493.1–.2001 Medicare/Medicaid Psychiatric Hospital Survey Data; *Use:* The application must be completed by entities performing laboratory's testing specimens for diagnostic or treatment purposes. This information is vital to the certification process. *Form Number:* CMS–116 (OMB#: 0938–0581); *Frequency:* Biennially and Occasionally; *Affected Public:* Private Sector: Business or other for-profits and Not-for-profit institutions; *Number of Respondents:* 219,000; *Total Annual Responses:* 31,520; *Total Annual Hours:* 23,640. (For policy questions regarding this collection contact Sheila Ward at 410–786–3115. For all other issues call 410–786–1326.)

7. *Type of Information Collection Request:* Extension 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. *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:* 991,160,925; *Total Annual Hours:* 23,815,541.

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS' Web Site 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.

In commenting on the proposed information collections please reference the document identifier or OMB control number. To be assured consideration, comments and recommendations must be submitted in one of the following ways by *October 19, 2010:*

1. *Electronically.* You may submit your comments electronically to *http://www.regulations.gov.* Follow the instructions for "Comment or Submission" or "More Search Options" to find the information collection document(s) accepting comments.

2. *By regular mail.* You may mail written comments to the following address:

CMS, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development, Attention: Document Identifier/OMB Control Number, Room C4–26–05, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Dated: August 13, 2010.

Michelle Shortt,

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

[FR Doc. 2010–20385 Filed 8–19–10; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10314]

Agency Information Collection Activities: Submission for OMB Review; Comment Request

AGENCY: Centers for Medicare & Medicaid Services.

In compliance with the requirement of section 3506I(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:* Medicare Savings Program Protection from Medicaid Estate Recovery—State Plan Pre-print under Title XIX. *Form No.:* CMS–10314 (OMB# 0938–New); *Use:* Section 115 of the Medicare Improvements for Patients and Providers Act (MIPPA)—2008, provides new protections from Medicaid estate recovery for limited categories of dual eligibles age 55 and over. To offer these protections, States have to amend their Medicaid State plans to reflect these new limits on estate recovery. To reduce paperwork burden and expedite this process, CMS is providing States with a pre-printed document (*i.e.*, a State plan preprint) which neither needs nor requires any insertion of language or even completion of a check-off box. As Section 115 simply mandates compliance (there is no option not to comply), States only need return the preprint page (as prepared by CMS) to CMS, as a requested amendment to their State Plan. This is a one-time only submission, with little burden imposition and complete electronic routing to and from States.

Frequency: Reporting—Once; *Affected Public:* State, Local or Tribal Governments; *Number of Respondents:* 51; *Total Annual Responses:* 51; *Total Annual Hours:* 102. (For policy questions regarding this collection contact Nancy Dieter at 410–786–7219. For all other issues call 410–786–1326.)

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 *September 20, 2010.*

OMB, Office of Information and Regulatory Affairs, Attention: CMS Desk Officer. *Fax Number:* (202) 395–6974. *E-mail: OIRA_submission@omb.eop.gov.*

Dated: August 13, 2010.

Michelle Shortt,

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

[FR Doc. 2010–20386 Filed 8–19–10; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–2476–FN2]

Medicare and Medicaid Programs; Approval of the American Association for Accreditation of Ambulatory Surgery Facilities for Continued Deeming Authority for Ambulatory Surgical Centers

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

ACTION: Final notice.

SUMMARY: This final notice announces our decision to approve without condition the American Association for Accreditation of Ambulatory Surgery Facilities' (AAAASF) request for continued recognition as a national accreditation program for ambulatory surgical centers (ASC) seeking to participate in the Medicare or Medicaid programs.

DATES: *Effective Date:* This final notice is effective on November 27, 2009 through November 27, 2012.

FOR FURTHER INFORMATION CONTACT: Cindy Melanson (410) 786–0310. Patricia Chmielewski (410) 786–6899.

