Medicare

Rural Health Clinic and Federally Qualified Health Centers 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 132.6, 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

Administration of Medicare Program

Provider Participation in Medicare

Disclosure of Information

condition upon which consent expires without revocation;

- o The date on which the consent is signed; and
- o The signature of the patient or the signature of his/her 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 (e.g., PRO), as appropriate. You may also give authorization to HCFA and its contractors to re-disclose specific information to third party payers for complementary insurance purposes.

The provider keeps 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.

132.6 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.

134. DISCLOSURE OF INFORMATION ABOUT PROVIDERS BY HCFA

Information about participating providers may be disclosed by HCFA under the Freedom of Information Act in response to requests from the public.

134.1 Medicare Reports.--

A. Provider Survey Reports and Related Information.--Information concerning provider

survey reports, as well as statements of deficiencies, based on survey reports are available at the local Social Security office or the public assistance office in the area where the facility is located.

The following survey data may be released:

- o The official Medicare report of a survey;
- o Statements of deficiencies that have been conveyed to the provider after a survey; and
- o Plans of correction and pertinent comments submitted by the provider relating to Medicare deficiencies cited after a survey is concluded.

State agencies certify whether institutions or other entities meet Medicare conditions of participation. A State agency may disclose information it obtains relating to the qualification and certification status of providers it surveys. FQHCs are not included in such surveys.

B. Program Validation Review Reports and Other Formal Evaluations.--Upon written request, official reports and other formal evaluations of the performance of providers are made available to the public. After the survey reports and other formal evaluations are prepared by HCFA personnel, the provider is given an opportunity (not to exceed 30 days) to review the report and submit comments on the accuracy of the findings and conclusions. The provider's comments are incorporated in the report, if pertinent.

Program validation review reports are generally released from the HCFA RO serving the area in which the provider is located. Generally, informal reports and other evaluations of the performance of providers that are prepared by the contractor are available to the public.

C. Provider Cost Reports.--

1. General.--Submit to HCFA or the contractor in writing requests by the public either to inspect or to obtain a copy of a provider cost report. The request must identify the provider and specific cost report(s) in question.

Contractors are required to respond to requests in writing within 10 working days after receipt of a written request to advise the requestor of the date the reports will be made available. The date the report is to be made available is no earlier than 10 working days from the date of the contractor's response. A copy of the response to the requestor is sent simultaneously to the provider putting the provider on notice that its report has been requested by a particular person or organization. If a request for a report is submitted by a former owner of a provider, copies of the contractor's response to the requestor is sent to both the present owner and the former owner of the provider. If the request is for a report submitted by a provider no longer participating in the Medicare program, a copy of the contractor response is sent to the provider. In the case of both a former owner and a former participating provider, the copy of the response is sent to the last known address of the party.

2. Information That May Be Disclosed.--Disclosure by the contractor is limited to cost report documents that providers are required to submit by HCFA regulations and instructions, and, in case of a settled cost report, the contractor's notice of program payment. Cost reports and notices of program payment include the following information:

- o Statistical page;
- o Settlement pages;

- o Trial balance of expenses; and
- o Cost finding schedules or documents required by HCFA as part of the regular cost report process.

(Where a provider, 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 payment has not been sent, the contractor discloses a copy of the report as submitted by the provider. If settlement has been made, the contractor discloses the settled report. If a requester specifically asks for both the settled and unsettled cost reports of a provider, the contractor complies with such a request. When a report is made available for inspection or copying, it is clearly marked with one of the following captions, as applicable:

- o Cost report as submitted;
- o Settlement subject to audit; or
- o Audited settlement.

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

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

3. Information That May Not Be Disclosed.--If a provider chooses to submit with its cost report additional information not specifically required by regulations or instructions, the contractor does not disclose such information unless it is contained within an official document. For example, some providers 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 by cost reporting instructions), or income tax returns that are not required by the program. These items are not to be disclosed by the contractor as part of the cost report.

Except where a provider has not submitted an acceptable cost report and supplements are required to complete the report, any additional documents or schedules that the contractor requires the provider to submit in support of its cost representations would also not be disclosed by the contractor as part of the cost report. In addition, the following are not disclosed by the contractor as part of a cost report:

- o Audits;
- o Schedules;
- o Letters;

- o Notes;
- o General comments;
- o Comments on results of desk reviews (including copies of the actual desk review documents);
- o Contractor notices and comments (including transmittal letters);
- o Audit adjustment summaries that are required to be prepared by contractors and auditors; and
- o Information pertaining to an individual patient.

NOTE: Any informaton under the Privacy Act that is not to be disclosed by the contractor may be subject to disclosure under the Freedom of Information Act upon review by HCFA CO and RO or a court in response to a request for such information.

134.2 Disclosure of Medicare Statistics.--Numerous statistics on individual providers are available to the public. They include, but are not limited to, the following:

- o Waiver of liability statistics;
- o Interim rate payment data;
- o Amount of Medicare payment;
- o Overpayment data;
- o Data from the Provider Monitor Listing; and
- o Information from the Directory of Medical Facilities and the Directory of Medicare Providers and Suppliers of Services.

134.3 Other Information That May Be Disclosed.--The following information may also be disclosed:

- o Provider presumptive waiver of liability status; and
- o Information as to whether a provider participates in the Medicare program.

136. COST TO A PROVIDER THAT REQUESTS INFORMATION AVAILABLE TO THE PUBLIC

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