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MEDICAL EXPENDITURE PANEL SURVEY

MEDICAL PROVIDER COMPONENT

MEDICAL EVENT FORM

FOR

HOSPITAL PROVIDERS

FOR

REFERENCE YEAR 2010

VERSION 1.0

Revision History

Version	Author/Title	Date	Comments
1.0	Multiple RTI and SSS authors	04/01/10	Changes from final 2009 version made via track changes

HOSPITAL EVENT FORM

1. VERIFY ALL PATIENT(S)

First, I'd like to review the patient(s) in our study who reported receiving care from your practice or facility during 2010. I'm going to read their names to you, and for each one please confirm whether the patient received health care services from you during the calendar year 2010.

For each of the patient(s) you confirm as receiving care during the calendar year 2010, I'll need to ask about services you provided and charges for those services. I will ask about each confirmed patient individually.

READ EACH PATIENT NAME FROM THE LIST. IF THE PERSON ON THE PHONE SAYS "NO", ASK: Did the patient receive services in some year other than 2010, or do you have no records at all?

FOR EACH LISTED PATIENT, CHOOSE A RESPONSE FROM THE DROP-DOWN LIST IN THE PATIENT CONFIRMATION COLUMN BELOW.

ONCE YOU CONFIRM A PATIENT FOR 2010, CLICK ON THE NAME OF THAT PATIENT AND COMPLETE THE EVENT FORM(S) FOR THAT PATIENT.

2. PATIENT DISAVOWAL

Finally, I need to review with you the patient(s) in the list who you indicated did not receive care during the calendar year 2010.

3. CLOSE OUT THE CALL

Thank you for your time.

Do you have any (more) medical events for (PATIENT NAME) for 2010?

OMB SECTION

DCS: READ THIS ALOUD ONLY IF REQUESTED BY RESPONDENT.

PRESS NEXT TO CONTINUE IN THIS EVENT FORM

PRESS BREAKOFF TO DISCONTINUE

MEDICAL RECORDS

A1. The (first/next) time (PATIENT NAME) received services during calendar year 2010, were the services received:

CODE ONLY ONE

As an Inpatient;.....1 (GO TO A2a)
In a Hospital Outpatient Department;.....2 (GO TO A2c)
In a Hospital Emergency Room; or .....3 (GO TO A2c)
In a Long Term Care Unit such as skilled nursing facility .....5 (GO TO A2a)
Somewhere else? ……4 (GO TO A2c)
(IF SOMEWHERE ELSE: Where was that?)
_____

A2a. What were the admit and discharge dates of the (event/inpatient stay)?

REFERENCE PERIOD – CALENDAR YEAR 2010

MO DAY YR
ADMIT: _____/_____ / _____
DISCHARGE: _____/_____ / _____
NOT YET DISCHARGED……1

A2b. Was (PATIENT NAME) admitted from the emergency room or outpatient department?

YES..... 1 (COMPLETE SEPARATE EVENT FORM FOR ER EVENT)
NO..... 2
(GO TO A3)

A2c. What was the date of this visit?

REFERENCE PERIOD – CALENDAR YEAR 2010

MO DAY YR
_____/_____ /_____

A3. I need to record the name and specialty of each physician who provided services during the (TYPE OF EVENT) on (DATE(S)) and whose charges might not be included in the hospital bill. We want to include such doctors as radiologists, anesthesiologists, pathologists, and consulting specialists, but not residents, interns, or other doctors-in-training whose charges are included in the hospital bill.

PROBE FOR MORE THAN ONE RADIOLOGIST, ANETHESIOLOGIST, ETC OR OTHER SEPARATE BILLING MEDICAL PROFESSIONAL.

IF RESPONDENT IS NOT SURE WHETHER A PARTICULAR DOCTOR'S CHARGES ARE INCLUDED IN THE HOSPITAL BILL, ANSWER YES HERE.

