Medicare
Skilled Nursing Facility Manual

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

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NEW/REVISED MATERIAL--EFFECTIVE DATE: JUNE 1, 2000
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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.

CHAPTER I

GENERAL INFORMATION ABOUT THE PROGRAM

Section

Supplementary Medical Insurance

Beneficiary Entitlement to Hospital Insurance Benefits

Entitlement to Supplementary Medical Insurance Benefits

Disclosure of Information

l9l.2 Disclosure to Third Parties for Proper Administration of the Health Insurance Program.--Disclosure of any record, report, or other information about an individual is authorized without the consent of the individual in connection with any claim or other proceeding under the Social Securty Act only when disclosure is necessary for the proper performance of the duties of:

A. Any officer or employee of the Department; or

B. Any officer or employee of a State agency, intermediary, provider of services, or other agency or organization participating in the administration of the program by contract or agreement in carrying out such contract or agreement.

These limitations apply whether or not the individual to whom the information pertains authorizes further disclosure to third parties (e.g., to a private medical plan).

l9l.3 Disclosure to Third Parties for Other Than Program Purposes.--Informa-tion obtained from HCFA or its intermediary is confidential and may be disclosed only under conditions prescribed in rules and regulations, or on the express authorization of the Administrator of the Health Care Financing Administration. However, certain limited information about the Medicare eligi-bility status of beneficiaries and related claims information may be released to third party payers with the beneficiary's express authorization.

A. Information Which May Be Released.--Subject to necessary authorization, only the following records may be released:

1. Beneficiary health insurance claim number;

2. Coinsurance and deductible;

3. Dates of entitlement to Medicare;

4. Copies of Medicare claims forms;

5. Medicare report of eligibility;

6. Explanation of Medicare Benefits (EOMB);

Requests for other information desired for complementary insurance purposes should be referred to the intermediary.

B. Form of Authorization.--Make certain that information is not released without the required authorization. The authorization must:

1. Be in writing;

2. Be signed and dated by the individual or someone authorized to act in his behalf;

3. Specify the name of the provider being authorized to disclose information;

4. Specify what information the individual is authorizing the provider to disclose;

5. Specify the names of the third party payers to whom the information is being released;

6. Specify the purpose for which the information is being released; and

7. Specify an expiration date for the authorization which should not exceed 2 years from the date it was signed and specify that it may be revoked at any time.

l91.4 Disclosure for Payment of Claims in Alcohol and Drug Abuse Cases.--The law requires providers to observe more stringent rules when disclosing medical information for claims processing purposes from the records of alcohol and drug abuse patients than when disclosing information for other Medicare beneficiaries. Since the standard consent statement on the provider billing form is not sufficient authority under the law to permit the provider to release information from the records of alcohol or drug abuse patients, more explicit consent statements are required.

Providers participating in Medicare and alcohol and drug abuse prevention and treatment programs must obtain written consent from beneficiaries to release medical information in each alcohol or drug abuse case. This written consent, which will allow the provider to disclose the records of the patient, should include all of the following:

l. The name of the organization (hospital, etc.) which is to make the disclosure;

2. The name or title of the person or organization to which disclosure is to be made (e.g., the Health Care Financing Administration, including the appropriate intermediary or carrier, specified by name);

3. The name of the patient;

4. The purpose or need for disclosure (e.g., for processing a claim for Medicare payment and for such evaluation of the treatment program as is 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 l9l.3 above.)

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.

l92. DISCLOSURE OF INFORMATION ABOUT SNFs BY HCFA

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

l92.l Medicare Reports.--

A. Provider Survey Report and Related Information.--Information concerning survey reports of SNFs, as well as statements of deficiencies, based on survey reports completed after January 3l, l973, 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:

l. The official Medicare report of a survey concluded on or after January 3l, l973;

2. Statements of deficiencies which have been conveyed to the SNF following a survey concluded on or after January 3l, l973;

3. Plans of correction and pertinent comments submitted by the provider relating to Medicare deficiencies cited following a survey concluded on or after January 3l, l973.

State agencies certify whether institutions or other entities meet the Medicare conditions of participation for SNFs. (See ll2.) A State agency may disclose information it obtains relating to the qualifications and certification status of SNFs it surveys.

B. Program Validation Review Reports and Other Formal Evaluations.--Upon written request, official reports and other formal evaluations of the performance of SNFs completed after January 3l, l973, 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 SNF 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 SNF'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 SNFs which are prepared by the intermediary are available to the public.

C. SNF Cost Reports.--

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

Intermediaries are required to respond to requests in writing within l0 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 l0 working days from the date of the intermediary's response. However, no l0-day delay in furnishing cost reports is necessary when the request is from a Federal or State agency that needs cost report information to carry out the requirements of the Social Security Act or the request is from a member of Congress acting in his official capacity. Requests from individual 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 SNF, putting the SNF 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 SNF, copies of the intermediary's response to the requester will go to both the present owner and the former owner of the SNF. 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 SNF. In the case of both a former owner and a former participating SNF, 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 SNFs 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 HCFA as part of the regular cost report process. (Where an SNF, after first obtaining program approval, has submitted equivalent documents in lieu of official program documents, such documents are subject to the same disclosure rules as apply to official forms.)

If a request is received to inspect or 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 SNF. 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 SNF, 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 SNF 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 specified adjustment, or supporting scheduels applicable to the settlement of the SNFs' operation are not disclosed by the intermediary.

Information obtained in auditing SNF cost reports and other financial records may be released by HCFA.

3. Information That May not be Disclosed.--If an SNF chooses to submit with its cost report additional information not specificall required by regulations or instructions, the intermediary will not disclose such information unless it is contained within an official document. For example, some SNFs may submit supplementary analysis of certain expenses, details of the professional component adjustment, financial statements (other than the statement of income and expenses and the balance shet as requried in accordance with cost reporting and 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 SNF has not submitted an acceptable cost report and supplements are required to complete the report, any additional documents or schedules that the intermediary requres the SNF 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 notes 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 Medicare 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 SNFs are available to the public. The 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 inpatient statistics (e.g., total inpatient days, number of admissions, average length of stay).

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

l. Presumptive waiver of liability status of the SNF

2. Information as to whether a provider particiates in the Medicare program.

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

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