practitioner, enrolling with another MAC, reporting a change of Medicare enrollment information, and voluntary termination of Medicare enrollment) are taken directly from the actual applications

processed for calendar year 2016. The new figures are exact and therefore more accurate than the prior estimates.

To derive average costs, CMS used data from the U.S. Bureau of Labor Statistics' (BLS) May 2016 National Occupational Employment and Wage Estimates for all salary estimates (http://www.bls.gov/oes/current/oes_nat.htm). For the purposes of this application, CMS used the wages under the general categories of "Medical Secretaries," "Health Diagnosing and Treating Practitioners," and "Physicians and Surgeons." In this regard, CMS adjusted the employee hourly wage estimates by a factor of 100 percent. This is necessarily an estimated 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 CMS believes that doubling the hourly wage to estimate total cost is an accurate estimation method that has been used successfully in previous burden calculations.

The cost burden to the respondents is calculated based on the following assumptions:

- MACs currently process approximately 513,872 provider/supplier CMS-855I applications per year.
- Completion of the CMS-855I costs burden depends on the reason for submittal and respondent.
 - The reason for submittal of the CMS-855I determines the hour burden.
 - The hour burden and the respondent determines the cost burden, as seen in Table 2.
- Cost to the respondents is calculated as follows based on the following assumption:
 - The CMS-855I will likely be completed by administrative staff (BLS category = medical secretaries),
 - The record keeping burden is included in the time determined for completion by administrative staff,
 - Approximately 66.6% of CMS-855I applications are reviewed and signed by the enrolling or enrolled physician, and
 - Approximately 33.3% of CMS-855I applications are reviewed and signed by the enrolling or enrolled non-physician practitioner.
- The cost per respondent per form has been determined using as follows:
 - The most recent wage data provided by the Bureau of Labor Statistics (BLS) for May 2016, the mean hourly wage for the general category of "Medical Secretary" is \$16.85 per hour (see http://www.bls.gov/oes/current/oes_nat.htm). With fringe benefits and overhead, the total per hour rate is \$33.70.

- The most recent wage data provided by the BLS for May 2016 (see http://www.bls.gov/oes/current/oes_nat.htm), the mean hourly wage for the general category of "Physicians and Surgeons" is \$101.04. With fringe benefits and overhead, the total per hour rate is \$202.08.
- The most recent wage data provided by the BLS for May 2016 (see http://www.bls.gov/oes/current/oes_nat.htm), the mean hourly wage for the general category of "Health Diagnosing and Treating Practitioners" is \$47.51. With fringe benefits and overhead, the total per hour rate is \$95.02.

CMS estimates the new total burden cost for this information collection to be approximately \$59,337,824. These figures are calculated based on why a respondent must complete and submit this enrollment application (CMS-855I), which also determines the time it takes for completion and submission, and if the respondent is a physician or a non-physician practitioner. The figures are reflected in the Tables below and in the calculations in Part II of the 83 Worksheets.

Table 1 – Total Number of CMS-855Is Processed per Year by Reason for Submittal (2016)

| Reason for Submittal | Total Number of CMS-855Is Processed per year (2016) |
|--|--|
| Initial Enrollment | 162,977 |
| Revalidation | 150,599 |
| Reactivation | 16,265 |
| Currently Enrolled as an Ordering/Certifying Provider and Wish to Enroll as an Individual Practitioner | 12,597 |
| Enrolling with Another MAC | 1,926 |
| Reporting a Change of Medicare Enrollment Information | 127,416 |
| Voluntary Termination of Medicare Enrollment | 42,092 |
| <u>GRAND TOTAL</u> (Total Processed CMS-855Is for All Reasons for Submission) | 513,872 |

Table 2 – Individual Burden Hours and Costs for Completion of the CMS-855I per Reason for Submittal and Respondent

| Reason for Submittal | Hours for Completion by Office Personnel per CMS-855I | Hours for a Physician to Review and Sign CMS-855I | Hours for an Individual Practitioner to Review and Sign CMS-855I | Total Hours for Completion per CMS-855I | Cost for Completion by Office Personnel per CMS-855I | Cost for Review and Signature by a Physician per CMS-855I (66.6%) | Cost for Review and Signature by an Individual Practitioner per CMS-855I (33.3%) | Total Cost of Completion per CMS-855I |
|---|--|--|---|--|---|--|---|--|
| Initial Enrollment | 2.5 | 0.5 | n/a | 3 | \$84.25 | \$101.04 | n/a | \$185.29 |
| Initial Enrollment | 2.5 | n/a | 0.5 | 3 | \$84.25 | n/a | \$47.51 | \$131.76 |
| Revalidation | 1.5 | 0.5 | n/a | 2 | \$50.55 | \$101.04 | n/a | \$151.59 |
| Revalidation | 1.5 | n/a | 0.5 | 2 | \$50.55 | n/a | \$47.51 | \$98.06 |
| Reactivation | 1.5 | 0.5 | n/a | 2 | \$50.55 | \$101.04 | n/a | \$151.59 |
| Reactivation | 1.5 | n/a | 0.5 | 2 | \$50.55 | n/a | \$47.51 | \$98.06 |
| Currently Enrolled as an Ordering/ Certifying Provider and Wish to Enroll as an Individual Practitioner | 1.5 | 0.5 | n/a | 2 | \$50.55 | \$101.04 | n/a | \$151.59 |
| Currently Enrolled as an Ordering/ Certifying Provider and Wish to Enroll as an Individual Practitioner | 1.5 | n/a | 0.5 | 2 | \$50.55 | n/a | \$47.51 | \$98.06 |
| Enrolling with Another MAC | 1.5 | 0.5 | n/a | 2 | \$50.55 | \$101.04 | n/a | \$151.59 |
| Enrolling with Another MAC | 1.5 | n/a | 0.5 | 2 | \$50.55 | n/a | \$47.51 | \$98.06 |

