MEMORANDUM

To: **All Clients**

From: **David Werfel, Esq.**
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Date: **November 26, 2007**

Subject: **Final Rule re: Beneficiary Signature Requirement**

PLEASE READ THIS MEMO CAREFULLY, AS MEDICARE IS CHANGING THE REQUIREMENTS FOR WHEN YOU ARE ALLOWED TO SUBMIT CLAIMS TO MEDICARE BASED ON THE SIGNATURE OF THE PATIENT.

On November 1, 2007, CMS posted the Final Rule for physicians and other suppliers. It is scheduled to be published in the Federal Register on November 27, 2007. While the majority of this rule dealt with physicians, there were a couple of items of importance to ambulance services.

The most significant change for ambulance is to the beneficiary signature requirement. First, the Final Rule created a new exception to the beneficiary signature requirement for emergency transports. In the Final Rule, CMS also gave a new interpretation of what it believes ambulance suppliers must do to comply with the beneficiary signature requirement. The effect of this new interpretation would be to substantially increase the time and effort associated with complying with the signature requirement, while reducing cash flow.

This memo sets out some recommendations for complying with these changes to the beneficiary signature requirement. A copy of the existing regulation 42 C.F.R. §424.36 is enclosed.

A. <u>New Exception for Emergency Transports</u>

As adopted, the exception would permit an ambulance service, in an emergency, to answer "Yes" for the signature question on electronic claims and submit the claim to Medicare for payment, provided each of the following conditions was met:

- the patient was physically or mentally incapable of signing the claim at the time of service;
- there is no one else legally entitled to sign on the patient's behalf at the time the service was provided; and
- the ambulance service obtains/maintains the following documentation for 4 years:

- a contemporaneous statement from the crew stating that the patient was unable to sign and that there was no one available to sign on the patient's behalf;
- documentation of the date and time of the transport, and the name and location of the receiving hospital.
- documentation from the receiving hospital of the name of the patient and the date and time the patient was received, in the form of either:
  - A contemporaneous statement from a representative of the receiving facility, **OR**
  - a secondary form of verification from the receiving facility, which can include a patient medical record, hospital admission record, hospital log, etc.

When the exception was first proposed by CMS, you would have been required to obtain the statement from the receiving facility at the time of transport. The Final Rule amended the proposed exception to provide an additional means of obtaining the required documentation from the receiving facility. As adopted, you can now also get this documentation at a later date. However, CMS stated that they expect any alternative documentation to be signed by a representative of the receiving hospital. The new exception would become effective **January 1, 2008**.

Unfortunately, the new exception makes no allowances for the inevitable situations where the ambulance service makes a good faith effort to comply, but is ultimately unable to obtain the required documentation from the receiving facility. When this happens, you will still be required to get the signature of the patient or an authorized representative.

Required Documentation

To qualify for the new exception, you must obtain 3 pieces of documentation:

1. Statement from crew member (i) that the patient was unable to sign and (ii) that no legally authorized person was available or willing to sign on the patient's behalf. **NOTE: this documentation must be obtained at the time of transport.**

2. Documentation of (i) the date and time of the transportation and (ii) the name and location of the facility that received the patient

3. Documentation from the receiving facility of (i) the name of the patient and (ii) the date and time the patient was received.

The first two items are already included in your crew's standard documentation for each transport. The only additional documentation, but it is a major one, is the documentation from the receiving facility.

Recommended Steps for Complying with New Exception

To help you qualify for the new exception for emergency transports, we recommend the following:

1. Crew Education & Training – One of the requirements is a statement from the crew that the patient was unable to sign and that there was no one to sign for the patient **at the time of transport**. If the crew fails to note both items on the trip report, you will be unable to meet the exception (and, therefore, under CMS' new interpretation, you would have to chase the patient for their signature before submitting the claim). Thus, the starting point for compliance with the new exception is crew education and training. As part of your crew education and training classes, we recommend:

- you place additional emphasis on the importance of obtaining the patient signature at the time of transport.
- where the crews are unable to obtain the signature due to the patient condition, crews **must** document: (i) that the patient was unable to sign and the reason why (e.g., unconscious, altered mental status, etc.) and (ii) that there was no one able to sign for the patient.
- Crews are permitted to use abbreviations such as "PUTS" (Patient Unable to Sign) or "NOTS" (No One to Sign).

2. Quality Assurance – We recommend that someone check to make sure crews are returning with either the patient's signature or a fully documented reason why they did not obtain the signature. You might also want to have the crew supervisors keep track of the percentage of trip reports that are returned with (a) no patient signature, (b) if no patient signature, no explanation by the crew and (c) "Patient refused to sign". The crews with high percentages need to be called in by the supervisors and advised of the review of the paperwork and the need to get signatures.

