

beneficiary's diabetes, provided certain requirements are met. We sometimes use national accreditation organizations to assess whether provider entities meet Medicare requirements when providing services for which Medicare payment is made.

Under section 1865(b)(1) of the Act, a national accreditation organization must have an agreement in effect with the Secretary and meet the standards and requirements specified by the Secretary in 42 CFR part 410, subpart H to qualify for deeming authority. The regulations pertaining to application procedures for national accreditation organizations for diabetes self-management training services are specified at § 410.142 (CMS process for approving national accreditation organizations).

A national accreditation organization applying for deeming authority must provide us with reasonable assurance that the accrediting organization requires accredited entities to meet requirements that are at least as stringent as CMS's requirements. We may approve and recognize a nonprofit or not-for-profit organization with demonstrated experience in representing the interests of individuals with diabetes to accredit entities to furnish training. The accreditation organization, after being approved and recognized by CMS, may accredit an entity to meet one of the sets of quality standards in § 410.144 (Quality standards for deemed entities).

Section 1865 (b)(2) of the Act further requires that we review the applying accreditation organization's requirements for accreditation, as follows:

- Survey procedures,
- Ability to provide adequate resources for conducting required surveys,
- Ability to supply information for use in enforcement activities,
- Monitoring procedures for providers found out of compliance with the conditions or requirements, and
- Ability to provide us with necessary data for validation.

We then examine the national accreditation organization's accreditation requirements to determine if they meet or exceed the Medicare conditions as we would have applied them. Section 1865(b)(3)(A) of the Act requires that we publish a notice identifying the national accreditation body making the request within 30 days of receipt of a completed application. The notice must describe the nature of the request and provide at least a 30-day public comment period. We have 210 days from receipt of the request to publish a finding of approval or denial

of the application. If we recognize an accreditation organization in this manner, any entity accredited by the national accreditation body's CMS-approved program for that service will be "deemed" to meet the Medicare conditions for coverage.

## II. Purpose

The purpose of this notice is to notify the public of the American Diabetes Association's (ADA's) request for the Secretary's approval of its accreditation program for outpatient diabetes self-management training services. This notice also solicits public comments on the ability of the ADA to develop and apply its standards to entities furnishing outpatient diabetes self-management training services that meet or exceed the Medicare conditions for coverage.

## III. Outpatient Diabetes Self-Management Training Services Conditions for Coverage and Requirements

The regulations specifying the Medicare conditions for coverage for outpatient diabetes self-management training services are located in 42 CFR part 410, subpart H. These conditions implement section 1861(qq) of the Act, which provides for Medicare Part B coverage of outpatient diabetes self-management training services specified by the Secretary.

Under section 1865(b)(2) of the Act and our regulations § 410.142 (CMS process for approving national accreditation organizations) and § 410.143 (Requirements for approved accreditation organizations), we review and evaluate a national accreditation organization based on (but not necessarily limited to) the criteria set for in § 410.142(b).

We may conduct on-site inspections of a national accreditation organization's operations and office to verify information in the organization's application and assess the organization's compliance with its own policies and procedures. The onsite inspection may include, but is not limited to, reviewing documents, auditing documentation of meetings concerning the accreditation process, evaluating accreditation results or the accreditation status decision making process, and interviewing the organization's staff.

## IV. Notice Upon Completion of Our Evaluation

Upon completion of our evaluation, including evaluation of comments received as a result of this notice, we will publish a notice in the **Federal**

**Register** announcing the result of our evaluation.

## V. Responses to Public Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

In accordance with the provisions of Executive Order 12866, the Office of Management and Budget did not review this notice.

**Authority:** Section 1865 of the Social Security Act (42 U.S.C. 1395bb). (Catalog of Federal Domestic Assistance Program No. 93.773 Medicare-Hospital Insurance Program; and No. 93.774, Medicare-Supplementary Medical Insurance Program)

Dated: May 11, 2007.

