GENERAL SERVICES ADMINISTRATION

[OMB Control No. 3090–0014; Docket 2015–0001; Sequence 8]

Submission for OMB Review; Transfer Order—Surplus Personal Property and Continuation Sheet, Standard Form (SF) 123

AGENCY: Federal Acquisition Service, General Services Administration (GSA).

ACTION: Notice of request for an extension to an existing OMB clearance.

SUMMARY: Under the provisions of the Paperwork Reduction Act, the Regulatory Secretariat Division will be submitting to the Office of Management and Budget (OMB) a request to review and approve an extension of a previously approved information collection requirement regarding the Transfer Order—Surplus Personal Property and Continuation Sheet, Standard Form (SF) 123. A notice was published in the **Federal Register** at 80 FR 21719, on April 20, 2015. No comments were received.

DATES: Submit comments on or before: August 14, 2015.

ADDRESSES: Submit comments identified by Information Collection 3090–0014, Transfer Order—Surplus Personal Property and Continuation Sheet, Standard Form (SF) 123, by any of the following methods:

- *Regulations.gov: http://www.regulations.gov.* Submit comments via the Federal eRulemaking portal by searching the OMB control number. Select the link ''Comment Now'' that corresponds with ''Information Collection 3090–0014, Transfer Order—Surplus Personal Property and Continuation Sheet, Standard Form (SF) 123''. Follow the instructions provided on the screen. Please include your name, company name (if any), and ''Information Collection 3090–0014, Transfer Order—Surplus Personal Property and Continuation Sheet, Standard Form (SF) 123,'' on your attached document.
- *Mail:* General Services Administration, Regulatory Secretariat Division (MVCB), 1800 F Street NW., Washington, DC 20405. ATTN: Ms. Flowers/IC 3090–0014.

Instructions: Please submit comments only and cite Information Collection 3090–0014, Transfer Order—Surplus Personal Property and Continuation Sheet, Standard Form (SF) 123, in all correspondence related to this collection. All comments received will be posted without change to *http://www.regulations.gov,* including any personal and/or business confidential information provided.

FOR FURTHER INFORMATION CONTACT: Joyce Spalding, Property Disposal Specialist, Federal Acquisition Service, at telephone 703–605–2888 or via email to *joyce.spalding@gsa.gov.*

SUPPLEMENTARY INFORMATION:

A. Purpose

The Transfer Order—Surplus Personal Property and Continuation Sheet, Standard form (SF) 123, is used by public agencies, nonprofit educational or public health activities, programs for the elderly, service educational activities, and public airports to apply for donation of Federal surplus personal property. The SF 123 serves as the transfer instrument and includes item descriptions, transportation instructions, nondiscrimination assurances, and approval signatures.

B. Annual Reporting Burden

Respondents: 20,110.

Responses per Respondent: 1.

Total Number of Respondents: 20,110.

Hours per Response: 0.019.

Total Burden Hours: 382.

C. Public Comments

Public comments are particularly invited on: Whether this collection of information is necessary and whether it will have practical utility; whether our estimate of the public burden of this collection of information is accurate, and based on valid assumptions and methodology; ways to enhance the quality, utility, and clarity of the information to be collected.

Obtaining Copies of Proposals: Requesters may obtain a copy of the information collection documents from the General Services Administration, Regulatory Secretariat Division (MVCB), 1800 F Street NW., Washington, DC 20006, telephone 202–501–4755. Please cite OMB Control No. 3090–0014, Transfer Order—Surplus Personal Property and Continuation Sheet, Standard Form (SF) 123, in all correspondence.

Dated: July 6, 2015.

David A. Shive,

Acting Chief Information Officer.

[FR Doc. 2015–17375 Filed 7–14–15; 8:45 am]

BILLING CODE 6820–34–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–6057–N2]

Medicare Program; Extension of Medicare Prior Authorization for Power Mobility Devices (PMDs) Demonstration

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

ACTION: Notice.

SUMMARY: This notice announces an extension of the Medicare Prior Authorization for Power Mobility Devices (PMDs) demonstration.