SEPARATELY BILLING DOCTORS FOR THIS EVENT…1 (GO TO EF1)
NO SEPARATELY BILLING DOCTORS FOR THIS EVENT2 (GO TO A4A)

EF1 What is the name of the doctor providing services for this event whose charges might not be included in the hospital bill?

Prefix
First
Middle
Last
Group Name

EF3 What is this physician's specialty?

Specialty: _____
If other, please specify:_____

EF2 Did this doctor provide any of the following services for this event: radiology, anesthesiology, pathology, or surgery?

1 Radiology
2 Anesthesiology
3 Pathology
4 Surgery
5 None of the above
6 DON'T KNOW

EF5 How would you describe the role of this doctor for this medical event

Active Physician/Providing Direct Care 1
Referring Physician 2
Copied Physician 3
Follow-up Physician 4
Department Head 5
Primary Care Physician 6
Some Other Physician 7
None of the above 8
DON'T KNOW 9

If other, please describe: _____

EF6 ENTER ANY COMMENTS ABOUT THIS SBD, INCLUDING ADDITIONAL SERVICE(S) TO THE ONE SELECTED IN EF2.

A4a. I need the diagnoses for (this stay/this visit). I would prefer the ICD-9 codes or DSM-4 codes, if they are available.

IF CODES ARE NOT USED, RECORD DESCRIPTIONS.

[SYSTEM WILL ALLOW FOR A MAXIMUM OF 5 ICD-9 CODES TO BE COLLECTED]

CODE	DESCRIPTION
_____	_____
_____	_____
_____	_____
_____	_____

CLICK HERE IF THIS IS AN ICD-10 CODE

A4c. Do you have any medical events for [PATIENT] in 2010?

YES, ALL EVENTS COVERED..... 1 (GO TO A4d)
NO, NEED TO COVER ADDITIONAL EVENTS..... 2 (GO TO A1–NEXT EVENT FORM)

A4d. IF ALL EVENTS ARE RECORDED FOR THIS PATIENT, REVIEW NUMBER OF EVENTS REPORTED BY HOUSEHOLD.	NO DIFFERENCE OR FACILITY REPORTED MORE EVENTS THAN HOUSEHOLD..... 1 (GO TO ENDING FOR MEDICAL RECORDS) FACILITY RECORDED FEWER VISITS..... 2 RECONCILIATION SCREEN: [DCS ONLY] PROBE: (PATIENT NAME) reported (NUMBER) events at (FACILITY) during 2010, but I have only recorded (NUMBER) visits. Do you have any information in your records that would explain this discrepancy? DON'T KNOW……1 UNACCESSIBLE ARCHIVED RECORDS….2 ACCESSIBLE ARCHIVED RECORDS…….. 3 COLLECT CONTACT INFORMATION FOR PERSON WITH RECORDS OTHER (SPECIFY):……4 _____ _____ (GO TO ENDING FOR MEDICAL RECORDS)

ENDING FOR MEDICAL RECORDS:

GO TO NEXT PATIENT. IF NO MORE PATIENTS, THANK RESPONDENT AND END. THEN ATTEMPT CONTACT WITH PATIENT ACCOUNTS OR ADMINISTRATIVE OFFICE.

QUESTIONS A5a THROUGH END: TO BE COMPLETED WITH PATIENT ACCOUNTS.

I have information from Medical Records that (PATIENT NAME) received health care services on (DATE OF FIRST/NEXT VISIT AND/OR INPATIENT STAY REPORTED BY MEDICAL RECORDS).
NOTE: IF THE ONLY EVENT OF THIS TYPE KNOWN BY PATIENT ACCOUNTS IS A DAY OR TWO LATER THAN WHAT WAS REPORTED BY MEDICAL RECORDS, ANSWER YES BELOW.

