Medicare
Renal Dialysis Facility Manual (Non-Hospital Operated)

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 125.3, 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.

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GENERAL INFORMATION ABOUT THE PROGRAM

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Section

Disclosure of Information

Fraud

Information furnished specifically for purposes of a claim under the health insurance program is suject to these rules and regulations. Such information includes the individual's health insurance claim number, proof of his entitlement to health insurance benefits, and medical and other information obtained from the Health Care Financing Administration (HCFA) or an intermediary.

However, the information in a facility's own records of a patient (e.g., name, date of birth, sex, marital status, address, medical records) is not subject to these rules and regulations. even though the patient receives benefits under the health insurance program. The facility's own records, however, are subject to the requirements in the "Conditions of Participation; Hospitals" that patients medical records be kept confidential (20 C.F.R. Part 405.l026). These records may also be subject to State or local laws governing disclosure.

When a facility receives a request for information about a Medicare beneficiary, a Medicare claim, or related information which it may not disclose, the inquirer should be referred to the appropriate intermediary for further consideration of his request.

125. DISCLOSURE OF HEALTH INSURANCE INFORMATION TO A BENEFICIARY, OR IN CONNECTION WITH A CLAIM

125.1 Disclosure to the Beneficiary or His Authorized Representative.--

A. General.-- Information directly relating to the beneficiary, such a Medicare entitlement or eligibility data, may be disclosed to the individual or his authorized representative (including his legal representative).

B. Medical Information.-- Facilities may not forward medical information to intermeidaries on a confidential basis, expressed or implied, since under the Privacy Act any medical information obtained by an intermediary is suject to disclosure to the indiviudal to whom it pertains, or to another person authorized by the individual to have access to it.

Some facilities document findings on medical forms preprinted "confidential," or routinely stamp all records "confidential," whether or not such records are ever intended for disclusure to an intermediary. Such records when transmitted to the intermediary, will be accepted only if accompanied by a signed statement that the facility understands the information is subject to disclosure to the patient under the Privacy Act and any words or statements that the transmitted records are confidential may be disregarded if the patient or his representative requests them from the intermediary or from SSA. The repeated preparation and forwarding of separate signed statements can be obviated if the facility signs an appropriate general statement of understanding with the intermediary that medical information may be disclosed to the individual under the Privacy Act, even if it is routinely designated "confidential."

125.2 Disclosure to Third Parties for Proper Administration of the Health Insurance Program.--Disclosure by the facility to persons other than the individual or his authorized representative of any records, reports, or other information about the individual is authorized without his consent in connection with any claim or other proceeding under the Social Security 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).

125.3 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.

126. DISCLOSURE OF INFORMATION ABOUT FACILITIES BY HCFA

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

126.1 Medicare Reports.--

A. Provider Survey Report and Related Information.--Information concerning survey reports of facilities 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.

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 facility following a survey concluded on or after January 31, 1973;

3. Plans of correction and pertinent comments submitted by the facility 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. A State agency may disclose information it obtains relating to the qualifications and certification status of facilities it surveys.

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

Program validation review reports are generally relased from the Bureau of Health Insurance regional office serving the area in which the facility is located.

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

C. Facility Cost Reports.--

1. General.-- Requests by any member of the public either to inspect or to obtain a copy of a facility cost report must be submitted to BHI or the intermediary in writing and must identify the facility and specific cost reports(s) in questions.

Intermediaries are required to respond to requests in writing within l0 working days after receipt of a written request, to advise the requestor 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. A copy of the response to the requestor will be sent simultaneously to the facility putting the facility 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 a facility, copies of the intermediary’s response to the requestor will go to both the present owner and the former owner of the facility. If the request is for a report submitted by a facility no longer participating in the Medicare program, a copy of the intermediary's response will be sent to the facility. In the case of both a former owner and a former participating facility, 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 facilities are required by BHI 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 BHI is part of the regular cost report process. (Where a facility, 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 facility. 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 a facility, 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: