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Home Health Agency Manual

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

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Section 191.5, Disclosure of Itemized Statement to an Individual for Any Item or Service Provided, reflects §4311(b) of the Balanced Budget Act of 1997, which declares that Medicare beneficiaries have the right to request and receive an itemized statement from their health care provider or supplier. Included in this section are suggested contents of an itemized statement.

DISCLAIMER: **The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.**

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CHAPTER I

GENERAL INFORMATION ABOUT THE PROGRAM

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legally and administratively required in the overall conduct of the Medicare program);

5. The specific extent or nature of information to be disclosed (e.g., all medical records regarding the beneficiary's treatment, hospitalization and/or outpatient care including treatment for drug abuse or alcoholism);

6. A statement that the beneficiary may revoke his consent at any time to prohibit disclosures on or after date of revocation;

7. A statement specifying a date (not to exceed 2 years), event, or condition upon which consent will expire without revocation;

8. The date on which the consent is signed;

9. The signature of the patient; or the signature of his authorized or legal representative.

If the beneficiary wishes, the consent statement may be expanded to permit disclosure by the provider to any other person, organization, or program, such as a PSRO, as appropriate. Authorization may also be given to HCFA and its contractors to redisclose specific information to third party payers for complementary insurance purposes. (See §191.3.)

The provider should keep the consent statement with the patient's medical and other records. The duration of the consent statement is not to exceed 2 years, after which it must be renewed by the beneficiary if further disclosures are necessary.

191.5 Disclosure of Itemized Statement to an Individual for Any Item or Service Provided.--

A. General.--Section 4311 of the Balanced Budget Act of 1997 requires that if a Medicare beneficiary submits a written request to a health services provider for an itemized statement for any Medicare item or service provided to that beneficiary, the provider must furnish this statement within 30 days of the request. The law also states that a health services provider not furnishing this itemized statement may be subject to a civil monetary penalty of up to $100 for each unfulfilled request. Since most institutional health practices have established an itemized billing system for internal accounting procedures as well as for billing other payers, the furnishing of an itemized statement should not pose any significant additional burden.

B. 30-Day Period to Furnish Statement.--You will furnish to the individual described above, or duly authorized representative, no later than 30 days after receipt of the request, an itemized statement describing each item or service provided to the individual requesting the itemized statement.

C. Suggested Contents of Itemized Statement.--Although §4311 of the Balanced Budget Act of 1997 does not specify the contents of an itemized statement, suggestions for the types of information that might be helpful for a beneficiary to receive on any statement include: beneficiary name, date(s) of service, description of item or service furnished, number of units furnished, provider charges, and an internal reference or tracking number. If the claim has been adjudicated by Medicare, additional information that can be included on the itemized statement are: amounts paid by Medicare, beneficiary responsibility for co-insurance, and Medicare claim number. The statement should also include a name and telephone number for the beneficiary to call if there are further questions.

D. Penalty.--A knowing failure to furnish the itemized statement shall be subject to a civil monetary penalty of up to $100 for each such failure.

192. DISCLOSURE OF INFORMATION ABOUT HHAs BY HCFA

The following information about HHAs participating in the Medicare program may be disclosed by HCFA under the Freedom of Information Act in response to requests from the public.

192.1 Medicare Reports.--

A. Provider Survey Report and Related Information.--Information concerning survey reports of HHAs, as well as statements of deficiencies, based on survey reports completed after January 31, 1973, are available at the local social security office or the public assistance office in the area where the facility is located. The following data may be released under this provision:

1. The official Medicare report of a survey concluded on or after January 31, 1973;

2. Statements of deficiencies which have been conveyed to the HHA following a survey concluded on or after January 31, 1973;

3. Plans of correction and pertinent comments submitted by the provider relating to Medicare deficiencies cited following a survey concluded on or after January 31, 1973. State agencies certify whether institutions or other entities meet the Medicare conditions of participation for HHAs. (See §112.) A State agency may disclose information it obtains relating to the qualifications and certi fication status of HHAs it surveys.

B. Program Validation Review Reports and Other Formal Evaluations.--Upon written request, official reports and other formal evaluations of the performance of HHAs completed after January 31, 1973, are made available to the public. After the survey reports and other formal evaluations are prepared by personnel of the Health Care Financing Administration, the evaluated HHA must be given an opportunity (not to exceed 30 days) to review the report and submit comments on the accuracy of the findings and conclusions. The HHA's comments must be incorporated in the report if pertinent.

Program validation review reports are generally released from the Medicare regional office serving the area in which the provider is located.

Generally, informal reports and other evaluations of the performance of HHAs which are prepared by the intermediary are available to the public.