**Leslie V. Norwalk,**  
*Acting Administrator, Centers for Medicare & Medicare Services.*

[FR Doc. 07-2454 Filed 5-24-07; 8:45 am]

**BILLING CODE 4120-01-P**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Medicare & Medicaid Services

[CMS-6040-N2]

### Medicare Program; Approval of Deeming Authority for National Accreditation Organizations to Accredit Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers

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

**ACTION:** Notice.

**SUMMARY:** This notice announces the 10 national accreditation organizations that have been approved by CMS to accredit durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers seeking to participate in the Medicare program.

**FOR FURTHER INFORMATION CONTACT:** Alisa Overgaard, (410) 786-2167.

#### SUPPLEMENTARY INFORMATION:

##### I. Background

Section 302(a)(1) of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) (Pub. L. 108-173) added section 1834(a)(20) of

the Social Security Act (the Act) and requires the Secretary to establish and implement quality standards for suppliers of certain items, including consumer service standards, to be applied by recognized independent accreditation organizations. Suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) must comply with the quality standards to furnish any item for which payment is made under Medicare Part B, and to receive and retain a provider or supplier billing number used to submit claims for reimbursement for any such item for which payment may be made under Medicare. Section 1834(a)(20)(D) of the Act requires us to apply these quality standards to suppliers of the following items for which we deem the standards to be appropriate:

- Covered items, as defined in section 1834(a)(13) of the Act, for which payment may be made under section 1834(a) of the Act.
- Prosthetic devices, orthotics, and prosthetics described in section 1834(h)(4) of the Act.
- Items described in section 1842(s)(2) of the Act, which include—(1) medical supplies; (2) home dialysis supplies and equipment; (3) therapeutic shoes; (4) parenteral and enteral nutrients; (5) equipment, and supplies; (6) electromyogram devices; (7) salivation devices; (8) blood products; and (9) transfusion medicine.

Section 1834(a)(20)(B) of the Act requires the Secretary, notwithstanding section 1865(b) of the Act, to designate and approve one or more independent accreditation organizations to apply the quality standards to suppliers of DMEPOS and other items. For most providers and suppliers, the Medicare program currently contracts with State Agencies to perform survey and review functions for such providers and suppliers to approve their participation in or coverage under the Medicare program. Additionally, section 1865(b) of the Act sets forth the general procedures for us to approve non-DMEPOS national accreditation organizations. We deem providers or suppliers to have met Medicare conditions of participation or coverage if they are accredited by a national accreditation organization that we have approved.

## II. Deeming Application Approval Process

We compared the standards contained in all the accrediting organization applications with that of the CMS quality standards as posted on the CMS Web site [www.cms.hhs.gov/competitiveAcqforDMEPOS](http://www.cms.hhs.gov/competitiveAcqforDMEPOS) and those

requirements set forth in the August 16, 2006 **Federal Register** notice (71 FR 47230).

An internal professional panel reviewed 11 applications, which were assessed on the basis of the criteria set out in the August 16, 2006 **Federal Register** notice. Those criteria included (but were not limited to) requirements in § 424.58(b). According to that notice, applicants had to furnish the following documentation and information to CMS:

- A description of all types and categories of accreditation offered by the organization for which approval of deeming authority is sought.
- A description of the duration of accreditation.
- A detailed comparison of the organization's accreditation requirements and standards with the applicable Medicare DMEPOS quality standard requirements such as a crosswalk.
- A detailed description of the organization's survey process, including:
  - Frequency of the surveys performed;
  - Procedures for performing unannounced surveys;
  - A description of the accreditation survey review process and the accreditation status decision-making process, including the process for addressing deficiencies identified with the accreditation requirements.
  - The procedures used to monitor the correction of deficiencies found during an accreditation survey;
  - Policies and procedures used when an organization has a dispute regarding survey findings or an adverse decision;
  - Procedures for coordinating surveys with another accrediting organization if the organization does not credit all products the supplier provides.
  - Detailed information about the individuals who perform survey for the accreditation organization including:
    - The size and composition of accreditation teams for each type of provider and supplier accredited.
    - The education and experience requirements surveyors must meet.
    - The content and frequency of the in-service training provided to survey personnel.
    - The evaluation systems used to monitor the performance of individual surveyors and survey teams.
  - Policies and procedures regarding an individual's participation in the survey or accreditation decision process of any organization with which the individual is professionally or financially affiliated.

