satisfaction, attitudes and perceptions regarding the services provided by Medicare Fee-for-Service (FFS) Carriers, Fiscal Intermediaries, Durable Medical Equipment Suppliers, and Regional Home Health Intermediaries and Medicare Administrative Contractors. The survey focuses on basic business functions provided by the Medicare Contractors such as inquiries, provider communications, claims processing, appeals, provider enrollment, medical review and provider audit & reimbursement. Providers will receive a notice requesting they use a specially constructed web site to respond to a set of questions customized for their contractor's responsibilities. The survey will be conducted yearly and annual reports of the survey results will be available via an online reporting system for use by CMS, Medicare Contractors, and the general public.

Due to changes in CMS' reporting needs, CMS is requesting a potential increase in the number of completed surveys. This increase will allow CMS to have not only Contractor-specific, but also jurisdiction and state-specific data which, in turn, will enable Contractors to increase and implement performance improvement activities within their organizations. This increase will affect the 2008 and 2009 administrations of the survey. *Frequency:* Reporting—Annually; *Affected Public:* Business or other for-profit, Not-for-profit institutions; *Number of Respondents:* 24,279; *Total Annual Responses:* 24,279; *Total Annual Hours:* 8,346.

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 E-mail your request, including your address, phone number, OMB number, and CMS document identifier, to *Paperwork@cms.hhs.gov,* or call the Reports Clearance Office on (410) 786–1326.

Written comments and recommendations for the proposed information collections must be mailed or faxed within 30 days of this notice directly to the OMB desk officer: OMB Human Resources and Housing Branch, Attention: Carolyn Lovett, New Executive Office Building, Room 10235, Washington, DC 20503, Fax Number: (202) 395–6974.

Dated: April 20, 2007.

Michelle Shortt,

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

[FR Doc. E7–7954 Filed 4–26–07; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10225, CMS–10116, CMS–R–39, and CMS–1500 (08–05)]

Agency Information Collection Activities: Proposed Collection; 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) 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 functions; (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:* Disclosures to Patients by Certain Hospitals and Critical Access Hospitals; *Form Numbers:* CMS–10225 (OMB#: 0938–New); *Use:* There is no Medicare prohibition against physician investment in a hospital or critical access hospital (CAH). Likewise, there is no Medicare requirement that a hospital or CAH have a physician on-site at all times, although there is a requirement that they be able to provide basic elements of emergency care to their patients. Medicare quality and safety standards are designed to provide a national framework that is sufficiently flexible to apply simultaneously to hospitals of varying sizes, offering varying ranges of services in differing settings across the nation. At the same time, however, patients might consider an ownership interest by their referring physician and/or the presence of a physician on-site to be important factors in their decisions about where to seek hospital care. A well-educated consumer is essential to improving the quality and efficiency of the healthcare system. Accordingly, patients should be made aware of the physician ownership of a hospital, whether or not a physician is present in the hospital at all times, and the hospital's plans to address patients' emergency medical conditions when a physician is not present. The intent of the proposed disclosures is to increase the transparency of the hospital's ownership and operations to patients as they make decisions about receiving care at the hospital. *Frequency:* Recordkeeping, Third-party disclosure—On occasion; *Affected Public:* Business or for-profits, Not-for-profit institutions; *Number of Respondents:* 2,679; *Total Annual Responses:* 2,925,468; *Total Annual Hours:* 59,473.

2. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Medicare Program; Conditions of Payment of Power Mobility Devices, Including Power Wheelchairs and Power-Operated Vehicles (CMS–3017–F); *Form Numbers:* CMS–10116 (OMB#: 0938–0971); *Use:* The CMS is seeking the reapproval of the collection requirements associated with the final rule, CMS–3017–F (71 FR 17021), which was published on April 5, 2006, and became effective on June 5, 2006. Specifically, we are seeking OMB approval for the following terms of clearance identified in the Notice of Action dated October 16, 2006, of which OMB has requested CMS to monitor the paperwork burden required of providers and suppliers to determine if the paperwork requirements impose any unnecessary burden on the industry and/or need to be revised in order to improve the utility of the information.

