their own enrollments through the web based version of the Provider Enrollment, Chain and Ownership System (PECOS).

In order to allow a provider or supplier to delegate the Medicare credentialing process to another individual or organization, it is necessary to establish a Security Consent Form for those providers and suppliers who choose to have another individual or organization access their enrollment information and complete enrollments on their behalf. These users could consist of administrative staff, independent contractors, or credentialing departments and are represented as a User group. User groups and its members must request access to enrollment data through a Security Consent Form. The security consent form replicates business service agreements between Medicare applicants and organizations providing enrollment services.

We have revised the information collection request since the publication of the 60-day **Federal Register** notice (72 FR 13793). Rather than the four original forms, we are proposing only two different versions of the Security Consent Form. The form, once signed, mailed and approved, grants a user group or its member's access to all current and future enrollment data for the Medicare provider. The user group administrator, within the user group, assigns to each member of the group, a security role that will define their levels of functionality within PECOS via the web for an individual or organization. *Frequency:* Reporting—On occasion; *Affected Public:* Business or other for-profit, not-for-profit institutions, individuals or households; *Number of Respondents:* 177,500; *Total Annual Responses:* 177,500; *Total Annual Hours:* 44,375.

2. *Type of Information Collection Request:* New collection; *Title of Information Collection:* HCPCS Level II Code Modification Request Process; *Use:* For Medicare and other health insurance programs to ensure that claims are processed in an orderly and consistent manner, standardized coding systems are essential. The Healthcare Common Procedure Coding System (HCPCS) Level I1 Code Set is one of the standard code sets used for this purpose. Level I1 of the HCPCS, also referred to as alpha-numeric codes, is a standardized coding system that is used primarily to identify products, supplies, and services not included in the Current Procedural Terminology (CPT) codes, such as ambulatory services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used in the home or outpatient setting. As technology evolves and new products are developed, there are continuous changes to the HCPCS code set. Modifications to the HCPCS are initiated via application form submitted by any interested stakeholder. These applications have been received on an on-going basis with an annual deadline for each cycle. In October 2003, the Secretary of Health and Human Services delegated CMS authority to maintain and distribute HCPCS Level I1 Codes. As a result, the National Panel was delineated and CMS continued with the decision-making process under its current structure, the CMS HCPCS Workgroup.

CMS' Council on Technological Innovation (CTI) has instituted a number of improvements to the HCPCS process. Specific process refinements include public notification of CMS' preliminary decisions, and a new opportunity to respond to CMS' preliminary decisions at a public meeting before a final decision is reached by the workgroup. CMS has streamlined the form into a user-friendly application. The content of the material is the same, but the questions have been refined. CMS is also preparing a system of records (SOR) notice.

Applications are received, and distributed to all workgroup members. Workgroup members review the material and provide comments at the HCPCS workgroup meetings. Discussions are posted to CMS' HCPCS Web site. Final decisions are released to the applicant via letter; and all resulting modifications to the HCPCS codes are reflected on the HCPCS update. *Form Number:* CMS–10224 (OMB#: 0938–New); *Frequency:* Reporting: Occasionally; *Affected Public:* Business or other for-profit and State, Local or Tribal Government; *Number of Respondents:* 300; *Total Annual Responses:* 300; *Total Annual Hours:* 3,300.

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 by the OMB desk officer at the address below, no later than 5 p.m. on December 10, 2007. OMB Human Resources and Housing Branch, Attention: Carolyn Lovett, New Executive Office Building, Room 10235, Washington, DC 20503, Fax Number: (202) 395–6974.

Dated: October 26, 2007.

Michelle Shortt,

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

[FR Doc. 07–5480 Filed 11–8–07; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10243]

Agency Information Collection Activities: Submission for OMB Review; 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), Department of Health and Human Services, 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 function; (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:* Data Collection for Administering the Medicare Continuity Assessment Record and Evaluation (CARE) Instrument; *Use:* The Medicare Continuity Assessment Record and Evaluation (CARE) is a uniform patient assessment instrument designed to measure differences in patient severity, resource utilization, and outcomes for patients in acute and post-acute care settings. This tool will be used to (1) standardize program information on Medicare beneficiaries' acuity at discharge from acute hospitals, (2) document medical severity,