- A description of the organization's data management and analysis system for its surveys and accreditation decisions, including the kinds of reports, tables, and other displays generated by that system.

- The organization's procedures for responding to and for the investigation of complaints against accredited facilities, including policies and procedures regarding coordination of these activities with appropriate licensing bodies (that is, National Supplier Clearinghouse, CMS, and ombudsman programs.)
- The organization's policies and procedures for the withholding or removal of accreditation status for facilities that fail to meet the accreditation organization's standards or requirements, and other actions taken by the organization in response to noncompliance with its standards and requirements, including the procedures for notifying CMS of facilities that fail to meet the requirements of the accrediting organization.

See the August 16, 2006 **Federal Register** (71 FR 47230) for a full description of the documentation and information requirements.

The national accreditation organizations that have applied for approval of deeming authority provided us with assurance that the accreditation organizations met requirements that were at least as stringent as the Medicare quality standards.

The following organizations have been recognized as national accreditation organizations and have been given deeming authority to accredit DMEPOS suppliers seeking to participate in the Medicare program:

- Joint Commission on Accreditation of Healthcare Organizations
- Community Health Accreditation Program
- Healthcare Quality Association on Accreditation
- National Board of Accreditation for Orthotic Suppliers
- Board for Orthotist/Prosthetist Certification
- Accreditation Commission for Healthcare, Inc.
- National Association of Boards of Pharmacy
- Commission on Accreditation of Rehabilitation Facilities
- American Board for Certification in Orthotics and Prosthetics, Inc. and the Board of Certification in Pedorthics (We note that on January 1, 2007 these 2 organizations merged and we have updated our Web site to reflect this change. The organizations' new name is the American Board for Certification in

Orthotics, Prosthetics, and Pedorthics, Inc.).

- The Compliance Team, Inc.

**Authority:** Section 1834(a)(20) of the Social Security Act (42 U.S.C. 1395m(a)(20)). (Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance Program; and No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: May 17, 2007.

**Leslie V. Norwalk,**

*Acting Administrator, Centers for Medicare & Medicaid Services.*

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**BILLING CODE 4120-01-P**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Medicare & Medicaid Services

[CMS-1322-N]

#### Medicare Program; Second Semi-Annual Meeting of the Advisory Panel on Ambulatory Payment Classification Groups—September 5, 6, and 7, 2007

**AGENCY:** Centers for Medicare & Medicaid Services, Department of Health and Human Services.

**ACTION:** Notice.

**SUMMARY:** In accordance with section 10(a) of the Federal Advisory Committee Act (FACA) (5 U.S.C. Appendix 2), this notice announces the second semi-annual meeting of the Advisory Panel on Ambulatory Payment Classification (APC) Groups (the Panel) for 2007. The purpose of the Panel is to review the APC groups and their associated weights and to advise the Secretary of the Department of Health and Human Services (DHHS) (the Secretary) and the Administrator of the Centers for Medicare & Medicaid Services (CMS) (the Administrator) concerning the clinical integrity of the APC groups and their associated weights. We will consider the Panel's advice as we prepare the final rule that updates the hospital Outpatient Prospective Payment System (OPPS) for CY 2008.

**DATES: Meeting Dates:** We are scheduling the second semi-annual meeting in 2007 for the following dates and times:

- Wednesday, September 5, 2007, 1 p.m. to 5 p.m. (e.s.t.)<sup>1</sup>
- Thursday, September 6, 2007, 8 a.m. to 5 p.m. (e.s.t.)<sup>1</sup>
- Friday, September 7, 2007, 8 a.m. to 12 noon (e.s.t.)<sup>2</sup>

<sup>1</sup>The times listed in this notice are approximate times; consequently, the

meetings may last longer than listed in this notice—but will not begin before the posted times.

<sup>2</sup> If the business of the Panel concludes on Thursday, September 6, there will be no Friday meeting.