1 CONFIRM PATIENT RECEIVED SERVICES (GO TO BOX 1)

2 FACILITY KNOWS PATIENT BUT NO EVENTS RECORDED FOR 2010 (GO TO NEXT PATIENT, RETURN TO DISAVOWAL QUESTIONS FOR THIS PATIENT AFTER COLLECTING MEDICAL EVENTS FOR ALL PATIENTS.)

3 FACILITY DOES NOT KNOW PATIENT (GO TO NEXT PATIENT, RETURN TO DISAVOWAL QUESTIONS FOR THIS PATIENT AFTER COLLECTING MEDICAL EVENTS FOR ALL PATIENTS.)

BOX 1
IF EVENT IS AN OUTPATIENT VISIT OR EMERGENCY ROOM VISIT OR SOMEWHERE ELSE (A1=2, 3, or 4)), CONTINUE WITH A5a. IF EVENT IS AN INPATIENT STAY OR LONG–TERM CARE UNIT (A1=1 or 5), GO TO A8.

GLOBAL FEE

A5a. Was the visit on that date covered by a global fee, that is, was it included in a charge that covered services received on other dates as well?

EXPLAIN IF NECESSARY: An example would be a patient who received a series of treatments, such as chemotherapy, that was covered by a single charge.

YES..... 1
NO..... 2 (GO TO A6a)

A5b. Did the global fee for this date cover any services received while the patient was an inpatient?

YES..... 1
NO..... 2 (GO TO A5d)

A5c. What were the admit and discharge dates of that stay?

MO DAY YR
ADMIT: _____/_____/ _____
DISCHARGE: _____/_____/ _____
NOT YET DISCHARGED……..1

A5c1. Were there any other dates on which services were covered by this global fee?

YES..... 1
NO……..2 (GO TO A5e)

A5d. What were the other dates on which services covered by this global fee were provided? Please include dates before or after 2010 if they were included in the global fee.

[SYSTEM WILL SET UP AS A LOOP, SO NO LIMIT ON NUMBER OF DATES REQUIRED]

Did (PATIENT NAME) receive services on (DATE) in an:

Outpatient Department (TYPE=OP);
Emergency Room (TYPE=ER); or
Somewhere else (TYPE=96)?

MO	DAY	YR	TYPE	IF TYPE 96, SPECIFY:
____/	____/	_____	_____	_____
____/	____/	_____	_____	_____
____/	____/	_____	_____	_____
____/	____/	_____	_____	_____
____/	____/	_____	_____	_____
____/	____/	_____	_____	_____
____/	____/	_____	_____	_____
____/	____/	_____	_____	_____

A5e. Do you expect (PATIENT NAME) will receive any future services that will be covered by this same global fee?

YES..... 1
NO..... 2

A6a. I need to know what services were provided during (this visit/these visits). I would prefer the CPT-4 codes, if they are available.

IF CPT-4 CODES ARE NOT USED, RECORD DESCRIPTION OF SERVICES AND PROCEDURES PROVIDED.

IF CODE BEGINS WITH W, X, Y, OR Z , ENTER A DESCRIPTION INSTEAD.

[SYSTEM WILL SET UP AS A LOOP, SO NO LIMIT ON CPT-4 CODES REQUIRED]

A6b. ASK FOR EACH CPT-4 CODE OR DESCRIPTION: What was the full established charge for this service, before any adjustments or discounts?

EXPLAIN IF NECESSARY: The full established charge is the charge maintained in the hospital's master fee schedule for billing insurance carriers and Medicare or Medicaid. It is the "list price" for the service, before consideration of any discounts or adjustments resulting from contractual arrangements or agreements with insurance plans.

IF NO CHARGE: Some facilities that don't charge for each individual service do associate dollar amounts with services for purposes of budgeting or cost analysis. This is sometimes called a "charge equivalent." Could you give me the charge equivalent(s) for (this/these) procedure(s)?