| | | | | | | | | |
|---|------|------|------|-----|---------|---------|---------|---------|
| Reporting a Change of Medicare Enrollment Information | 0.75 | 0.25 | n/a | 1 | \$25.28 | \$50.52 | n/a | \$75.80 |
| Reporting a Change of Medicare Enrollment Information | 0.75 | n/a | 0.25 | 1 | \$25.28 | n/a | \$23.76 | \$49.04 |
| Voluntary Termination of Medicare Enrollment | 0.42 | 0.08 | n/a | 0.5 | \$14.15 | \$16.17 | n/a | \$30.32 |
| Voluntary Termination of Medicare Enrollment | 0.42 | n/a | 0.08 | 0.5 | \$14.15 | n/a | \$7.60 | \$21.75 |

Table 3 – Total Burden Hours and Costs

| Reason for Submittal | Total Number of CMS-855Is Processed per year (2016) (from Table 1) | Total Hours of Completion of CMS-855I per year (total number processed x hours per submission reason for CMS-855I from Table 2) | Total Cost per Completion of CMS-855I per year by Physicians (total number processed x .66 x cost per CMS-855I from Table 2) | Total Cost per Completion of CMS-855I per year by Non-physician practitioners (total number processed x .33 x cost per CMS-855I from Table 2) | Total Cost per Completion of CMS-855I by Physicians and Non-physician Practitioners |
|--|--|---|--|---|---|
| Initial Enrollment | 162,977 | 488,931 | \$19,930,718.80 | \$7,086,370.30 | \$27,017,089.10 |
| Revalidation | 150,599 | 301,198 | \$15,067,288.00 | \$4,873,385.90 | \$19,940,673.90 |
| Reactivation | 16,265 | 32,530 | \$1,627,318.70 | \$526,288.00 | \$2,153,606.70 |
| Currently Enrolled as an Ordering/Certifying Provider and Wish to Enroll as an Individual Practitioner | 12,597 | 25,194 | \$1,260,319.30 | \$407,635.40 | \$1,667,954.70 |

| | | | | | |
|--|----------------|------------------|------------------------|------------------------|------------------------|
| Enrolling with Another MAC | 1,926 | 3,852 | \$192,670.90 | \$62,366.20 | \$255,037.10 |
| Reporting a Change of Medicare Enrollment Information | 127,416 | 127,416 | \$6,374,401.00 | \$2,061,984.90 | \$8,436,385.90 |
| Voluntary Termination of Medicare Enrollment | 42,092 | 21,046 | \$842,319.90 | \$302,107.50 | \$1,144,427.40 |
| <u>GRAND TOTAL</u> (Total of All Column Categories) | 513,872 | 1,000,167 | \$45,295,036.60 | \$15,320,138.20 | \$60,615,174.80 |

13. Cost to Respondents (Capital)

There are no capital costs associated with this collection.

14. Cost to Federal Government

Medicare contractors currently finalize approximately 1.3 million provider/supplier enrollment applications a year. The form changes will not result in any additional cost to the federal government because Medicare contractors are already processing applications from individuals who are enrolling or enrolled in the Medicare program. Applications will continue to be processed in the normal course of Federal duties.

15. Changes in Burden/Program Changes

There is an overall increase of burden hours, from 190,332 hours to 1,000,167 hours. The increase of 809,835 burden hours is the difference from the estimated 190,332 burden hour estimate in 2011 to the accurately reported 1,000,167 total hours for processing in calendar year 2016. In 2011, there was no way to accurately count the number of hours it took per response and there were less submittal reasons, so the figure was determined by totaling MAC estimates. With the use of the PECOS system, updated information technology allows CMS to accurately count the hours per submittal reason and consequently, total hours annually. The 2011 the burden hour estimates were based on old data. With the more accurate and current data, the burden hours were determined to be 1,000,167, which, in turn, was also a factor in the increase in processing cost. The previous inaccurate estimated burden hours, the lack of wage differentiation, and additional submittal reasons all factor into the increased cost.

The decrease in the number of respondents is 206,128 (from 720,000 to 513,872). Since its last revision in 2011, the reasons for submission of the CMS-855I have increased to seven (initial enrollment, revalidation, reactivation, currently enrolled as an ordering/referring provider

and wish to enroll as an individual practitioner, enrolling with another MAC, reporting a change of Medicare enrollment information, and voluntary termination of Medicare enrollment) and the number of providers have decreased. In 2011, it was estimated that the CMS-855I had 720,000 respondents. Presently, using better information collection techniques (exact figures from the Internet-based PECOS system, which are taken directly from the actual applications processed for calendar year 2016 in PECOS) CMS knows MACs currently process approximately 513,872 CMS-855I applications per year.

16. Publication/Tabulation

There are no plans to publish the outcome of the data collection.

17. Expiration Date

The expiration date will be displayed on the top, right-hand corner of page 1 of the CMS-855I application.