3. Educate Hospital Personnel – The new exception will require you to ask hospital personnel for a signature at the time of transport, or for certain documentation after the fact. Therefore, we recommend that you meet with hospital administrators and ED personnel to explain why you will be asking for this documentation.

4. Changes to Your Trip Report – We recommend two possible changes to your Trip Report:

a. Patient Signature – The requirement will not be met if crews simply write "patient unable to sign" or some equivalent. Therefore, you might want to include a checkbox or some other prompt that forces the crews to document the reason the patient was unable to sign, and that no one was able to sign for the patient.

One way to meet this requirement is to have a different signature line that is completed by the crew if they do not obtain the signature of the patient or their authorized representative.

For example (using lifetime signature language):

> I request payment of authorized Medicare benefits and/or other insurance benefits be made on my behalf to **[**name of ambulance service**]** for any ambulance services and supplies furnished to me by **[**name of ambulance service**]**. I authorize any holder of medical information about me or other relevant documentation about me to release to the Centers for Medicare and Medicaid Services and its agents and carriers, any and all appropriate third party payers and their respective agents and carriers, as well as **[**name of ambulance service**]**, any information or documentation in their possession needed to determine these benefits and/or the benefits payable for related services, now or in the future.
>
> I acknowledge that I have been provided with a copy of **[**name of ambulance service**]** Notice of Privacy Practices on this date.
>
> _____ _____
> Signature of Patient or Representative Date
>
> _____
> Crew Signature
>
> By signing above, I certify that the above named patient was physically or mentally incapable of signing at the time of transport, and that none of the individuals listed in 42 C.F.R. §424.36(b)(1) – (4) was available or willing to sign the claim on behalf of the beneficiary

In this example, the crew would list "PUTS" and the reason on the signature line for the patient. **NOTE:** the new exception does not explicitly require the above language, or that the crew statement to be signed. The above example is simply one way of meeting the requirement.

If your crew's use an electronic PCR or tablet to capture trip data, we recommend changing your fields for the patient's signature to require the crew's to answer the following questions:

- Patient Signature? (Y/N)
- If "No", Reason why signature was not obtained? (if you want, you can add a pull down menu for some typical reasons)
- Did someone sign for Patient? (Y/N)

When the crew answers that the patient did not sign, and that no one signed for the patient, you would want the crew to sign an electronic signature, with the certification language suggested above.

b. Statement of Receiving Facility – The Final Rule expressly permits an ambulance service to add an attestation clause and signature block to its Trip Report, to be completed by the receiving facility. The language we recommend is as follows:

> I certify that the above named patient was received by our facility on the date and time set forth above.
>
> _____ _____
> Signature of Representative of Receiving Hospital Title

If your crews use an electronic PCR or tablet to capture trip data, we recommend adding a field with this language. The representative of the receiving hospital would then sign with an electronic signature.

5. Cover Letter for Alternative Documentation – There will be times where your crews fail to obtain a signature from the receiving facility at the time of transport, e.g. the crew forgets, ED personnel refuse to sign, etc. When this happens, you can still qualify for the exception to the signature requirement if you get a form of "secondary" verification from the receiving facility. According to the Final Rule, such secondary verification can include (i) getting your Trip Report or an attestation clause signed after the fact, (ii) the hospital registration/admission sheet, (iii) patient's medical records, (iv) the hospital log, or (v) other internal hospital records. **NOTE:** in its explanation, CMS stated that it expected that these secondary forms of verification be signed by a representative of the hospital; however, the regulation (42 C.F.R. §424.36(b)(6)) makes no reference to these records being signed.

We recommend you develop a standard cover letter, that you can use whenever you request a secondary form of verification. The cover letter would explain why you are asking for these records, summarize the new exception, and list the acceptable forms of secondary verification that CMS would accept.

B. New Interpretation of Signature Requirement

The beneficiary signature requirement is set forth in 42 C.F.R. § 424.36. This regulation states that the patient's signature is required on a claim, unless the patient has died or one of the exceptions set forth in subparagraph (b). One of the existing exceptions, 42 C.F.R. § 424.36(b)(5), permits an entity furnishing services to a Medicare beneficiary to sign on the beneficiary's behalf, in certain instances. To apply, the beneficiary must be physically or mentally unable to sign the claim and no other authorized person must be available or willing to sign on the beneficiary's behalf.

