

From AAA: Proposed CMS Fee Schedule Change



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MEMBER ADVISORY

TO: AAA Membership

FROM: Russell Honeycutt

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The Centers for Medicare and Medicaid Service (CMS) will issue a proposed rule to the physician fee schedule which will include several important changes to the Medicare ambulance fee schedule. I am extremely pleased to report that one of those proposed changes is to the beneficiary signature requirement for ambulance services. CMS is proposing to expand the signature exceptions for emergency transports from the November 2007 final rule to also apply to non-emergency transports.

The AAA working closely with a team from American Medical Response spearheaded by Deb Gault advocated for CMS to expand the exception. In April, AAA representatives met with CMS Deputy Administrator Herb Kuhn and made this issue a top priority. It is a direct result of the efforts by the AAA and AMR that CMS included in the proposed rule the ease on signature requirements for non-emergency transports.

Below is an analysis by Brian Werfel, Esq. of all of the ambulance provisions in the proposed rule which is scheduled to be published in the Federal Register on Monday, July 7, 2008.

Analysis of Proposed Rule

On June 30, 2008, CMS posted a proposed rule that would make important changes to the Medicare beneficiary signature requirement. These proposed changes follow changes to the signature requirement made as part of last year's Final Rule.

The proposed changes are as follows:

- As part of last year's Final Rule, CMS created a new exception to the beneficiary signature requirement for emergency ambulance transports. CMS is proposing to expand this exception to also cover non-emergency transports.
- CMS is proposing to further clarify when a claim can be submitted to Medicare in those situations where the patient's signature is not obtained, but where the provider or supplier obtained a signature on the patient's behalf from an authorized person. As proposed, when the provider or supplier gets a signature from an authorized representative, the provider or supplier could not immediately submit the claim. Instead, CMS would require them to first follow-up with the patient for a signature. If these "reasonable efforts" fail, the provider or supplier could then submit the claim to Medicare in reliance upon the representative's signature.
- The proposed rule would also make clear that the patient or authorized representative does not need to sign the claim form itself, i.e., that the patient signature requirement could also be met by having the person sign a separate signature form, provided that form contained adequate notice that the purpose of the signature was to authorize the provider or supplier to submit a claim to Medicare. **This is not a change in policy, as CMS had previously confirmed this in correspondence with the AAA.** Rather, CMS is simply revising the regulations to clarify its earlier interpretation.

Analysis of Changes in Proposed Rule

The proposed rule would expand the existing exception for emergency ambulance transports to also cover non-emergency transports. If adopted, it would permit ambulance services to satisfy the patient signature requirement for both emergencies and non-emergencies by obtaining a "transfer of care" signature from the receiving facility at the time of transport (assuming the crew documented that the patient was unable to sign and that there was no one to sign for the patient). In the event the ambulance service did not obtain a "transfer of care" signature from the receiving facility at the time of transport, it could still meet the exception by getting an acceptable form of secondary verification.

At the same time, the proposed rule would limit the instances in which ambulance services could submit claims to Medicare based on an "on behalf of signature" from one of the authorized representatives. Specifically, the proposed rule would require that they first use "reasonable efforts" to follow up with the patient to obtain his or her signature, before submitting the claim in reliance upon a signature from an authorized representative.

Effect of Proposed Changes

The proposed changes would eliminate the current distinction between emergency and non-emergency claims. However, it would create a new distinction between: (a) those claims where the patient's signature was obtained (or a lifetime signature is on file) or where the ambulance exception is met and (b) those claims where the provider or supplier obtained a valid signature on the patient's behalf. The former could be immediately submitted to Medicare. The latter

would require the provider or supplier to attempt to contact the patient after the fact. If those attempts failed to result in a signature from the patient, the claim could then be submitted to Medicare in reliance on the representative's signature.

Assuming the proposed changes are adopted without further revision, ambulance services would be able to submit claims to Medicare in the following instances:

1. They have obtained the patient's signature; or
2. They have not obtained the patient's signature, but the patient is deceased; or
3. They have not obtained the patient's signature. However, the crew documented that the patient was unable to sign and that there was no authorized person was available or willing to sign on the patient's behalf. The crew also obtained a "transfer of care" signature from a representative of the receiving facility, or the company obtained a form of secondary verification; or
4. They have not obtained the patient's signature, but they have obtained a signature on the patient's behalf from one of the authorized persons (e.g., the patient's legal guardian). Before submitting the claim, however, they must use "reasonable efforts" to try to obtain the patient's signature; or
5. They are a Part A provider. They have not obtained the patient's signature, nor have they obtained a signature on the patient's behalf from one of the other authorized representatives. However, they have documented that they have taken "reasonable efforts" to try to get the patient's signature or an authorized representative's signature, without success. In this case, they may sign the claim themselves, and submit the claim.

Revised GPCIs

The proposed rule also sets out revised GPCIs for 2009. One of these, the Practice Expense GPCI, is one of the factors used to calculate payments under the Ambulance Fee Schedule.

We have attached the relevant pages of the proposed rule, which set out the changes to the beneficiary signature requirement and the new proposed GPCIs.

<http://www.magnetmail.net/images/clients/CMGAA/attach/ProposedRule.pdf>

The entire proposed rule can be downloaded from the CMS website at:

<http://www.cms.hhs.gov/center/physician.asp> by clicking on the link at the top of the page titled "CMS-1403-P ". <http://www.cms.hhs.gov/physicianfeesched/downloads/CMS-1403-P.pdf>

The proposed rule is scheduled to be published in the Federal Register on Monday, July 7, 2008.

Please see the attached document for additional information

<http://www.magnetmail.net/images/clients/CMGAA/attach/ProposedRule.pdf>