DATES: This demonstration will now end on August 31, 2018.

FOR FURTHER INFORMATION CONTACT: Doris M. Jackson, (410) 786–4459.

Questions regarding the Medicare Prior Authorization for Power Mobility Device Demonstration should be sent to *pademo@cms.hhs.gov.*

SUPPLEMENTARY INFORMATION:

I. Background

Section 402(a)(1)(J) of the Social Security Amendments of 1967 (42 U.S.C. 1395b–1(a)(1)(J)), authorizes the Secretary to conduct demonstrations designed to develop or demonstrate improved methods for the investigation and prosecution of fraud in the provision of care or services provided under the Medicare program.

On September 1, 2012, we implemented the Medicare Prior Authorization for Power Mobility Devices (PMDs) Demonstration that would operate for a period of 3 years (September 1, 2012 through August 31, 2015). The demonstration was initially implemented in California, Florida, Illinois, Michigan, New York, North Carolina, and Texas. These states were selected for the demonstration based upon their history of having high levels of improper payments and incidents of fraud related to PMDs. On October 1, 2014, we expanded the demonstration to 12 additional states (Pennsylvania, Ohio, Louisiana, Missouri, Washington, New Jersey, Maryland, Indiana, Kentucky, Georgia, Tennessee, and Arizona) that have high expenditures and improper payments for PMDs based on 2012 billing data.

The objective of the demonstration is to develop improved methods for the investigation and prosecution of fraud in order to protect the Medicare Trust Funds from fraudulent actions and any resulting improper payments. The

demonstration's extension will continue to provide the agency with valuable data through which the agency, working with its partners, can develop new avenues for combating the submission of fraudulent claims to the Medicare program for PMDs and improving methods for the investigation and prosecution of PMD fraud. We will continue to share demonstration data within the agency, with our contractors, with state Medicaid agencies, and with law enforcement partners for further analysis and investigation. We believe that data evidencing changes in physician ordering and supplier billing practices that coincide with this demonstration could provide investigators and law enforcement with important information for determining how and where to focus their investigations concerning fraud in the provision of PMDs. For instance, results from this demonstration could potentially indicate collaboration between ordering physicians and suppliers in submitting fraudulent claims for PMDs. This data could assist investigators and law enforcement in targeting their investigations in this area. Additionally, changes in billing practices that result from this demonstration could provide specific leads for investigators and law enforcement personnel. For instance, where a supplier that frequently submitted claims prior to the demonstration stops submitting claims during the demonstration, law enforcement may determine it prudent to investigate that supplier. Our data analysis will include the following:

- Suppliers who no longer bill or have a significant decrease in billing during the demonstration.
- Physicians/treating practitioners with a high volume of submissions.
- Codes that show a dramatic increase in use.

Based on preliminary data collected, spending per month on PMDs in the seven original demonstration states decreased after September 2012, indicating that physicians ordering and supplier billing practices have changed as a result of the demonstration. In addition, based on the preliminary data, spending per month on PMDs decreased in the non-demonstration states. National suppliers have adjusted their billing practices nationwide and appear to have increased compliance with our policies in all locations, not just their offices in the demonstration states.

II. Provisions of the Notice

This notice announces the extension of the Medicare PMDs demonstration for an additional 3 years, until August 31, 2018. Extending the demonstration allows us to continue developing improved methods to investigate and prosecute fraud in order to protect the Medicare Trust Funds from fraudulent actions and any resulting improper payments. This continuation will provide the agency with additional information through which the agency can develop new avenues for combating the submission of fraudulent claims to the Medicare program for PMDs and improving methods for the investigation and prosecution of PMD fraud. We will continue to share demonstration data within the agency, with our contractors, with state Medicaid agencies, and with law enforcement partners for further analysis and investigation.

This notice will serve as notification of the extended demonstration. In addition, we will publicize the extended demonstration through postings to our Web site and tweets.

CMS or its agents will continue to conduct outreach and education including webinars, state meetings, and other educational sessions as appropriate. Updated information will be posted to the CMS Web site (*http://go.cms.gov/PADemo*). We will also continue to work to limit the impact on Medicare beneficiaries by educating the Medicare beneficiaries about their protections.

We will continue to follow the policies and procedures that are currently in place for the demonstration. In accordance with current demonstration policy, a request for prior authorization and all relevant documentation to support the medical necessity along with the written order for the covered item must be submitted when one of the following Healthcare Common Procedures Coding System (HCPCS) codes for a PMD is ordered:

- Group 1 Power Operated Vehicles (K0800 through K0802 and K0812).
- All standard power wheelchairs (K0813 through K0829).
- All Group 2 complex rehabilitative power wheelchairs (K0835 through K0843).
- All Group 3 complex rehabilitative power wheelchairs without power options (K0848 through K0855).
- Pediatric power wheelchairs (K0890 and K0891).
- Miscellaneous power wheelchairs (K0898).

Under this demonstration, a physician, treating practitioner, or supplier may submit the prior authorization request and all relevant documentation to support Medicare coverage of the PMD item along with the written order for the covered item to their Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC). The physician, treating practitioner, or supplier who submits the request is referred to as the ''submitter.''

In order to be affirmed, the request for prior authorization must meet all applicable rules, policies, and National Coverage Determination (NCD)/Local Coverage Determination (LCD) requirements for PMD claims. The LCD documentation requirement mandates that the physician or treating practitioner shall complete the seven element order, face-to-face encounter, and any other clinical documentation that is necessary to determine medical necessity regardless of which entity is functioning as the submitter. The supplier must also complete the detailed product description (DPD) regardless of which entity is functioning as the submitter.

After receipt of all relevant documentation, CMS or its agents will make every effort to conduct a complex medical review and postmark the notification of their decision with the prior authorization number within 10 business days. Notification is provided to the physician/treating practitioner, supplier, and the Medicare beneficiary for the initial submission. If a subsequent prior authorization request is submitted after a non-affirmative decision on a prior authorization request, CMS or its agents will make every effort to conduct a review and postmark the notification of decision with the prior authorization number within 20 business days.

If the prior authorization request is not affirmed, and the claim is subsequently submitted by the supplier, the claim will be denied. Medicare beneficiaries may use existing appeal rights to contest claim denials. Suppliers must issue an Advance Beneficiary Notice of Noncoverage (ABN) to the beneficiary, per CMS policy, prior to delivery of the item for the beneficiary to be held financially liable when a Medicare payment denial is expected for a PMD.

Submitters may also request expedited reviews in emergency situations where a practitioner indicates clearly, with supporting rationale, that the standard (routine) timeframe for a prior authorization decision (10 days) could seriously jeopardize the beneficiary's life or health. The expedited request must be accompanied by the required supporting documentation for this request to be considered complete, thus commencing the 48-hour review. Inappropriate expedited requests may be downgraded to standard requests. After conducting

an expedited review, CMS or its agents will communicate a decision for the prior authorization request to the submitter within 48-hours of the complete submission.

The following explains the various prior authorization scenarios:

• *Scenario 1:* A submitter sends a prior authorization request to the DME MAC with appropriate documentation, and all relevant Medicare coverage and documentation requirements are met for the PMD. The DME MAC then sends an affirmative prior authorization decision to the physician or treating practitioner, supplier, and Medicare beneficiary. The supplier submits the claim to the DME MAC, and the claim is linked to the prior authorization via the claims processing system. Provided all requirements in the applicable NCD/LCD are met, the claim is paid.

• *Scenario 2:* A submitter sends a prior authorization request, but all relevant Medicare coverage and documentation requirements are not met for the PMD. The DME MAC sends a non-affirmative prior authorization decision to the physician or treating practitioner, supplier, and Medicare beneficiary advising them that Medicare will not pay for the item. If the supplier delivers the PMD and submits a claim with a non-affirmative prior authorization decision, the DME MAC would deny the claim. The supplier or the Medicare beneficiary would then have the Medicare denial for secondary insurance purposes and would have full appeal rights. Existing liability provisions with respect to delivery of a valid ABN apply.

