In that notice, we detailed our evaluation criteria. Under section 1865(a)(2) of the Act and our regulations at § 410.142 and § 410.143, we conducted a review of ADA's NAO based on the criteria set forth in § 410.142(b), which include, but are not limited to the following: (1) A review of the NAO's operations and office to verify information in the organization's application and assess the organization's compliance with its own policies and procedures; (2) evaluating accreditation results or the accreditation status decision making process; and (3) interviewing the organization's staff.

The April 30, 2015 proposed notice also solicited public comments on the ability of ADA to continue to develop standards that meet or exceed the Medicare conditions for coverage and apply them to accredit entities to furnish training. We received no public comments in response to our proposed notice.

IV. Provisions of the Final Notice

ADA's application to continue as an accredited NAO to deem entities for the purposes of DSMT is approved for a period of 6 years. The accreditation is effective on September 25, 2015. This approval is subject to renewal subsequent to the receipt of an application from the ADA and subject to review, evaluation, and approval of its program.

Based on our review and observations described in section III of this final notice, we approve ADA as a NAO for entities furnishing DSMT that request participation in the Medicare program, effective September 25, 2015 through effective September 27, 2021.

V. Collection of Information Requirements

This document does not impose information collection requirements, that is, reporting, recordkeeping or third-party disclosure requirements. Consequently, there is no need for review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

Dated: September 17, 2015.

Andrew M. Slavitt,

Acting Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2015–24358 Filed 9–24–15; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifiers: CMS–10519 and CMS–10583]

Agency Information Collection Activities: Proposed Collection; Comment Request

AGENCY: Centers for Medicare & Medicaid Services, HHS.

ACTION: Notice.

SUMMARY: The Centers for Medicare & Medicaid Services (CMS) is announcing an opportunity for the public to comment on CMS' intention to collect information from the public. Under the Paperwork Reduction Act of 1995 (the PRA), federal agencies are required to publish notice in the **Federal Register** concerning each proposed collection of information (including each proposed extension or reinstatement of an existing collection of information) and to allow 60 days for public comment on the proposed action. Interested persons are invited to send comments regarding our burden estimates 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.

DATES: Comments must be received by November 24, 2015.

ADDRESSES: When commenting, please reference the document identifier or OMB control number. To be assured consideration, comments and recommendations must be submitted in any one of the following ways:

1. *Electronically.* You may send 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) that are 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.

To obtain copies of a supporting statement and any related forms for the proposed collection(s) summarized in this notice, you may make your request using one of following:

1. Access CMS' Web site address at *http://www.cms.hhs.gov/PaperworkReductionActof1995.*

2. Email your request, including your address, phone number, OMB number, and CMS document identifier, to *Paperwork@cms.hhs.gov.*

3. Call the Reports Clearance Office at (410) 786–1326.

FOR FURTHER INFORMATION CONTACT: Reports Clearance Office at (410) 786–1326.

SUPPLEMENTARY INFORMATION:

Contents

This notice sets out a summary of the use and burden associated with the following information collections. More detailed information can be found in each collection's supporting statement and associated materials (see **ADDRESSES**).

CMS–10519 Physician Quality Reporting System (PQRS) and the Electronic Prescribing Incentive (eRx) Program Data Assessment, Accuracy and Improper Payments Identification Support

CMS–10583 Data Collection for Medicare Beneficiaries Receiving Beta Amyloid Positron Emission Tomography (PET) for Dementia and Neurodegenerative Disease

Under the PRA (44 U.S.C. 3501–3520), federal agencies must obtain approval from the Office of Management and Budget (OMB) for each collection of information they conduct or sponsor. The term ''collection of information'' is defined in 44 U.S.C. 3502(3) and 5 CFR 1320.3(c) and includes agency requests or requirements that members of the public submit reports, keep records, or provide information to a third party. Section 3506(c)(2)(A) of the PRA requires federal agencies to publish a 60-day notice in the **Federal Register** concerning each proposed collection of information, including each proposed extension or reinstatement of an existing collection of information, before submitting the collection to OMB for approval. To comply with this requirement, CMS is publishing this notice.

Information Collection

1. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Physician

Quality Reporting System (PQRS) and the Electronic Prescribing Incentive (eRx) Program Data Assessment, Accuracy and Improper Payments Identification Support; *Use:* The incentive and reporting programs have data integrity issues, such as rejected and improper payments. This four year project will evaluate incentive payment information for accuracy and identify improper payments, with the goal of recovering these payments. Additionally, based on the project's results, recommendations will be made so that we can avoid future data integrity issues.

Data submission, processing, and reporting will be analyzed for potential errors, inconsistencies, and gaps that are related to data handling, program requirements, and clinical quality measure specifications of PQRS and eRx program. Surveys of Group Practices, Registries, and Data Submission Vendors (DSVs) will be conducted in order to evaluate the PQRS and eRx Incentive Program. Follow-up interviews will occur with a small number of respondents. *Form Number:* CMS–10519 (OMB control number: 0938–1255); *Frequency:* Annually; *Affected Public:* Business or other for-profits; *Number of Respondents:* 115; *Total Annual Responses:* 115; *Total Annual Hours:* 201. (For policy questions regarding this collection contact Timothy Jackson at 410–786–4006.)