NOTE: WE NEVER ENTER $0 FOR A CHARGE
IF SPECIFIC CHARGE WAS APPLIED TO ANOTHER SERVICE, ENTER -4
IF CHARGES ARE APPLIED TO ANOTHER LINKED EVENT, ENTER -5

CODE	DESCRIPTION	Full established charge at time of visit or charge equivalent
a. _____	_____	$_____.____
b. _____	_____	$_____.____
c. _____	_____	$_____.____
d. _____	_____	$_____.____
e. _____	_____	$_____.____
f. _____	_____	$_____.____
g. _____	_____	$_____.____
h. _____	_____	$_____.____
i. _____	_____	$_____.____
j. _____	_____	$_____.____
k. _____	_____	$_____.____

CHARGES
Service charge: CPT4 code:
Charges

Charge=$____.__

Total amount$_____.___

(IF A6b=5, GO TO LC2; OTHERWISE, GO TO C3.]
NO……..2
(GO BACK TO B5a)

C2. I show the total charge as [SYSTEM WILL COMPUTE AND DISPLAY TOTAL]. Is that correct? IF INCORRECT, CORRECT ENTRIES ABOVE AS NEEDED.

LC2 You reported just now that the charges are linked to another event. What was the date of that other event where the charges appear?

MO DAY YR
_____/_____ /_____

LC3 And what kind of event was that, was it…

Inpatient	1
Hospital Outpatient Department.	2
Hospital Emergency Room	3
Long term care unit such as skilled nursing facility	4
Somewhere else?	5

PATIENT ACCOUNTS QUESTIONS FOR INPATIENT.

A8. According to Medical Records, (PATIENT NAME) was an inpatient during the period from [ADMIT DATE] to [DISCHARGE DATE]. What was the DRG for this stay?

DRG IS A CODE USED TO CLASSIFY INPATIENT STAYS AND IT IS USUALLY ONE TO THREE DIGITS LONG.

[SYSTEM WILL COLLECT A RANGE OF 1 TO 989 FOR THE DRG]

DRG:_____ (GO TO C2a)

DRG NOT RECORDED..... 1 (GO TO A9)

A9. Did the patient have any surgical procedures during this stay?

YES..... 1

NO..... 2 (GO TO C2a)

A10a. What surgical procedures were performed during this stay? Please give me the procedure codes, that is the CPT-4 codes, if they are available.

IF CPT-4 CODES ARE NOT USED, RECORD DESCRIPTION OF SERVICES AND PROCEDURES PROVIDED.

IF CODE BEGINS WITH W, X, Y, OR Z ENTER DESCRIPTION INSTEAD.

[SYSTEM WILL SET UP AS A LOOP, SO NO LIMIT ON CPT-4 CODES REQUIRED]

CODE	DESCRIPTION
_____	_____
_____	_____
_____	_____
_____	_____

C2a. What was the **full established charge** for this inpatient stay, before any adjustments or discounts?

IF PATIENT WAS ADMITTED FROM ER OR OP (A2b=YES) READ: Please do <u>not</u> include any emergency room or outpatient charges.

EXPLAIN IF NECESSARY: The **full established charge** is the charge maintained in the hospital's master fee schedule for billing insurance carriers and Medicare or Medicaid. It is the "list price" for the service, before consideration of any discounts or adjustments resulting from contractual arrangements or agreements with insurance plans.

IF NO CHARGE: Some facilities that don't charge for each individual service do associate dollar amounts with services for purposes of budgeting or cost analysis. This is sometimes called a "**charge equivalent**." Could you give me the charge equivalent for this inpatient stay?

IF POSSIBLE, RECORD ONLY INPATIENT CHARGE HERE. IF YOU CANNOT SEPARATE THE INPATIENT CHARGE FROM THE EMERGENCY ROOM OR OUTPATIENT CHARGE, YOU MAY REPORT THE COMBINDED TOTAL.