**Deadlines:** Deadline for Hardcopy Comments/Suggested Agenda Topics—

5 p.m. (e.s.t.), Thursday, August 9, 2007

Deadline for Hardcopy Presentations—  
5 p.m. (e.s.t.), Thursday, August 9, 2007

Deadline for Attendance Registration—  
5 p.m. (e.s.t.), Wednesday, August 29, 2007

Deadline for Special Accommodations—  
5 p.m. (e.s.t.), Wednesday, August 29, 2007

#### Submission of Materials to the Designated Federal Officer (DFO)

Because of staffing and resource limitations, we cannot accept written comments and presentations by FAX, nor can we print written comments and presentations received electronically for dissemination at the meeting.

Only hardcopy comments and presentations can be reproduced for public dissemination. All hardcopy presentations *must be accompanied by Form CMS-20017 (revised 01/07)*. The form is now available through the CMS Forms Web site. The Uniform Resource Locator (URL) for linking to this form is as follows: <http://www.cms.hhs.gov/cmsforms/downloads/cms20017.pdf>.

Presenters must use the most recent copy of CMS-20017 (updated 01/07) at the above URL. Additionally, presenters must *clearly* explain the action(s) that they are requesting CMS to take in the appropriate section of the form. They must also clarify their relationship to the organization that they represent in the presentation.

**(Note:** Issues that are vague, or that are outside the scope of the APC Panel's purpose, will not be considered for presentations and comments. There will be no exceptions to this rule. We appreciate your cooperation on this matter.)

We are also requiring electronic versions of the written comments and presentations, in addition to the hardcopies, to send electronically to the Panel members for their review prior to the meeting.

In summary, presenters and/or commenters must do the following:

- Send *BOTH electronic and hardcopy versions of their presentations and written comments by the prescribed deadlines.*

- Send electronic transmissions to the e-mail address below.

- Mail (or send by courier) to the DFO all hardcopies, accompanied by Form CMS-20017 (revised 01/07), if they are presenting, as specified in the "FURTHER INFORMATION CONTACT" section of this notice.

- Commenters are not required to send Form CMS-20017 with their written comments.

**ADDRESSES:** The meeting will be held in the Auditorium, CMS Central Office, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

#### FOR FURTHER INFORMATION CONTACT:

- For further information, contact: Shirl Ackerman-Ross, DFO, CMS, CMM, HAPG, DOC, 7500 Security Boulevard, Mail Stop C4-05-17, Baltimore, MD 21244-1850. *Phone:* (410) 786-4474.

**(Note:** Please advise couriers of the following: When delivering hardcopies of presentations to CMS, if no one answers at the above phone number, please call (410) 786-4532.)

- E-mail address for comments, presentations, and registration requests is [CMSAPCPanel@cms.hhs.gov](mailto:CMSAPCPanel@cms.hhs.gov).

**(Note:** There is NO underscore in this e-mail address; there is a SPACE between CMS and APCPanel.)

- News media representatives must contact our Public Affairs Office at (202) 690-6145.

#### Advisory Committees' Information Lines

The phone numbers for the CMS Federal Advisory Committee Hotline are 1-877-449-5659 (toll free) and (410) 786-9379 (local).

#### Web Sites

Please search the CMS Web site at [http://www.cms.hhs.gov/FACA/05\\_AdvisoryPanelonAmbulatoryPaymentClassificationGroups.asp#TopOfPage](http://www.cms.hhs.gov/FACA/05_AdvisoryPanelonAmbulatoryPaymentClassificationGroups.asp#TopOfPage) in order to obtain the following information:

**(Note:** There is an UNDERSCORE after FACA/05(like this.); there is no space.)

- Additional information on the APC meeting agenda topics,
- Updates to the Panel's activities,
- Copies of the current Charter, and
- Membership requirements.

You may also search information about the APC Panel and its membership in the FACA database at the following URL: <https://www.fido.gov/facadatabase/public.asp>.

#### SUPPLEMENTARY INFORMATION:

##### I. Background

The Secretary is required by section 1833(t)(9)(A) of the Social Security Act (the Act), [as amended by section 201(h) of the Medicare, Medicaid, and SCHIP