• *Scenario 3:* A submitter sends a prior authorization request where documentation is incomplete. The DME MAC sends back the prior authorization request to the submitter with an explanation about what information is missing and notifies the physician or treating practitioner, supplier, and Medicare beneficiary. The submitter may resubmit the prior authorization request.

• *Scenario 4:* An applicable PMD claim is submitted without a prior authorization decision or the DME supplier fails to submit a prior authorization request, but nonetheless delivers the item to the Medicare beneficiary and submits the claim to the DME MAC for payment. The claim will be stopped and documentation will be requested to conduct medical review. The PMD claim is reviewed under normal medical review processing timeframes, and if approved, a 25-percent payment reduction would apply.

++ If the claim is determined to be not medically necessary, or insufficiently documented, the claim will be denied. The supplier or Medicare beneficiary can appeal the claim denial. If the claim, after review, is deemed not payable, then all current Medicare beneficiary/supplier liability policies and procedures and appeal rights remain in effect.

++ If the claim is determined to be payable, it will be paid. However, a 25-percent reduction in the Medicare payment will be applied for failure to receive a prior authorization decision before the submission of a claim. This payment reduction will not be applied to competitive bidding program contract suppliers submitting claims for Medicare beneficiaries who maintain a permanent residence in a competitive bidding area according to the Common Working File (CWF). These contract suppliers will continue to receive the applicable single payment amount as determined in their contract. The 25-percent payment reduction is non-transferrable to the Medicare beneficiary for claims that are deemed payable and is not subject to appeal. In the case of capped rental items, the payment reduction will be applied to all claims in the series. After a claim is submitted and processed, appeal rights are available if necessary.

If the prior authorization request is not affirmed, and the claim is submitted by the supplier, the claim will be denied. Medicare beneficiaries may use existing appeal rights to contest claim denials. Suppliers must issue an ABN to the beneficiary, per CMS policy, prior to delivery of the item in order for the beneficiary to be held financially liable when a Medicare payment denial is expected for a PMD.

Additional information is available on the CMS Web site (*http://go.cms.gov/PADemo*).

III. Collection of Information Requirements

This notice announces the extension of the Medicare PMDs Demonstration and does not impose any new information collection burden under the Paperwork Reduction Act of 1995. However, there is an information collection burden associated with the demonstration that is currently approved under OMB control number 0938–1169 which expires January 31, 2018.

IV. Regulatory Impact Statement

This document announces an extension of the Medicare PMDs Demonstration. Therefore, there are no regulatory impact implications associated with this notice.

Dated: July 1, 2015.

Andrew M. Slavitt,

Acting Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2015–17365 Filed 7–14–15; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Proposed Information Collection Activity; Comment Request

Title: Job Search Assistance (JSA) Strategies Evaluation.

OMB No.: 0970–0440.

Description: The Administration for Children and Families (ACF) is proposing a data collection activity as part of the Job Search Assistance (JSA) Strategies Evaluation. The JSA evaluation aims to determine which JSA strategies are most effective in moving TANF applicants and recipients into work. The impact study will randomly assign individuals to contrasting JSA approaches and then compare their employment and earnings to determine their relative effectiveness. The implementation study will describe services participants receive under each approach as well as provide operational lessons gathered directly from practitioners.

Data collection efforts previously approved for JSA, include: Data collection activities to document program implementation, a staff survey and a baseline information form for program participants. These collection activities will continue with this new request.

This **Federal Register** Notice provides the opportunity to comment on a proposed new information collection activity for JSA: A follow-up survey for JSA participants approximately 6 months after program enrollment. The purpose of the survey is to follow-up with study participants and document their job search assistance services and experiences including their receipt of job search assistance services, their knowledge and skills for conducting a job search, the nature of their job search process, including tools and services used to locate employment, and their search outputs and outcomes, such as the number of applications submitted, interviews attended, offers received and jobs obtained. In addition, the survey will provide an opportunity for