functional status and other factors related to outcomes and resource utilization at admission, discharge, and interim times during post acute treatment, and (3) understand the relationship between severity of illness, functional status, social support factors, and resource utilization. The CARE instrument will be used in the Post-Acute Care (PAC) Payment Reform Demonstration program mandated by Section 5008 of the Deficit Reduction Act of 2005 to develop payment groups that reflect patient severity and related cost and resource use across post acute settings. Specifically, the data collected using the CARE instrument during the Post-Acute Care Payment Demonstration will be used by CMS to develop a setting neutral post-acute care payment model as mandated by the Congress. The data will be used to characterize patient severity of illness and level of function in order to predict resource use, post-acute care discharge placement, and beneficiary outcomes. CMS will use the data from the CARE instrument to examine the degree to which the items on the instrument can be used to predict beneficiary resource use and outcomes.

CMS made over 150 changes and improvements to the CARE instrument following the 60 day public comment period. Many revisions were minor word changes or clarifications to item-coding instructions. A significant number of changes were made to delete unnecessary items and to add skip patterns to allow respondents to skip over items/sections that do not apply to a particular condition. The revised version of CARE retains its clinical integrity while allowing for greater response specificity. *Form Number:* CMS–10243 (OMB#: 0938–NEW); *Frequency:* Reporting—Daily; *Affected Public:* Private Sector—Business or other for-profit and Not-for-profit institutions; *Number of Respondents:* 388; *Total Annual Responses:* 244,292; *Total Annual Hours:* 179,341.

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 by the OMB desk officer at the address below, no later than 5 p.m. on *December 10, 2007.* OMB Human Resources and Housing Branch, Attention: Carolyn Lovett, New Executive Office Building, Room 10235, Washington, DC 20503, Fax Number: (202) 395–6974.

Dated: November 2, 2007.

Michelle Shortt,

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

[FR Doc. E7–21989 Filed 11–8–07; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10239 and CMS–R–48]

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:* Conditions of Participation for Critical Access Hospitals; *Use:* With this submission, we are creating a new information collection request for critical access hospitals (CAH). Currently, the information collection requirements associated with the critical access hospital (CAH) conditions of participation (CoPs) are included with the hospital CoPs reported under CMS–R–48 (0938–0328). Because the CAH program has grown in scope of services and the number of providers, we have removed the CAH burden from the CMS–R–48 with the exception of the burden associated with the 101 CAHs that have distinct part units (DPUs), and created a separate information collection request for OMB review and approval. Section 1820(c)(2)(E)(i) of the Social Security Act states that if a CAH operates a distinct part psychiatric or rehabilitation unit it must have 10 beds or less in the DPU and it must comply with the hospital requirements specified in 42 CFR Subpart A, B, C, and D of part 482. Based on 2007 data from HRSA, 81 CAHs have psychiatric distinct part units (DPUs) and 20 CAHs have rehabilitation DPUs. The burden associated with the 101 CAHs with DPUs is reported in CMS–R–48. *Form Number:* CMS–10239 (OMB#: 0938–New); *Frequency:* Yearly; *Affected Public:* Private sector—Business or other for-profit; *Number of Respondents:* 1,189; *Total Annual Responses:* 137,990; Total Annual Hours: 23,291.

2. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Hospital Conditions of Participation and Supporting Regulations in 42 CFR 482.12, 482.13, 482.21, 482.22, 482.23, 482.24, 482.27, 482.30, 482.41, 482.43, 482.45, 482.53, 482.56, 482.57, 482.60, 482.61, 482.62, and 485.616 and 485.631; *Use:* The information collection requirements described in this information collection request are needed to implement the Medicare and Medicaid conditions of participation (CoP) for 4,890 accredited and non-accredited hospitals and an additional 101 critical access hospitals (CAHs) that have distinct part psychiatric or rehabilitation units (DPUs). CAHs that have DPUs must comply with all of the hospital CoPs on these units. Thus, this package reflects the paperwork burden for a total of 4,991 (that is, 4,890 hospitals and 101 CAHs which include 81 CAHs that have psychiatric DPUs and 20 CAHs that have rehabilitation DPUs). The information collection requirements for the remaining 1,183 CAHs have been reported in a separate package under CMS–10239.

The CoPs and accompanying requirements specified in the regulations are used by our surveyors as a basis for determining whether a hospital qualifies for a provider agreement under Medicare and Medicaid. CMS and the health care industry believe that the availability to the facility of the type of records and general content of records, which this regulation specifies, is standard medical practice and is necessary in order to ensure the well-being and safety of patients and professional treatment