

TABLE 6.—ESTIMATED ANNUAL REPORTING BURDEN

CFR sections	Annual number of responses	Frequency	Average burden per response (hours)	Annual burden (hours)	Annual cost (millions)
424.535(b)	2000	1	8	16,000	\$1.2

The annual dollar cost is based on \$600 per respondent to re-enroll in the Medicare program.

Providers must also be re-surveyed or re-certified by the State Survey Agency and must establish a new provider agreement with our Regional Office. The burden associated with the survey and certification requirement is exempt from the PRA, as provided in section 4204(c) of Pub. L. 100–203 COBRA 87, as

amended by Pub. L. 100–360 (Medicare Catastrophic Coverage Act of 1988). The burden associated with the requirement to establish a new provider agreement (Form HCFA–460) is currently approved under OMB Approval Number 0938–0373.

Section 424.540 Deactivation of Medicare Billing Privileges

Section 424.540(a)(1) states that if no Medicare claims are submitted for two consecutive calendar quarters (6 months) we would deactivate a provider or supplier's Medicare billing number. The provider or supplier must complete and submit a CMS 855 for validation to reactivate its Medicare billing number and billing privileges.

TABLE 7.—ESTIMATED ANNUAL REPORTING BURDEN

CFR sections	Annual No. of responses	Frequency	Average burden per response (minutes)	Annual burden hours	Annual cost
424.540 (a)(1)	1200	1	95	1,900	\$48,000

The annual cost is based on \$40 per respondent to review and re-certify via

signature their previously submitted enrollment application/information. Table 8 below shows the total estimated hourly and financial burden

for all requirements outlined and proposed in this rule.

TABLE 8.—ESTIMATED HOURLY AND FINANCIAL BURDEN FOR ALL REQUIREMENTS

CFR section	Annual No. of responses	Annual burden hours	Annual cost (million)
424.500	618,250	1.2 million	\$36.6

We have submitted a copy of this proposed rule to OMB for its review of the information collection requirements in §§ 424.510, 424.515, 424.520, 424.525, 424.535, and 424.540 and related forms in the addendum. These requirements are not effective until they have been approved by OMB.

If you have any comments on any of these information collection and record keeping requirements, please mail the original and 3 copies directly to the following:

Centers for Medicare and Medicaid Services, Office of Information Services, Information Technology Investment Management Group, Division of CMS Enterprise Standards, Room C2–26–17, 7500 Security Boulevard, Baltimore, MD 21244–1850, Attn.: John Burke CMS–6002–P.

And,

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Brenda Aguilar, CMS Desk Officer.

VII. Regulatory Impact Analysis

We have examined the impacts of this proposed rule under Executive Order (E.O.) 12866, the Unfunded Mandate Reform Act of 1995, and the Regulatory Flexibility Act. E.O. 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits. In addition, a Regulatory Impact Analysis must be prepared for major rules with economically significant effects (\$100 million or more in any one year). This proposed rule would establish in regulations specific provider and supplier initial enrollment procedures and the periodic

revalidation of eligibility. It is not expected to have an impact that would meet the threshold criteria to be considered economically significant.

The Unfunded Mandate Reform Act of 1995, in section 202, requires that agencies prepare an assessment of anticipated costs and benefits before proposing any rule that may result in an annual expenditure by State, local, or tribal governments, in the aggregate, or by the private sector, of \$110 million adjusted for inflation. The rule has no consequential adverse impact on State, local, or tribal governments. This rule may reduce some State burdens since they will no longer certify providers that are not qualified to participate in the Medicare program. The impact on the private sector is well below the threshold.

Consistent with the Regulatory Flexibility Act, we prepare a Regulatory Flexibility Analysis (RFA) unless we certify that a rule would not have a