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, OMB 0938-1049)

Background

Federal regulations at 42 CFR 424.36(a) require 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 of 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.

The most recent approval of this information collection request (ICR) was issued by the Office of
Management and Budget on April 19, 2017. We are now seeking to renew this approval before it expires on April 30, 2020. We have made no changes to the information being collected and are updating burden estimates to reflect changes in the number of ambulance suppliers, the number of claims, and the hourly wages of the personnel collecting the information.

A. Justification

1. Need and Legal Basis

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. Federal regulations at 42
CFR 424.32(a) (3) state that all claims must be signed by the beneficiary or on behalf of t h e Beneficiary (in accordance with 424.36). 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.

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 42 CFR 424.36. The information required in this ICR is needed to help ensure that services were in fact rendered and were rendered as billed.

2. Information Users

Ambulance providers and suppliers are the primary information users, because they are required by the beneficiary signature regulation at 42 CFR 424.36(b) (6) to collect and

maintain the information described above. 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 Inspector General, the Department of Justice, and the Federal Bureau of Investigations.

3. Improved Information Technology

The regulations are silent regarding the use of information technology for collection of this information.

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 42 CFR 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 four years from the date of service.

8. Federal Register Notice/Outside Consultation

The 60-day notice was published in the Federal Register on December 06, 2019 (84 FR 66910). No comments were received during the public comment period.

The 30-day notice was published in the Federal Register on March 2, 2020 (85 FR 12303).

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 HIPAA 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 & Wage s)

The latest available CMS data indicates that 10,229 Medicare-enrolled ambulance suppliers submitted a Medicare Part B ambulance claim in 2018. We estimate that it would take 5 minutes or less per affected transport for an ambulance supplier to comply with these recordkeeping Requirements. Based on the best available data, we estimate the total annual burden associated with the documentation requirements in 424.36(b) (6) to be 1,110,757 hours nationwide. We arrived at the estimated total number of annual burden hours by multiplying 5

minutes (5 /60 = .0834) by the latest available number of Part B-paid ambulance supplier transport claims for services furnished in 2018 (13,318,440).

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 and (2) the 13,318,440 number of ambulance supplier transport claims does not include Part A ambulance provider transport claims because such claims are bundled into hospital payments.

We anticipate that this information will be prepared by emergency medical technicians and paramedics. According to the Bureau of Labor Statistics (BLS), U.S. Department of Labor, Occupational Employment and Wages, May 2018, the mean hourly wage for emergency medical technicians and paramedics was $18.15. The wage data can be viewed on the BLS web site, https://www.bls.gov/oes/current/oes_nat.htm. We have added 100% of the mean hourly wage to account for fringe and overhead benefits, which calculates to $36.30 ($18.15 +$18.15). Thus, the total ambulance supplier cost burden estimate is 1,110,757 total nationwide hours multiplied by $36.30/hour, which equals $40,320,479. The estimated cost per ambulance supplier is $3,941.78 ($40,320,479 ÷ 10,229 suppliers).

13. Capital Costs

There are no capital costs associated with this collection.

14. Cost to the Federal Government

There is no additional cost to the Federal government. All ambulance claims are processed during the normal course of Federal duties.

15. Changes to Burden

We updated the burden estimate in section A.12 from the last burden estimate to reflect changes in the number of ambulance suppliers, the number of claims, and the addition of 100% of the hourly wage for the cost calculations used to account for fringe and overhead. We have not changed the information collection requirements in any way.

The number of Medicare-enrolled ambulance suppliers decreased from 10,402 to 10,229. The total estimated number of ambulance transports for Part B-paid claims in 2018 was 13,318,440. This number represents a 5.91% decrease in the number of Part B-paid ambulance transport claims from 2015. In light of these facts, we have adjusted the annual time and cost burden estimates accordingly. The total number of burden hours decreased from 1,180,578 to 1,110,757. The estimated average hourly wage for emergency medical technicians and paramedics increased from $34.08 to $36.30. The total estimated cost for obtaining the documentation

requirements in 42 CFR 424.36(b) (6) increased from approximately $3,867.92 to $3,941.78 per ambulance supplier.

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. However, upon receiving OMB approval, CMS will publish a notice in the Federal Register to inform the public of both the approval as well as the expiration date.

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.