Medicare Hospital 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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permit the provider to release information from the records of alcohol or drug abuse patients, more explicitly 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.)

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 HOSPITALS BY HCFA

The following information about hospitals 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 hospitals 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 hospital following a survey concluded on or after January 31, 1973;

3. Plans of correction and pertinent comments submitted by the hospital 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 hospitals. (See §112.) A State agency may disclose information it obtains relating to the qualifications and certification status of hospitals it surveys.

B. Program Validation Review Reports and Other Formal Evaluations.--Upon written request, official reports and other formal evaluations of the performance of hospitals 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 Social Security Administration, the evaluated hospital 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 hospital's comments must be incorporated in the report if pertinent.

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

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

C. Hospital Cost Reports.--

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