

## **Guidance on Beneficiary Signature Requirements for Ambulance Claims Calendar Year (CY) 2009 Update**

### **I. Introduction**

On November 27, 2007, CMS published the CY 2008 Medicare Physician Fee Schedule (PFS) Final Rule (CMS-1385-FC) in which changes were made to the beneficiary signature requirement at 42 C.F.R. §424.36(b)(6) for emergency ambulance transport services. On November 19, 2008, CMS published the CY 2009 Medicare PFS Final Rule (CMS-1403-FC) which amended §424.36(b)(6) to include non-emergency ambulance transport services.

In this CMS policy statement, we explain the important changes the CY 2008 PFS Final Rule made to the beneficiary signature requirement at §424.36(b)(6) for emergency ambulance transport services. We also affirm the requirements at §424.36(b)(4) as they pertain to the ability of ambulance providers and suppliers to rely on signatures from institutional providers acknowledging non-emergency and emergency transports. In addition, we explain the changes that the CY 2009 PFS Final Rule made to the beneficiary signature requirement at §424.36(b)(6) for non-emergency ambulance transport services.

### **II. New Regulatory Provisions for Emergency and Non-emergency Ambulance Transports**

Medicare regulations at §424.36 require the beneficiary's own signature on the claim, unless the beneficiary has died or the provisions of paragraphs (b), (c) or (d) of this section apply. In the November 27, 2007 PFS Final Rule, effective for services rendered on or after January 1, 2008, CMS adopted a new exception to the beneficiary signature requirement that is intended to provide greater flexibility to ambulance providers in emergency situations. The new exception applies to any emergency ambulance transport where the beneficiary was physically or mentally incapable of signing a claim form at the time of transport, and none of the individuals listed in §424.36(b)(1) – (4) was available or willing to sign a claim on behalf of the beneficiary. Although ambulance providers and suppliers (like all providers and suppliers) are required to use reasonable efforts to obtain the beneficiary's signature before submitting the claim, when relying on the exceptions at §424.36(b)(1) – (5), the new exception at §424.36(b)(6) allows an ambulance provider or supplier to submit a claim without first making such efforts, if the documentation requirements of the new exception are met.

\* Note that §424.36(b)(5) does not apply to ambulance suppliers.

To qualify for the new exception at §424.36(b)(6), the ambulance provider or supplier must obtain the following documentation, which must be kept in its files for a period of not less than 4 years from the date of service:

1. A signed contemporaneous statement, made by an ambulance employee present during the trip to the receiving facility, that the beneficiary was physically or mentally incapable of signing a claim form and that none of the individuals listed in §424.36(b)(1) through (b)(4) were available or willing to sign the claim form on behalf of the beneficiary at the time the service was provided; **and**
2. The date and time the beneficiary was transported, and the name and location of the facility where the beneficiary was received; **and**
3. **Either (a)** a signed contemporaneous statement from a representative of the facility that received the beneficiary, which documents the name of the beneficiary and the time and date that the beneficiary was received by that facility, **or (b)** the requested information from a representative of the facility using a secondary form of verification obtained at a later date, but prior to submitting the claim to Medicare for payment.

As we stated in the final rule, an ambulance provider/supplier can meet the signed contemporaneous statement requirement simply by adding an attestation clause and signature block to the trip report or using a separate form containing the required information. A representative of the receiving facility would then sign to confirm receipt of the patient at the time of transport.

Acceptable forms of such secondary verification include a copy of any of the following: a signed patient care/trip report, hospital registration/admissions sheet, the patient's medical record, hospital log, or other internal hospital records.

In the November 19, 2008 PFS Final Rule, effective for services rendered on or after January 1, 2009, CMS amended §424.36(b)(6) to include non-emergency ambulance transports, when the beneficiary is physically or mentally incapable of signing a claim *at the time of transport*, and there is no one authorized to sign the claim on behalf of the beneficiary available or willing to sign. CMS also amended §424.36(a) to define "claim" for purposes of the beneficiary signature requirement, as the claim form itself, or a form that contains adequate notice to the beneficiary or other authorized individual that the purpose of the signature is to authorize a provider or supplier to submit a claim to Medicare for specified services furnished to the beneficiary. In addition, CMS revised §424.36(b)(6)(ii)(c)(2) to include secondary forms of verification from either a "hospital" or a "facility." Finally, CMS clarified that a facility signature would not be required on secondary forms of verification if the official hospital or facility record documents the beneficiary's name, date, and time the beneficiary was received by that facility.

### **III. Affirmation of Existing Regulatory Provisions**

The existing Medicare regulation at §424.36(b)(4) permits an ambulance provider or supplier to submit a claim even in the absence of a beneficiary signature, where the ambulance provider/supplier, after making reasonable efforts+ to obtain the beneficiary's signature, has obtained the signature of an institutional provider reflecting that the transport was provided. Note that §424.36(b)(4) may be relied upon by ambulance providers and suppliers for both emergency and non-emergency transports.

Ambulance services are often provided to beneficiaries who are mentally or physically incompetent to provide their own signatures. Where an ambulance provider or supplier has a reasonable basis for believing that a beneficiary is physically or mentally incapable of signing the claim at the time of transport, and that this disability will continue indefinitely (for example, where the ambulance provider or supplier transports a patient who is known by it to have a significant form of dementia), the reasonable efforts requirement is satisfied.

We will allow an ambulance provider or supplier to submit a claim on behalf of a patient despite having been unable to obtain the patient's signature, in reliance on §424.36(b)(4), under the following conditions:

1. An employee or representative of the institutional provider has signed a form++ acknowledging: (a) the identity of the patient; (b) the fact that the patient was transported by the specified ambulance provider/supplier to the specified facility on the specified date; and (c) the purpose of the representative's signature is to enable the ambulance provider or supplier to submit a bill for that transport service; **and**
2. The beneficiary has received other care, services, or assistance from the institutional provider whose representative signs the form.

Because ambulance claims often are submitted electronically, it is not necessary for the institutional provider to sign an actual claim form (such as the CMS 1500 or the CMS 1450). Rather, the ambulance provider or supplier may furnish its own form for this purpose, or the facility may provide the form. In either event, the form should provide a space for the individual signing the form to print his/her name. The institutional provider should not sign if it knows, or reasonably should know, that the services alleged to have been furnished by the ambulance provider or supplier were in fact not furnished.

### **IV. No Financial Liability on Facility Signing on Behalf of the Beneficiary**

We have received reports of reluctance on the part of transporting and receiving facilities to sign on behalf of the beneficiary because of uncertainty as to whether the facilities

would be financially liable for the transport. Under both provisions discussed above (42 C.F.R. §424.36 (b)(6) and (b)(4)), a signature provided by the facility representative to the ambulance provider/supplier acknowledging the transport simply authorizes the ambulance provider/supplier to submit a claim to Medicare for the ambulance transport. Such a signature does not impose financial responsibility by Medicare for the ambulance transport on the facility or its representative signing on behalf of the beneficiary in the event that Medicare initially allows but later denies it. Specifically, such a signature does not constitute a certification by the facility that ambulance transportation was medically necessary or otherwise in compliance with existing regulations regarding Medicare payment for ambulance services.

- **This paper provides guidance on beneficiary signature requirements for ambulance transport claims. It is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations, and manual instructions.**

Prepared by DTPP, CCPG, CMM, CMS - 1/15/2009