Justification for OMB Approval of Documentation Requirements in the Medicare Physician Fee Schedule Proposed Rule Concerning Emergency Ambulance Transports and Beneficiary Signature Requirements in 42 CFR 424.36(b)
CMS-1385-P

A. **Background**

Section 424.36(a) requires the beneficiary's signature on a claim unless the beneficiary has died or the provisions of 424.36(b), (c), or (d) apply. Section 424.36(b) states that if the beneficiary is physically or mentally incapable of signing the claim, the claim may be signed by one of the persons specified in 424.36(b)(1) through (5). Ambulance providers and suppliers have complained that it is often impossible or impractical to get a beneficiary's signature on a claim (or the signature of a person authorized to sign a claim on behalf of the beneficiary) in order to properly bill Medicare, because: (1) beneficiaries are often incapable of signing claims due to their medical condition at the time of transport; (2) another person authorized to sign the claim under 424.36(b) is unavailable or unwilling to sign the claim at the time of transport; and, (3) it is impractical or not feasible to later locate the beneficiary or the beneficiary's authorized representative to obtain a signature on the claim before submitting the claim to Medicare for payment.

We are sympathetic to the concerns of the ambulance industry. Therefore, we are proposing to add 424.36(b)(6), stating that an ambulance provider or supplier may submit a claim to Medicare without the beneficiary's signature, for emergency ambulance services, if certain conditions and documentation requirements are met. Thus, an ambulance provider or supplier will be required to maintain in its files for a period of at least four years from the date of service the following documentation: (1) a signed contemporaneous statement by an ambulance employee present during the time of transport that the beneficiary was physically or mentally incapable signing the claim form and that none of the individuals listed in 424.36(b) were available or willing to sign the claim form on behalf of the beneficiary at the time of transport; (2) the date and time the beneficiary was transported, and the name and location of the facility that received the beneficiary; and, (3) a signed contemporaneous statement from a representative of the facility that received the beneficiary documenting the name of the beneficiary and the time and date that the beneficiary was received by that facility.

For non-emergency ambulance transport services, where beneficiaries are physically and mentally capable of signing claim forms, the ambulance provider or supplier will continue to be required to obtain a signature from the beneficiary (or from one of the individuals listed in 424.36(b)) prior to submitting claims to Medicare.

B. **Justification**

1. **Need and Legal Basis**

Section 424.33(a)(3) states that all claims must be signed by the beneficiary or the beneficiary's representative (in accordance with 424.36(b)). Section 424.36(a) states that the beneficiary's signature is required on a claim unless the beneficiary has died or the provisions of 424.36(b), (c), or (d) apply. The statutory authority requiring a beneficiary's signature on a claim submitted by a provider is located in section 1835(a) and in 1814(a) of the Social Security Act (the Act), for Part B and Part A services, respectively. The authority requiring a beneficiary's signature for supplier claims is implicit in sections 1842(b)(3)(B)(ii) and in 1848(g)(4) of the Act.

We believe that for emergency ambulance transport services, where the beneficiary is physically or mentally incapable of signing the claim (and the beneficiary's authorized representative is unavailable or unwilling to sign the claim), that it is impractical and infeasible to require an ambulance provider or supplier to later locate the beneficiary or the person authorized to sign on behalf of the beneficiary to obtain a signature on the claim before submitting the claim to Medicare for payment. Therefore, for purposes of this regulation, we are allowing an exception to the beneficiary signature requirement on a claim (for emergency ambulance transport services only) when the beneficiary is physically or mentally incapable of signing the claim, and if certain documentation requirements are met. We are proposing to add an exception to the beneficiary signature requirement regulations found in 424.36(b), by creating 424.36(b)(6).

Thus, we are requesting OMB approval of the collection of information requirements described in the proposed beneficiary signature regulation (424.36(b)(6)) for emergency ambulance transport services. The documentation requirements should take less than five minutes to obtain for, both, the ambulance provider or supplier and the facility receiving the beneficiary. We believe that all or most ambulance providers and suppliers will comply with the proposed written requirements in order to get paid by Medicare for their emergency ambulance transport services. Moreover, waiving the beneficiary signature requirement on claims in certain emergency ambulance transport situations will reduce an infeasible burden placed on ambulance providers and suppliers and on our beneficiaries.

2. **Information Users**

The information collected will be used by CMS contractors (both, fiscal intermediaries and carriers) that process and pay emergency ambulance transport claims. This information may also be used by employees of CMS that deal with payment policy and claims processing requirements, and others for investigating fraudulent and/or abusive billing practices. Therefore, the CMS offices using the information collected may be employees of the Center for Medicare Management, the Office of Financial Managements, the Office of General Counsel, and the Office of the Inspector General. In addition, the information collected may be used by other Federal agencies, such as the Department of Justice, the Federal Bureau of Investigations, the General Accounting Office, etc. as necessary.