Ambulance services have historically interpreted 42 C.F.R. § 424.36(b)(5) to apply to both providers and suppliers, including ambulance suppliers. As a result, the industry has submitted claims when the patient signature was not obtained, so long as the crew documented "PUTS—No One to Sign" on the Trip Report. This interpretation was based on provisions of the CMS Internet Only Manual, including Pub. 100-02, Chapter 10, Section 20.1.2 and Pub. 100-04, Chapter 1, Section 50.1.6(A)(3)(c), as well as previous guidance from CMS and Carriers.

In the Final Rule, CMS stated its belief that 42 C.F.R. § 424.36(b)(5) applied only to institutional providers, such as hospitals. CMS went further, by stating that *"[t]o the extent that ambulance suppliers have been relying on §424.36(b)(5) under any circumstances, such suppliers have been failing to follow the regulations, as this subparagraph does not pertain to suppliers*." Based on this new interpretation, CMS believes that an ambulance supplier would be prohibited from submitting a claim to Medicare unless the supplier had previously obtained the signature of either the patient or their authorized representative (or, starting January 1, 2008 met the requirements of the new exception for emergencies). In those situations where you are unable to obtain the signature, CMS now believes you should bill the patient.

As you can imagine, this new interpretation would require you to spend considerable time and effort tracking down patient's signatures after the date of transport and will disrupt cash flow dramatically.

Alternative Means of Satisfying Beneficiary Signature Requirement for Non-Emergencies

As stated above, CMS now believes that 42 C.F.R. § 424.36(b)(5) does not apply to ambulance suppliers. **NOTE: We do not agree with this new interpretation.** However, if CMS is correct, ambulance suppliers would not be able to submit a claim to Medicare unless and until they obtained the signature of the patient or an authorized representative.

42 C.F.R. § 424.36(b)(1) – (4) sets out the list of people who are authorized to sign a claim on the patient's behalf:

> (b) *Who may sign when the beneficiary is incapable.* If the beneficiary is physically or mentally incapable of signing the claim, the claim may be signed on his or her behalf by one of the following:
> (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.
> (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.

42 C.F.R. § 424.36(b)(4) includes any representative of an institution that furnished other care, services or assistance to the patient. We interpret this section to include a hospital or SNF that provides treatment to the patient. You are already required to obtain a PCS from these facilities for non-emergencies. Therefore, we suggest adding language to your PCS forms immediately above the signature line, so that it can also serve as a signature on the patient's behalf. The language we recommend is as follows:

> I certify that our institution has furnished care or other services to the above named patient in the past. In the event you are unable to obtain the signature of the patient or another authorized representative, I hereby sign on the patient's behalf, in accordance with 42 C.F.R. §424.36(b)(4).

If this language is added, you can comply with the beneficiary signature requirement, and submit the claim to Medicare, as long as you receive a PCS.

Please note that the A.A.A. will be submitting comments seeking further clarification, in addition to trying to convince CMS to withdraw this part of the Final Rule. When the A.A.A's comment letter becomes publicly available, we will forward each of you a copy.

The provisions of the Final Rule go into effect on January 1, 2008. You need to be ready for January 1, 2008. The simplest course of action is to convince crews to get the signature on all non-emergencies, from either the patient or an authorized representative. For emergencies, crews need to get the signature of the either patient or someone at the receiving hospital.

§ 424.36 Signature requirements.

(a) *General rule.* The beneficiary's own signature is required on the claim unless the beneficiary has died or the provisions of paragraph (b), (c), or (d) of this section apply.

(b) *Who may sign when the beneficiary is incapable.* If the beneficiary is physically or mentally incapable of signing the claim, the claim may be signed on his or her behalf by one of the following:

(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.

(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.

(5) A representative of the provider or of the nonparticipating hospital claiming payment for services it has furnished if the provider or nonparticipating hospital is unable to have the claim signed in accordance with paragraph (b) (1), (2), (3), or (4) of this section.

(c) *Who may sign if the beneficiary was not present for the service.* If a provider, nonparticipating hospital, or supplier files a claim for services that involved no personal contact between the provider, hospital, or supplier and the beneficiary (for example, a physician sent a blood sample to the provider for diagnostic tests), a representative of the provider, hospital, or supplier may sign the claim on the beneficiary's behalf.

(d) *Claims by entities that provide coverage complementary to Medicare.* A claim by an entity that provides coverage complementary to Medicare Part B may be signed by the entity on the beneficiary's behalf.

(e) *Acceptance of other signatures for good cause.* If good cause is shown, CMS may honor a claim signed by a party other than those specified in paragraphs (a) through (c) of this section.

[53 FR 6640, Mar. 2, 1988; 53 FR 12945, Apr. 20, 1988, as amended at 53 FR 28388, July 28, 1988]