2. *Type of Information Collection Request:* New collection (Request for a new OMB control number); *Title of Information Collection:* Data Collection for Medicare Beneficiaries Receiving Beta Amyloid Positron Emission Tomography (PET) for Dementia and Neurodegenerative Disease *Use:* In the Decision Memorandum #CAG–00431N issued on September 27, 2013, CMS determined there is sufficient evidence that the use of beta amyloid PET is promising in 2 scenarios: (1) to exclude Alzheimer's Disease (AD) in narrowly defined and clinically difficult differential diagnoses; and (2) to enrich clinical trials seeking better treatments or prevention strategies for AD. CMS will cover one beta amyloid PET scan per patient through Coverage with Evidence Development under section 1862(a)(1)(E) of the Social Security Act, in clinical studies that meet specific criteria established by CMS. Clinical studies must be approved by CMS, involve subjects from appropriate populations, and be comparative and longitudinal. Radiopharmaceuticals used in the scan must be FDA approved. Approved studies must address defined research questions established by CMS. Clinical studies in this National Coverage Determination (NCD) must adhere to the designated timeframe and meet standards establish by CMS in the NCD. Consistent with section 1142 of the Social Security Act, the Agency for Healthcare and Quality (AHRQ) supports clinical research studies that CMS determines meet specifically identified requirements and research questions.

To qualify for payment, providers must prescribe beta amyloid PET for beneficiaries with a set of clinical criteria specific to each cancer. Data elements will be transmitted to CMS for evaluation of the short and long-term benefits of beta amyloid PET to beneficiaries and for use in future clinical decision making. *Form Number:* CMS–10583 (OMB control number: 0938–NEW); *Frequency:* Annually; *Affected Public:* Private sector (Business or other for-profit); *Number of Respondents:* 300; *Total Annual Responses:* 3,700; *Total Annual Hours:* 6,475. (For policy questions regarding this collection contact Stuart Caplan at 410–786–8564).

Dated: September 22, 2015.

William N. Parham, III,

Director, Paperwork Reduction Staff, Office of Strategic Operations and Regulatory Affairs.

[FR Doc. 2015–24474 Filed 9–24–15; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–4178–N]

Medicare Program; Medicare Appeals; Adjustment to the Amount in Controversy Threshold Amounts for Calendar Year 2016

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

ACTION: Notice.

SUMMARY: This notice announces the annual adjustment in the amount in controversy (AIC) threshold amounts for Administrative Law Judge (ALJ) hearings and judicial review under the Medicare appeals process. The adjustment to the AIC threshold amounts will be effective for requests for ALJ hearings and judicial review filed on or after January 1, 2016. The calendar year 2016 AIC threshold amounts are $150 for ALJ hearings and $1,500 for judicial review.

DATES: *Effective Date:* This notice is effective on January 1, 2016.

FOR FURTHER INFORMATION CONTACT: Liz Hosna (*Katherine.Hosna@cms.hhs.gov*), (410) 786–4993.

SUPPLEMENTARY INFORMATION:

I. Background

Section 1869(b)(1)(E) of the Social Security Act (the Act), as amended by section 521 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), established the amount in controversy (AIC) threshold amounts for Administrative Law Judge (ALJ) hearing requests and judicial review at $100 and $1,000, respectively, for Medicare Part A and Part B appeals. Section 940 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), amended section 1869(b)(1)(E) of the Act to require the AIC threshold amounts for ALJ hearings and judicial review to be adjusted annually. The AIC threshold amounts are to be adjusted, as of January 2005, by the percentage increase in the medical care component of the consumer price index (CPI) for all urban consumers (U.S. city average) for July 2003 to July of the year preceding the year involved and rounded to the nearest multiple of $10. Section 940(b)(2) of the MMA provided conforming amendments to apply the AIC adjustment requirement to Medicare Part C/Medicare Advantage (MA) appeals and certain health maintenance organization and competitive health plan appeals. Health care prepayment plans are also subject to MA appeals rules, including the AIC adjustment requirement. Section 101 of the MMA provides for the application of the AIC adjustment requirement to Medicare Part D appeals.

A. Medicare Part A and Part B Appeals

The statutory formula for the annual adjustment to the AIC threshold amounts for ALJ hearings and judicial review of Medicare Part A and Part B appeals, set forth at section 1869(b)(1)(E) of the Act, is included in the applicable implementing regulations, 42 CFR 405.1006(b) and (c). The regulations require the Secretary of the Department of Health and Human Services (the Secretary) to publish changes to the AIC threshold amounts in the **Federal Register** (§ 405.1006(b)(2)). In order to be entitled to a hearing before an ALJ, a party to a proceeding must meet the AIC requirements at § 405.1006(b). Similarly, a party must meet the AIC requirements at § 405.1006(c) at the time judicial review is requested for the court to have jurisdiction over the appeal (§ 405.1136(a)).