or elect to delegate this task to a Surrogate. A Surrogate is an individual or organization identified by an Individual or Organizational Provider as someone authorized to access CMS computer systems, such as Internet-based PECOS, National Provider Plan and Enumeration System (NPPES) and the Medicare and Medicaid Electronic Health Records (EHR) Incentive Program Registration and Attestation System (HITECH), on their behalf and to modify or view any information contained therein that the Individual or Organizational Provider may have permission or right to access in accordance with Medicare statutes, regulations, policies, and usage guidelines for any CMS system. Surrogates may consist of administrative staff, independent contractors, 3rd party consulting companies or credentialing departments. In order for an Individual or Organizational Provider to delegate the Medicare credentialing process to a Surrogate to access and update their enrollment information in the above mentioned CMS systems on their behalf, it is required that a Security Consent and Surrogate Authorization Form be completed, or Individual and Organizational Providers use an equivalent online process via the PECOS Identity and Access Management (I&A) system. The Security Consent and Surrogate Authorization form replicates business service agreements between Medicare providers, suppliers or both and Surrogates providing enrollment services.

We are proposing one version of the Security Consent and Surrogate Authorization Form. The form, once signed, mailed and approved, grants a Surrogate access to all current and future enrollment data for the Individual or Organization Provider. *Form Number:* CMS–10220 (OCN: 0938–1035); *Frequency:* Occasionally; *Affected Public:* Individuals and Private Sector—Business or other for-profits and Not-for-profit institutions; *Number of Respondents:* 88,650; *Total Annual Responses:* 88,650; *Total Annual Hours:* 22,162. (For policy questions regarding this collection contact Alisha Banks at 410–786–0671.)

6. *Type of Information Collection Request:* New collection (Request for a new OMB control number); *Title of Information Collection:* Medicare Enrollment Application for Registration of Eligible Entities That Provide Health Insurance Coverage Complementary to Medicare Part B; *Use:* The primary function of a Medicare enrollment application is to gather information from a provider, supplier or other entity that tells us who it is, whether it meets certain qualifications to be a health care provider, supplier or entity, where it practices or renders its services, the identity of the owners of the enrolling entity, and information necessary to establish correct claims payments. We are adding a new CMS–855 Medicare Registration Application, the CMS–855C: Medicare Enrollment Application for Registration of Eligible Entities That Provide Health Insurance Coverage Complementary to Medicare Part B. This Medicare registration application is to be completed by all entities that provide a complimentary health benefit plan and intend to bill Medicare as an indirect payment procedure (IPP) biller and the entity or health plan meets all Medicare requirements to submit claims for indirect payments. The entity must furnish the name of at least one authorized official, preferably the administrator of the health plan, who must sign this registration application attesting that the registering entity meets the requirements to register as an indirect payment procedure biller and will also abide by the requirements stated in the Certification & Attestation Statement in Section 10 of the application.

The CMS–855C will be submitted at the time the applicant first requests a Medicare identification number for the sole purpose of submitting claims under the ''Indirect Payment Procedure (IPP)'' for reimbursement, and when necessary to report any changes to information previously submitted. The application will be used by Medicare contractors to collect data to ensure the applicant has the necessary credentials to submit Medicare claims for reimbursement, including information that allows Medicare contractors to ensure that the entity and its owners and administrators are not sanctioned from the Medicare program, or debarred, suspended or excluded from any other Federal agency or program. *Form Number:* CMS–855C (OCN: 0938—New); *Frequency:* Occasionally; *Affected Public:* Private sector—Business or other for-profits and Not-for-profit institutions; *Number of Respondents:* 440; *Total Annual Responses:* 440; *Total Annual Hours:* 500. (For policy questions regarding this collection contact Kim McPhillips at 410–786–5374.)

Dated: October 29, 2013.

Martique Jones,

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

[FR Doc. 2013–26107 Filed 10–31–13; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1462–N]

Medicare Program; Solicitation of Five Nominations to the Advisory Panel on Hospital Outpatient Payment (HOP, the Panel)

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

ACTION: Notice.

SUMMARY: This notice solicits nominations for five new members to the Advisory Panel on Hospital Outpatient Payment (HOP, the Panel). There are five vacancies on the Panel effective September 30, 2013.

The purpose of the Panel is to advise the Secretary of the Department of Health and Human Services and the Administrator of the Centers for Medicare & Medicaid Services on the clinical integrity of the Ambulatory Payment Classification (APC) groups and their associated weights, and supervision of hospital outpatient services.

The Secretary rechartered the Panel in 2012 for a 2-year period effective through November 19, 2014.

DATES: *Submission of Nominations:* We will consider nominations if they are received no later than 5 p.m. (e.s.t.) December 31, 2013.

ADDRESSES: Please mail or hand deliver nominations to the following address: Centers for Medicare & Medicaid Services; Attn: Chuck Braver, Advisory Panel on HOP; Center for Medicare, Hospital & Ambulatory Policy Group, Division of Outpatient Care; 7500 Security Boulevard; Mail Stop C4–05–17 Baltimore, MD 21244–1850.

Web site: For additional information on the Panel and updates to the Panel's activities, we refer readers to our Web site at the following address: *http://www.cms.gov/Regulations-and-Guidance/Guidance/FACA/AdvisoryPanelonAmbulatoryPaymentClassificationGroups.html.*

FOR FURTHER INFORMATION CONTACT: Persons wishing to nominate individuals to serve on the Panel or to obtain further information may contact Chuck Braver at the following email address: *APCPanel@cms.hhs.gov* or call (410) 786–3985.