C. HHA Cost Reports.--

1. General.--Requests by any member of the public either to inspect or to obtain a copy of an HHA cost report must be submitted to HCFA or the inter-mediary in writing and must identify the HHA and specific cost report(s) in question.

Intermediaries are required to respond to requests in writing within 10 working days after receipt of a written request, to advise the requester of the date the reports will be made available. That date will be no earlier than 10 working days from the date of the intermediary's response. However, no members of the House or Senate are considered as requests from the public. A copy of the response

to the requester will be sent simultaneously to the HHA, putting the HHA on notice that its report has been requested by a particular person. If a request is for a report submitted by a former owner of an HHA, copies of the intermediary's response to the requester will go to both the present owner and the former owner of the HHA. If the request is for a report submitted by a provider no longer participating in the Medicare program, a copy of the intermediary's response will be sent to the HHA. In the case of both a former owner and a former participating HHA, the copy of the response will be sent to the last known address of the party.

2. Information That May Be Disclosed.--Disclosure by the intermediary is limited to cost report documents which HHAs are required by HCFA regulations and instructions to submit and, in case of a settled cost report, the intermediary's notice of program reimbursement. These documents include the statistical page, the settlement pages, trial balance of expenses, and cost finding schedules or documents required by SSA as part of the regular cost report process. (Where an HHA, after first obtaining program approval, has submitted equivalent documents in lieu of official program documents, these documents are subject to the same disclosure rules as official forms.)

If a request is received to inspect or to obtain a copy of a report that has not been settled, i.e., the final settlement notice of program reimbursement has not been sent, the intermediary will disclose a copy of the report as submitted by the HHA. If settlement has been made, the intermediary will disclose the settled report. If a requestor specifically asks for both the settled and unsettled cost reports of an HHA, the intermediary will comply with such request. When a report is made available for inspection or copying, it will be clearly marked with one of the following captions, as applicable:

a. Cost report as submitted

b. Settlement subject to audit

c. Audited settlement

When an intermediary discloses a settled report, schedules applicable to the settlement that have been reworked by the intermediary are disclosable. The general rule is that if the intermediary has reworked any of the schedules that were required to be submitted by the HHA with its original submission, these schedules become an integral part of the report for disclosure purposes. However, any details containing intermediary or auditor comments concerning the settlement, details of specific adjustments, or supporting schedules applicable to the settlement of the HHA's operation are not disclosed by the intermediary.

Information obtained in auditing HHA cost reports and other financial records may be released by SSA.

3. Information That May Not be Disclosed.-- If an HHA chooses to submit with its cost report additional information not specifically required by regulations or instructions, the intermediary will not disclose such information unless it is contained within an official document. For example, some HHA's may submit supplementary analyses of certain expenses, details of the professional component adjustment, financial statements (other than the statement of income and expenses and the balance sheet as required in accordance with cost reporting instructions), or income tax returns, etc., that are not required by the program. These items would not be disclosed by the intermediary as part of the cost report.

Except where an HHA has not submitted an acceptable cost repot and supplements are required to complete the report, any additional documents or schedules that the intermediary requires the HHA

to submit in support of its cost representations would also not be disclosed by the intermediary as part of the cost report. In addition, the following are not disclosed by the intermediary as part of a cost report: audits, schedules, letters, notes, general comments; comments on results of desk reviews (including copies of the actual desk review documents), intermediary notices and comments (including transmittal letters), audit adjustment summaries that are required to be prepared by intermediaries and auditors, and information pertaining to an individual patient.

NOTE: Any of the information indicated above that is not to be disclosed by the intermediary may be subject to disclosure under the Freedom of Information Act upon review by the health insurance regional office, central office, or a U.S. District Court in response to a request for such information. The description of what will be made available by an intermediary as part of a cost report pertains only to requests that indicate that the requestor specifically wants cost reports.

l92.2 Disclosure of Medicare Statistics.-- Numerous statistics on individual HHA's are available to the public. They include, but are not limited to, the following:

l. Waiver of liability statistics

2. Interim rate payment data

3. Amount of Medicare reimbursement

4. Overpayment data

5. Data from the Provider Monitor Listing

6. Information from the Directory of Medical Facilities and the Directory of Medicare Providers and Suppliers of Services

7. Medicare statistics (e.g., total visits, number of starts of care).

l92.3 Other Information That May be Disclosed.--

l. Presumptive waiver of liability status of the HHA;

2. Information as to whether an HHA participates in the Medicare program.

l93. COST TO AN HHA WHICH REQUESTS INFORMATION AVAILABLE TO THE PUBLIC

HHA's are required to pay appropriate fees for information they may request pertaining to other providers, Medicare contractors, or State agencies. An HHA may claim such fees as allowable costs only if it demonstrates to the intermediary the information is necessary in developing and maintaining the operations of patient care facilities and activities.