HEALTH CARE

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CMS Revises Signature Requirements for Ambulance Transports in Final Physician Fee Schedule Rule

On Thursday, November 1, 2007, the Centers for Medicare & Medicaid Services (CMS) released the Final 2008 Physician Fee Schedule Rule with Comment Period (Final Rule), which included a revised version of the ambulance beneficiary signature provision included in the proposed rule released in July of this year (Proposed Rule). That part of the Proposed Rule was intended by CMS to alleviate the burdens ambulance providers face in obtaining patient signatures for emergency transports. However, the CMS proposal was viewed by the ambulance industry as insufficient and even counterproductive, since it would create substantial new documentation burdens by requiring a contemporaneous signature from the receiving facility verifying delivery of the patient. The Final Rule does very little to address the industry's concerns and, unfortunately, adds additional burdens related to obtaining signatures for non-emergency transports.

Overview of the Proposed Rule

In the Proposed Rule, CMS proposed to amend the current signature regulation, 42 CFR § 424.36 (Signature Regulation), in a way it thought would alleviate providers' difficulties in obtaining signatures for emergency patients. Specifically, the Proposed Rule would have permitted ambulance providers to submit a claim for an emergency patient who was physically and mentally unable to sign, without obtaining a signature from one of the representatives identified in the Signature Regulation[1], if it obtained and maintained all three of the following pieces of documentation:

(1) A contemporaneous statement, signed by an ambulance employee present during the trip to the receiving facility that, at the time of service, the beneficiary was physically or mentally incapable of signing the claim and that none of the representatives specified in the Signature Regulation was available or willing to sign the claim on behalf of the beneficiary

(2) Documentation with the date and time the beneficiary was transported, and the name and location of the facility that received the beneficiary

[1] The specified representatives are (1) the beneficiary's legal guardian; (2) a relative or other person who receives Social Security or other governmental benefits on the beneficiary's behalf; (3) a relative or other person who arranges for the beneficiary's treatment or exercises other responsibility for his or her affairs; or (4) a representative of an agency or institution that did not furnish the services for which payment is claimed but furnished other care, services, or assistance to the beneficiary (e.g., a nurse at the sending or receiving facility).

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(3) *A signed **contemporaneous statement** from a representative of the facility that received the beneficiary, which documented the name of the beneficiary and the date and time the beneficiary was received by that facility*

The Ambulance Industry's Reaction to the Proposed Rule

According to the preamble to the Final Rule, in comments to the Proposed Rule, the ambulance industry pointed out that: (a) providers are already permitted by the existing Signature Regulation to submit a claim if it meets the first of these three documentation requirements; (b) the second piece of documentation is routinely obtained and is not a problem; (c) but the third documentation requirement would present enormous new administrative and practical difficulties, since it would be difficult to obtain signatures from receiving facilities, especially in the context of an emergency. Therefore, the industry asserted that the Proposed Rule failed to accomplish CMS' stated goal of alleviating the burdens posed by the existing Signature Regulation and would actually make things worse.

In lieu of this flawed proposal, the industry requested that CMS simply eliminate the signature requirement as applied to all ambulance services, since it is redundant, unnecessary, and burdensome. If CMS declined to do so, the industry's "fall-back" position was that CMS should permit ambulance providers to rely on signatures on file in a health facility or, for Medicaid patients, the signature in the beneficiary's Medicaid application. At a minimum, if CMS declined to heed any of these requests, the industry made it clear that the new documentation requirement for a receiving facility signature needed to be eliminated in the Final Rule.

The Final Rule's Impact on Emergency Transports

In the Final Rule, CMS declined to eliminate the signature requirement altogether or to adopt the industry's fall-back recommendation of permitting the use of signatures on file with the hospital or the state Medicaid agency. The agency also refused to eliminate the proposed new requirement for documentation of delivery of the patient. Instead, CMS modified the Proposed Rule so that, under the Final Rule, providers will have two options for meeting the new requirement. Providers may either: (1) obtain a "signed contemporaneous statement from a representative" of the receiving facility at the time of delivery; or (2) may obtain "secondary verification" containing the required information (i.e., the name of the beneficiary and the date and time the beneficiary was received by the facility). This secondary verification may take the form of any of the following documents that contains a signature from the receiving facility: (1) a copy of the patient care or trip report; (2) the hospital's registration/admissions sheet; (3) the patient's medical record; (4) the hospital's log; or (5) other internal hospital records. The secondary verification may be obtained after the transport, but must be obtained before submission of the claim.

The Final Rule's Impact on Non-Emergency Transports

Unfortunately, the Final Rule contains other bad news, in addition to CMS' refusal to heed the industry's requests to eliminate or soften the existing signature requirement. Based upon the comments it received, CMS concluded that the industry does not properly understand the current Signature Regulation as it pertains to patients who lack capacity to sign, including non-emergency patients. CMS' view is that the existing provision in the Signature Regulation permitting providers to sign for such patients when there is no representative available to do so, 42 CFR § 424.36(b)(5), only applies to Part A institutional providers such as hospitals. Therefore, CMS states Part B ambulance suppliers should not rely upon this provision. CMS also states that, even if that provision did apply (and, to the extent it applies to Part A providers), the regulation would not permit ambulance providers to determine and document at the time of transport that there is no representative who will sign for the patient and to then submit the claim. CMS' view is that regulation requires an ambulance provider to make "reasonable efforts (over a reasonable period of time)" to secure either the beneficiary's or one of the specified representatives' signature.

CMS uses the Final Rule to change the relevant section of the Signature Regulation to reflect this interpretation. As amended, the regulation states that a claim for a patient who is unable to sign may be signed by a "representative of the provider… for services it has furnished if the provider… is unable to have the claim signed" by the patient or one of the other specified representatives only *"after making reasonable efforts to locate and obtain the signature"* of one of these individuals (emphasis added). CMS interprets the reference to "provider" in this provision as referring only to Part A providers such as hospitals.

As a practical matter, CMS' interpretation of this provision, as amended, affects Part A (provider-based) ambulance services and Part B ambulance suppliers differently, with the most negative impact on the latter. Since CMS says this provision is not applicable to Part B suppliers, it is unclear how they are supposed to bill for non-emergency transports when the patient is unable to sign and there is no representative available, either at the time of transport or afterwards, who is willing to sign. CMS' interpretation appears to deprive Part B suppliers of the regulatory authority they have previously relied upon to submit claims in that situation. Part A ambulance companies may continue to rely upon this provision for non-emergency transports, but will now be required to make reasonable attempts, over a reasonable period of time, before they may sign the claim themselves.

Additional Comment Period

The Final Rule is effective January 1, 2008. Fortunately, CMS has issued the Final Rule with an additional comment period until 60 days after publication of the Final Rule in the Federal Register, which is scheduled for November 27, 2007. This will provide a further opportunity to point out the deficiencies in the Final Rule, including the problem it will create for ambulance providers — especially Part B suppliers — when they are unable to obtain a patient or representative signature either at the time of transport or afterward.

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