News Media: Representatives should contact the CMS Press Office at (202) 690–6145.

SUPPLEMENTARY INFORMATION:

I. Background

The Secretary of the Department of Health and Human Services (the Secretary) is required by section 1833(t)(9)(A) of the Social Security Act (the Act), and section 222 of the Public Health Service Act (PHS Act) to consult with an expert outside advisory panel regarding the clinical integrity of the Ambulatory Payment Classification (APC) groups and relative payment weights that are components of the Medicare Hospital Outpatient Prospective Payment System (OPPS), and the appropriate supervision level for hospital outpatient services. The Panel is governed by the provisions of the Federal Advisory Committee Act (FACA) (Pub. L. 92–463), as amended (5 U.S.C. Appendix 2), which sets forth standards for the formation and use of advisory panels. The panel may consider data collected or developed by entities and organizations (other than the Department of Health and Human Services) as part of their deliberations.

The Charter requires that the Panel meet up to three times annually. We consider the technical advice provided by the Panel as we prepare the proposed and final rules to update the OPPS for the following calendar year.

The Panel shall consist of a chair and up to 19 members who are full-time employees of hospitals, hospital systems, or other Medicare providers that are subject to the OPPS. (For purposes of the Panel, consultants or independent contractors are not considered to be full-time employees in these organizations.)

The current Panel members are as follows: (**Note:** The asterisk [*] indicates the Panel members whose terms end effective September 30, 2013.)

- E.L. Hambrick, M.D., J.D., Chair, a CMS Medical Officer.
- Karen Borman, M.D.
- Ruth L. Bush, M.D., M.P.H.*
- Lanny Copeland, M.D.
- Kari S. Cornicelli, C.P.A., FHFMA
- Dawn L. Francis, M.D., M.H.S.*
- David A. Halsey, M.D.*
- Brain D. Kavanagh, M.D., M.P.H.
- Scott Manaker, M.D., Ph.D.
- John Marshall, CRA, RCC, RT
- Jim Nelson
- Leah Osbahr
- Jacqueline Phillips
- Daniel J. Pothen, M.S., RHIA, CHPS, CPHIMS, CCS, CCS–P, CHC*
- Gregory J. Przbylski, M.D.*
- Traci Rabine
- Michael Rabovsky, M.D.
- Marianna V. Spanki-Varelas M.D., Ph.D., M.B.A.
- Gale Walker
- Kris Zimmer

Panel members serve without compensation, according to an advance written agreement; however, for the meetings, CMS reimburses travel, meals, lodging, and related expenses in accordance with standard Government travel regulations. CMS has a special interest in ensuring, while taking into account the nominee pool, that the Panel is diverse in all respects of the following: geography; rural or urban practice; race, ethnicity, sex, and disability; medical or technical specialty; and type of hospital, hospital health system, or other Medicare provider subject to the OPPS.

Based upon either self-nominations or nominations submitted by providers or interested organizations, the Secretary, or her designee, appoints new members to the Panel from among those candidates determined to have the required expertise. New appointments are made in a manner that ensures a balanced membership under the FACA guidelines.

II. Criteria for Nominees

The Panel must be fairly balanced in its membership in terms of the points of view represented and the functions to be performed. Each Panel member must be employed full-time by a hospital, hospital system, or other Medicare provider subject to payment under the OPPS. All members must have technical expertise to enable them to participate fully in the Panel's work. Such expertise encompasses hospital payment systems; hospital medical care delivery systems; provider billing systems; APC groups; Current Procedural Terminology codes; and alpha-numeric Health Care Common Procedure Coding System codes; and the use of, and payment for, drugs, medical devices, and other services in the outpatient setting, as well as other forms of relevant expertise. For supervision deliberations, the Panel shall have members that represent the interests of Critical Access Hospitals (CAHs), who advise CMS only regarding the level of supervision for hospital outpatient services.

It is not necessary for a nominee to possess expertise in all of the areas listed, but each must have a minimum of 5 years experience and currently have full-time employment in his or her area of expertise. Generally, members of the Panel serve overlapping terms up to 4 years, based on the needs of the Panel and contingent upon the rechartering of the Panel. A member may serve after the expiration of his or her term until a successor has been sworn in.

Any interested person or organization may nominate one or more qualified individuals. Self-nominations will also be accepted. Each nomination must include the following:

- Letter of Nomination stating the reasons why the nominee should be considered.
- Curriculum vitae or resume of the nominee.
- Written and signed statement from the nominee that the nominee is willing to serve on the Panel under the conditions described in this notice and further specified in the Charter.
- The hospital or hospital system name and address, or CAH name and address, as well as all Medicare hospital and or Medicare CAH billing numbers of the facility where the nominee is employee.

III. Copies of the Charter

To obtain a copy of the Panel's Charter, we refer readers to our Web site at the following: *http://www.cms.gov/Regulations-and-Guidance/Guidance/FACA/AdvisoryPanelonAmbulatoryPaymentClassificationGroups.html.*

IV. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 35).

(Catalog of Federal Domestic Assistance Program No. 93.774, Medicare—Supplementary Medical Insurance Program).

Dated: October 29, 2013.

Marilyn Tavenner,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2013–26258 Filed 10–31–13; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. FDA–2013–N–1161]

Agency Information Collection Activities; Proposed Collection; Comment Request; Food Safety Survey

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA or we) is announcing an opportunity for public comment on our proposed collection of certain information. Under the Paperwork Reduction Act of 1995 (the