SUPPLEMENTARY INFORMATION:

I. Background

Under the Medicare program, eligible beneficiaries may receive covered services in an ambulatory surgical center (ASC) provided certain requirements are met. Section 1832(a)(2)(F)(i) of the Social Security Act (the Act) establishes distinct criteria for a facility seeking designation as an ASC. Under this authority, the minimum requirements that an ASC must meet to participate in Medicare are set forth in regulations at 42 CFR part 416, which determine the basis and scope of ASC covered services, and the conditions for Medicare payment for facility services. Regulations concerning provider agreements are at 42 CFR part 489 and those pertaining to activities relating to the survey and certification of facilities are at 42 CFR part 488.

Generally, to enter into an agreement, an ASC must first be certified by a State survey agency as complying with conditions or requirements set forth in part 416 of our regulations. Then, the ASC is subject to regular surveys by a State survey agency to determine whether it continues to meet those requirements. There is an alternative, however, to surveys by State agencies.

Section 1865(a)(1) of the Act provides that, if a provider entity demonstrates through accreditation by an approved national accreditation organization that all applicable Medicare conditions are met or exceeded, we may "deem" those provider entities to have met the requirements. Accreditation by an accreditation organization is voluntary and is not required for Medicare participation.

If an accreditation organization is recognized by the Secretary as having standards for accreditation that meet or exceed Medicare requirements, a provider entity accredited by the national accrediting body's approved program may be deemed to meet the Medicare conditions. A national accreditation organization applying for approval of deeming authority under part 488, subpart A, must provide us with reasonable assurance that the accreditation organization requires the accredited provider entities to meet requirements that are at least as stringent as the Medicare conditions. Our regulations concerning re-approval of accrediting organizations are set forth at section § 488.4 and § 488.8(d)(3). The regulations at § 488.8(d)(3) require accreditation organizations to reapply for continued approval of deeming authority every 6 years, or sooner as determined by CMS. The regulation at § 488.8(f)(3)(i) provides CMS the authority to grant conditional approval of an accreditation organization's deeming authority, with a probationary period of up to 180 days, if the accreditation organization has not adopted comparable standards during the reapplication process.

We received a complete application from AAAASF for continued recognition as a national accreditation organization for ASCs on March 31, 2009. In accordance with the requirements at § 488.4 and § 488.8(d)(3), we published a proposed notice on June 26, 2009 (74 FR 30587) and a final notice on November 27, 2009 (74 FR 62330). This final notice provides CMS' final determination in response to the conditional approval with a 180-day probationary period granted to the American Association for Accreditation of Ambulatory Surgery Facilities on November 27, 2009.

II. Deeming Applications Approval Process

Section 1865(a)(3)(A) of the Act provides a statutory timetable to ensure that our review of deeming applications is conducted in a timely manner. The Act provides us with 210 calendar days after the date of receipt of an application to complete our survey activities and application review process. Within 60 days of receiving a completed application, we must publish a notice in the **Federal Register** that identifies the national accreditation body making the request, describes the request, and provides no less than a 30-day public comment period. At the end of the 210-day period, we must publish an approval or denial of the application. In accordance with § 488.8(f)(2), if CMS determines following the deeming authority review that the organization has failed to adopt requirements comparable to CMS requirements, the accreditation organization may be given a conditional approval of its deeming authority for a probationary period of up to 180 days to adopt comparable requirements. Within 60 days after the end of this period, we must make a final determination as to whether or not the AAAASF's accreditation program for ASCs is comparable to CMS requirements and issue an appropriate notice that includes our reasons for our determination.

III. Provisions of the November 27, 2009 Final Notice

Our review of AAAASF's renewal application for ASC deeming authority revealed that AAAASF had on-going, serious, widespread areas of non-compliance. Specifically, AAAASF's inability to provide accurate and timely data on deemed providers; lack of complete and accurate deemed facility survey files; and, inadequate surveyor training and evaluation program. Due to the significant number of areas of noncompliance identified during the review of AAAASF's renewal application for deeming authority, we conditionally approved AAAASF's ASC accreditation program for 3 years with a 180 day probationary period. Under section 1865(a)(2) of the Act and our regulations at § 488.4 and § 488.8, we conducted a comparability review of