After analyzing the documentation requirements burden, CMS does not believe that the documentation requirements impose any additional unnecessary burden on the durable medical equipment (DME) industry. We believe that most physicians are already conducting a face-to-face examination before prescribing a wheelchair. Given that physicians and treating practitioners can now prescribe power-operated vehicles (POVs), thereby removing the requirement that a specialist can order a POV, CMS believes that the increased burden of 48,600 hours for physicians and treating practitioners is based on the

Congressional decision to allow a broader range of physicians and treating practitioners to prescribe POVs. This increased burden is offset by the new payments implemented in connection with the Final Rule, which is demonstrated by the shift in prescriptions from one class of equipment, power wheelchairs, to another class of equipment, POVs.

In addition, CMS believes that with the recent coverage decision on Mobility Assistive Equipment, the implementing details in the Final Rule (*e.g.* improved documentation for suppliers; physician and treating practitioner payments; improved classification of mobility equipment; the elimination of the certificate of medical necessity (CMN)), and the provider outreach and education provided by CMS, the DME program safeguard contractors (PSCs) and DME Medicare administrative contractors (MACs), the needs of mobility-impaired beneficiaries and the needs of suppliers have been better met. *Frequency:* Recordkeeping—On occasion; *Affected Public:* Business or for-profits, Not-for-profit institutions, and State, Local or Tribal governments; *Number of Respondents:* 38,000; *Total Annual Responses:* 342,000; *Total Annual Hours:* 48,600.

3. *Type of Information Collection Request:* Extension of a currently approved collection; *Title of Information Collection:* Home Health Conditions of Participation (CoP) Information Collection Requirements and Supporting Regulations in 42 CFR 484.10, 484.12, 484.16, 484.18, 484.36, 484.48, 484.52; *Form Numbers:* CMS–R–39 (OMB#: 0938–0365); *Use:* The information collection requirements contained in this request are part of the requirements classified as the conditions of participation (CoPs) which are based on criteria prescribed in law and are standards designed to ensure that each facility has properly trained staff to provide the appropriate safe physical environment for patients. These particular standards reflect comparable standards developed by industry organizations such as the Joint Commission on Accreditation of Healthcare Organizations, and the Community Health Accreditation Program. The primary users of this information will be State agency surveyors, the regional home health intermediaries, CMS and home health agencies (HHAs) for the purpose of ensuring compliance with Medicare CoPs as well as ensuring the quality of care provided by HHA patients. *Frequency:* Recordkeeping and Reporting—Annually, On occasion; *Affected Public:* Business or for-profits, Not-for-profit institutions, and State, Local or Tribal governments; *Number of Respondents:* 9,354; *Total Annual Responses:* 9,354; *Total Annual Hours:* 1,048,483.5.

4. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Health Insurance Common Claims Form and Supporting Regulations at 42 CFR Part 424, Subpart C; *Form Number:* CMS–1500(08–05), CMS–1490–S (OMB#: 0938–0999); *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.

Since the last submission of this information collection request, we discontinued form CMS–1490U which was used by employers, unions, employer-employee organizations that pay physicians and suppliers for their services to employees, group practice prepayment plans, and health maintenance organizations. Therefore, this collection will no longer contain the CMS–1490U.

In sum, the CMS–1500 and CMS–1490S result in less paperwork burden placed on the public. The CMS–1500 provides efficiency in office procedures for physicians and suppliers; the CMS–1490S provides beneficiaries with a relatively easy form to use when filing their claims. Without the collection of this information, claims for reimbursement relating to the provision of Part B medical services/supplies could not be acted upon. This would result in a nationwide paralysis of the operation of the Federal Government's Medicare Part B program, and major problems for the other health plans that use the CMS–1500, inflicting severe physical and financial hardship on providers/suppliers as well as beneficiaries. *Frequency:* Reporting—On occasion; *Affected Public:* State, Local, or Tribal Government, Business or other-for-profit, Not-for-profit institutions; *Number of Respondents:* 1,048,243; *Total Annual Responses:* 970,174,260; *Total Annual Hours:* 33,067,757.

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 E-mail your request, including your address, phone number, OMB number, and CMS document identifier, to *Paperwork@cms.hhs.gov,* or call the Reports Clearance Office on (410) 786–1326.

To be assured consideration, comments and recommendations for the proposed information collections must be received at the address below, no later than 5 p.m. on June 26, 2007.

CMS, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development—B, Attention: William N. Parham, III, Room C4–26–05, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Dated: April 20, 2007.

Michelle Shortt,

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

[FR Doc. E7–7955 Filed 4–26–07; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1387–N]

Medicare Program; Meeting of the Practicing Physicians Advisory Council, May 21, 2007

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

ACTION: Notice.