Supporting Statement Part A
Documentation Requirements Concerning Emergency and Nonemergency
Ambulance Transports Described in the Beneficiary Signature Regulations in 42 CFR 424.36(b)
CMS-10242, OCN 0938-1049

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, in CMS-1385-FC (72 FR 66321, published November 27, 2007), we added an exception to the beneficiary signature requirement for submitting claims, at 424.36(b)(6), stating that an ambulance provider or supplier may sign the claim when the beneficiary is incapable of signing in emergency ambulance transport situations, if certain conditions and documentation requirements are met. As a result of this regulation, we received comments requesting that ambulance providers and suppliers should also be allowed to sign claims in certain nonemergency ambulance transport situations when a beneficiary is incapable of signing, for example, during ambulance transports of beneficiaries that have Alzheimer's disease or dementia. Therefore, in CMS-1403-FC (73 FR 69860, published November 19, 2008), we revised 424.36(b)(6) by stating that an ambulance provider or supplier may also sign the claim when the beneficiary is incapable of signing in certain nonemergency ambulance transport situations, if certain conditions and documentation requirements are met. We stated in, both, CMS-1385-FC and CMS-1403-FC, that an ambulance provider or supplier is 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.

A. 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 and nonemergency 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, before submitting the claim to Medicare for payment. Therefore, we created an exception to the beneficiary signature requirement with respect to emergency and nonemergency ambulance transport services, where the beneficiary is physically or mentally incapable of signing the claim, and if certain documentation requirements are met. Thus, we added subsection (6) to paragraph (b) of 424.36.

We wish to continue the documentation requirements described in 424.36(b)(6) for ambulance providers and suppliers, with respect to emergency and nonemergency ambulance transports where the beneficiary is physically or mentally incapable of signing the claim form. Therefore, we are requesting to reinstate the collection of information requirements described in the beneficiary signature regulations in 424.36(b)(6) for emergency and nonemergency ambulance transport services. The documentation requirements take less than five minutes to obtain by the ambulance provider or supplier and the facility receiving the beneficiary. We believe that all or most ambulance providers and suppliers have complied with these documentation requirements. We do not have any evidence to suggest otherwise. We also believe that waiving the beneficiary signature requirement on claims in certain emergency and nonemergency ambulance transport situations has removed an infeasible burden on ambulance providers and suppliers and on our beneficiaries.

2. Information Users

Ambulance providers and suppliers are the primary information users, because they are required by the beneficiary signature regulation at 42 C.F.R 424.36(b)(6) to collect and maintain the information described above (in section A. Background). When ambulance providers and suppliers sign claims on behalf of beneficiaries they are required by 424.36(b)(6) to keep certain documentation in their files for at least four years from the date of service. The purpose of this information collection by ambulance providers and suppliers is to document emergency and nonemergency ambulance transports where the beneficiary was incapable of signing the claim and the ambulance provider or supplier signed the claim on the beneficiary's behalf. However,

the information collected by ambulance providers and suppliers may also be used by: (1) CMS Part A and Part B Medicare Administrative Contractors that process and pay ambulance claims; (2) CMS staff who review and audit claims for medical necessity; (3) CMS staff who review claims for overpayments; and, (4) by others who investigate ambulance billing practices to ensure compliance under the False Claims Act and anti-kickback statute. Therefore, besides ambulance providers and suppliers, the information collected may be used by CMS, the Office of the General Counsel, the Office of the Inspector General, Department of Justice, and the Federal Bureau of Investigations.

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 and/or nonemergency ambulance transported beneficiaries who are incapable of signing the claim form. However, only the ambulance provider or supplier submitting the claim is required by regulation to store and maintain the required documentation, for a period of at least four years from the date of service.

6. Less Frequent Collection

The collection of this information is 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 regulations specified at 424.44, then claims for emergency and certain nonemergency 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 is 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 published on June 7, 2013 (78 FR 34387). No comments were received.

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)

The latest available CMS data indicates that there are 11,564 Medicare-enrolled ambulance providers and suppliers. We believe that most or all are complying with the documentation requirements described in 42 C.F.R. 424.36(b)(6). We estimate that it takes 5 minutes or less for each ambulance 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)(6) to be 1,303,857 hours nationwide.

This estimated total number of annual burden hours was arrived at by multiplying 5 minutes (5 /60 = .0834) by the total estimated number of Part B-paid ambulance supplier transport claims for services furnished in 2011 (15,633,781).

We note the following: (1) the total number of burden hours may be overstated, because not every beneficiary who receives an ambulance transport is unable to sign the claim; (2) the 15,633,781 number does not include Part A ambulance provider transport claims, because such claims are bundled into hospital payments; and (3) the 15,633,781 number represents a 9.07% increase in Part B ambulance transports from 2007 to 2011. We believe that the required documentation benefits ambulance providers and suppliers by allowing them an alternative procedure for submitting claims to Medicare, and also assures the Medicare program that claims are properly billed. Thus, the required documentation in 42 C.F.R. 424.36(b)(6) may save the Medicare program money by reducing incorrect billings and potential overpayments.

According to the Bureau of Labor Statistics, U.S. Department of Labor, Occupational Employment and Wages, May 2012, the average hourly wage for Emergency Medical

Technicians and Paramedics is $16.53. Thus, the total ambulance provider and supplier burden estimate is 1,303,857 total nationwide hours times $16.53/hour equals $21,552,756 divided by 11,564 ambulance providers and suppliers which equals an approximate cost of $1,863.78 per ambulance provider or supplier.

13. Capital Costs

There is no capital cost associated with this collection.

14. Cost to the Federal Government

The Federal government should not incur any additional costs to process and pay emergency and nonemergency ambulance transport claims than what is already in our contractors' budgets to perform their claims processing function. Contractors would process these claims like claims for other covered-services. Therefore, no budget increase is necessary.

15. Changes to Burden

We updated the burden estimate in section A.12 from the last burden estimate. The number of Medicare-enrolled ambulance providers and suppliers increased from 9,000 to 11,564. The total number of burden hours increased from 541,667 to 1,303,857. The total estimated number of ambulance transports for Part B-paid claims in 2011 was 15,633,781. This number represents a 9.07% increase from the number of Part B-paid ambulance transport claims in 2007. We also made note that the total number of burden hours may be overstated, because not every beneficiary who receives an emergency or nonemergency ambulance transport service is unable to sign the claim form.

The estimated average hourly wage for Emergency Medical Technicians and Paramedics increased from $14.61 to $16.53. Thus, the total ambulance provider and supplier burden estimate is 1,303,857 total nationwide hours times $16.53/hour equals $21,552,756 divided by 11,564 ambulance providers and suppliers which equals an approximate cost of $1,863.78 per ambulance provider or supplier. Therefore, the total estimated cost for obtaining the documentation requirements in 42 C.F.R. 424.36(b)(6) is approximately $1,863.78 per ambulance provider or supplier.

In section A.2, we clarified that the information is collected by ambulance providers and suppliers and that they must keep this information in their files for at least four years from the date of service. The purpose for collecting this information is to document emergency and nonemergency ambulance transports where the beneficiary is incapable of signing the claim form. The information collected by ambulance providers and suppliers may also be used by: (1) CMS contractors that process and pay ambulance transport claims; and, (2) by CMS staff and staff working for other Federal agencies who monitor or investigate the submission of ambulance claims for medical necessity, overpayments, abusive billing practices and/or the submission of false claims.

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.

B. Collections of Information Employing Statistical Methods

CMS does not intend to collect information employing statistical methods.