

**Supporting Statement for Paperwork Reduction Act
Submissions Emergency and Foreign Hospital Services and
Supporting Regulation in 42 CFR Section 424.103**

CMS-1771, OMB 0938-0023

A. Background

Payment may be made for certain Medicare Part A inpatient and Part B outpatient hospital services provided in a nonparticipating U.S. or foreign hospital when services are necessary to prevent the death or serious impairment of the health of the individual Medicare Beneficiary. In these situations, the threat to the life or health of the individual necessitates the use of the most accessible hospital available that is equipped to furnish such services.

In establishing an emergency the physician's statement must accompany any emergency claim. It must describe the nature of the emergency and state that the services were necessary to prevent the death, or the serious impairment of the beneficiary. The medical necessity can be documented by the physician on a CMS-1771, Attending Physician's Statement and Documentation of Medicare Emergency.

This information collection request (ICR) was last submitted for OMB review and approval in June 2011. It was approved in July 2011 and expired in July 2014. Subsequent to the lapse of approval, we are seeking to reinstate this ICR without change.

B. Justification

1. Need and Legal Basis

Section 1866 of the Social Security Act states that any provider of services shall be qualified to participate in the Medicare program and shall be eligible for payments under Medicare if it files an agreement with the Secretary to meet the conditions outlined in this section of the Act. Section 1814 (d)(1) of the Social Security Act and 42 CFR 424.100, allows payment of Medicare benefits for a Medicare beneficiary to a nonparticipating hospital that does not have an agreement in effect with the Centers for Medicare and Medicaid Services. These payments can be made if such services were emergency services and if CMS would be required to make the payment if the hospital had an agreement in effect and met the conditions of payment. This form is used in connection with claims for emergency hospital services provided by hospitals that do not have an agreement in effect under Section 1866 of the Social Security Act.

Section 424.103 (b) of Title 42 of the CFR requires that before a non-participating hospital may be paid for emergency services rendered to a Medicare beneficiary, a statement must be submitted that is sufficiently comprehensive to support that an emergency existed. Form CMS- 1771 contains a series of questions relating to the medical necessity of the emergency. The attending physician must attest that the hospitalization was required under

the regulatory emergency definition (42 CFR 424.101 attached) and give clinical documentation to support the claim. A photocopy of the beneficiary's hospital records may be used in lieu of the CMS-1771 if the records contain all the information required by the form.

2. Information Users

The form is sent to the attending physician by the beneficiary's Medicare Administrative Contractor (MAC) intermediary or can be down loaded from the CMS Web Site at <http://www.cms.hhs.gov/cmsforms/downloads/cms1771.pdf>. The Part A MAC provides the CMS 1771 form to the providers based on a submitted claim. Once the form is completed and received by MAC, it makes a coverage determination under the special emergency provisions. The MAC uses the patient data collected from the CMS 1771 form to obtain (1) sufficient identifying information about the patient to verify coverage and eligibility under Medicare; (2) facts that support the claim that an emergency existed with regard to the patient's condition which necessitated admission to a nonparticipating hospital.

3. Use of Information Technology

This request does not lend itself to automated/electronic processing. The requested information is received from the attending physician (in most instances this physician is not US based). Due to the low volume, no study has ever been conducted to determine its cost effectiveness.

4. Duplication of Efforts

The data required on this form are unique and not available from other sources.

5. Small Businesses

This request places minimal burden on small businesses.

6. Less Frequent Collection

This information is required for beneficiary identification and eligibility for Medicare payment. Failure to provide the information would result in non-participating hospitals not being paid for claims covered under Section 1814(d)(1) of the Social Security Act.

7. Special Circumstances

The information collection complies with the guidelines in 5 CFR 1320.6. There are no special circumstances.

8. Federal Register/Outside Consultation

The 60-day Federal Register notice published on September 21, 2015. No comments were received. We did not conduct outside consultation since this is a non-controversial form which has been in use for some time.

9. Payments/Gifts to Respondents

No gift to respondents.

10. Confidentiality

There is no pledge to keep this information confidential. The information on this form will become part of the beneficiary's claim for Medicare benefits.

11. Sensitive Questions

This form does not solicit sensitive data.

12. Burden Estimates (Hours & Wages)

We estimate the average response time to be 15 minutes. Due to the individual differences of each case, the circumstances of the emergency and the fact that the physician may submit a copy of the patient's hospital chart in lieu of completing the individual items on this form, the range of time variation to complete the form is from 5 minutes to 25 minutes. Responses should certainly not require over 30 minutes from individual physicians. The time estimate for preparation of the CMS-1771 is based upon the professional judgment of staff members at the Centers for Medicare and Medicaid Services. It is estimated that there are 200 claims filed annually at an average response time of 15 minutes per filing. Therefore, we have calculated the burden as follows: 200 responses x 15 minutes per response = 50 burden hours (annual).

As referenced earlier, we believe physicians will be responding to the information collection requirements. Based on the most recent Bureau of Labor and Statistics Occupational and Employment Data (May 2015) for Category 29-1069 (Physicians and Surgeons, All Other), the mean hourly wage for a physician is \$95.05.¹ We have added 100% of the mean hourly wage to account for fringe and overhead benefits, which calculates to \$190.10 (\$95.05 + \$95.05). We estimate the total annual cost to be \$9505.00 (50 hours x \$191.10/hour).

13. Capital Costs

There are no capital costs associated with this collection.

14. Cost to Federal Government

Estimated costs were developed as follows:

Cost of 1 year's supply of forms	= \$36
MAC handling and processing	= \$808.80
Postage or mailing forms to physician and	

¹ <http://www.bls.gov/oes/current/oes291069.htm>

return = \$148

Total yearly processing cost to the
Federal Government = \$992.80

There is no transfer of funds from other agencies involved with the processing of this form.

15. Changes to Burden

There have been no program changes or adjustments. We are seeking reinstatement without change. The associated labor cost has increased to account for recent wage data and adjusting it by 100% to cover fringe and overhead benefits.

16. Publication/Tabulation Dates

This data is not intended for publication.

17. Expiration Date

CMS will display the expiration date on the form.

18. Certification Statement

There are no exceptions associated with this collection.