3. **Improved Information Technology**

The collection of the required documentation will require recordkeeping in paper form. We are not aware of any alternative technological collection method for this material. For this reason, we do not believe that alternate technological collection mechanisms are necessary at this point in time.

4. **Duplication of Similar Information**

This information collection does not duplicate any other information collection effort.

5. **Small Businesses**

Small businesses and other small entities are affected by the collection of this information. The information will be collected by ambulance providers and suppliers, and part of the required documentation for claims submission will come from the facilities receiving the emergency ambulance transported beneficiaries. However, only the ambulance provider or supplier submitting the claim will be required to furnish the required documentation.

6. **Less Frequent Collection**

The collection of this information will be required by section 424.36(b)(6). If the required documentation is not submitted in accordance with this regulation and in accordance with our timely filing regulation specified at 424.44, then claims for emergency ambulance transport services will not be paid by Medicare, unless an authorized beneficiary signature (as described in 424.36(b)) is obtained.

7. **Special Circumstances**

The only special circumstance that applies to this collection of information is that an ambulance provider or supplier will be required to maintain in its files the required documentation for a period of at least fours years from the date of service.

8. **Federal Register Notice/Outside Consultation**

The 60-day Federal Register notice was published July 13, 2007.

An additional 60-day public comment process was undertaken with publication of the Medicare physician fee schedule proposed rule on July 6, 2007.

9. **Payments/Gifts to Respondents**

We are not providing any payments or gifts to respondents in connection with this information collection.

10. **Confidentiality**

The confidentiality of the beneficiary's patient records will be assured according to all HIPPA rules and regulations and in accordance with the Privacy Act. The confidentiality and privacy of the beneficiary's information for emergency ambulance transport claims will be treated the same as with any other claim submitted to Medicare for payment.

11. **Sensitive Questions**

This collection of information does not include any questions of a sensitive nature.

12. **Burden Estimate (Total Hours & Wages)**

We estimate that approximately 9,000 ambulance providers and suppliers will comply with these requirements. We estimate that it will take less than 5 minutes for each provider or supplier to comply with these recordkeeping requirements. Based on the best available data, we estimate that the total annual burden associated with the documentation requirements in 424.36(b)n to be 541,667 hours nationwide. This annual total number of burden hours was arrived at by multiplying 5 minutes by the total estimated number of emergency ambulance transports of 6,500,000. We note that the total number of burden hours may be overstated, because not every beneficiary who receives emergency ambulance transport services is unable to sign the claim. However, we also note that the 6.5 million figure for emergency ambulance transports is the estimated number of ALS1-emergency and BLS-emergency ambulance claims processed by Part B carriers incurred in 2006 and processed through April 2007, and thus, does not include the number of emergency ambulance transport services billed to fiscal intermediaries by ambulance providers, which number was not available to us. In any event, we believe that the required documentation will benefit ambulance providers and suppliers by allowing them an alternative procedure for submitting claims to Medicare, and will also assure the Medicare program that claims will be properly billed. Thus, requiring the documentation in the proposed 424.36(b)(6) should save the Medicare program money by reducing incorrect billings that may result in Medicare overpayments.

The estimated hourly wage for an ambulance employee (or, an emergency medical technician) present during an emergency transport is approximately $ 14.61, based on a Federal GS-5 grade level salary of $ 30,386 (which is close to the national average salary for EMTs).

13. **Capital Costs**

There are no capital costs associated with this collection.

14. **Cost to the Federal Government**

The Federal government should not incur any additional costs to process and pay emergency ambulance service claims than what is already in our contractors' budgets to perform the claims processing function. Contractors would process these claims like claims for other covered-services. Medicare may be paying more for these services, because of the difficulty that

ambulance providers and suppliers may have had in the past, in obtaining authorized beneficiary signatures on the claim forms. However, Medicare should be paying for covered services that were actually furnished as billed. Nonetheless, no budget increase is necessary.

15. **Changes to Burden**

The is a new collection.

16. **Publication/Tabulation Dates**

There are no publication or tabulation dates.

17. **Expiration Date**

There is no collection data instrument used in the collection of this information. Therefore, this collection does not lend itself to an expiration date. The only expiration date is the timely filing deadline for submitting claims, as described in the Medicare regulations at 424.44.

18. **Certification Statement**

There are no exceptions to the certification statement.