NOTE: WE NEVER ENTER $0 FOR A CHARGE

FULL ESTABLISHED CHARGE OR CHARGE EQUIVALENT:

$_____ . _____

C2b: IF HS EVENT (IF A1=1 OR 5):
EMERGENCY ROOM OR OUTPATIENT CHARGES INCLUDED..... 1
EMERGENCY ROOM OR OUTPATIENT CHARGES NOT INCLUDED OR NOT APPLICABLE..... 2

C2c: IF IC EVENT (IF A1=5):
ANCILLARY CHARGES INCLUDED..... 1
ANCILLARY CHARGES NOT INCLUDED OR NOT APPLICABLE..... 2

C2b. Were the emergency room or outpatient charges included with the full established charge?

C3. Was the facility reimbursed for (this visit/these visits) on a fee-for-service basis or capitated basis?

EXPLAIN IF NECESSARY:
Fee-for-service means that the facility was reimbursed on the basis of the services provided.

Capitated basis means that the patient was enrolled in a prepaid managed care plan where reimbursement is not tied to specific visits.

IF IN DOUBT, CODE FEE-FOR-SERVICE.

FEE-FOR-SERVICE BASIS 1
CAPITATED BASIS..... 2 (GO TO C7a)

C4. From which of the following sources has the facility received payment for (this visit/these visits) and how much was paid by each source? Please include all payments that have taken place between (VISIT DATE) and now for this visit.
RECORD PAYMENTS FROM ALL THAT APPLY

[DCS ONLY] IF NAME OF INSURER, PUBLIC, OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance?

[SYSTEM WILL SET UP "SOMETHING ELSE" AS A LOOP, SO NO LIMIT REQUIRED]

IF PROVIDER VOLUNTEERS THAT PATIENT PAYS A MONTHLY PREMIUM, VERIFY: So, you receive a monthly payment rather than payment for the specific service? IF YES: GO BACK TO C3 AND CODE AS CAPITATED BASIS.

a. Patient or Patient's Family;..... $_____.____
b. Medicare;..... $_____.____
c. Medicaid;..... $_____.____
d. Private Insurance;..... $_____.____
e. VA/Champva;..... $_____.____
f. Tricare; $_____.____
g. Worker's Comp; or..... $_____.____
h. Something else?
(IF SOMETHING ELSE: What was that?)
_____ $_____.____

C5. I show the total payment as [SYSTEM WILL COMPUTE AND DISPLAY TOTAL]. Is that correct?

IF NO, CORRECT ENTRIES ABOVE AS NEEDED.

IF THE ONLY PAYMENT FOR THIS EVENT WAS A LUMP SUM, PAYMENT SHOULD BE "ZERO."

BOX 2
DO TOTAL PAYMENTS EQUAL TOTAL CHARGES?

YES, AND ALL PAID BY PATIENT OR PATIENT'S FAMILY (IF A1=2, 3, OR 4)……(GO TO BOX 3)

YES, AND ALL PAID BY PATIENT OR PATIENT'S FAMILY (IF A1=1 OR 5)……(GO TO FINISH SCREEN)

YES, OTHER PAYERS…….. (GO TO C5a)

NO…….. .(GO TO UNDERPAYMENT SECTION IF PAYMENTS LESS THAN CHARGES; GO TO C6 OVERPAYMENT SECTION IF PAYMENTS MORE THAN CHARGES)

.

C5a. I recorded that the payment(s) you received equal the charge(s). I would like to make sure that I have this recorded correctly. I recorded that the total payment is [SYSTEM WILL DISPLAY TOTAL PAYMENT FROM C5]. Does this total payment include any other amounts such as adjustments or discounts, or is this the final payment?

IF NECESSARY, READ BACK AMOUNT(S) RECORDED IN C4.

YES, FINAL PAYMENTS RECORDED IN C4 AND C5……..1 (GO TO BOX 3 IF A1=2, 3, OR 4)
(GO TO FINISH SCREEN IF A1=1 OR 5)
NO……2 (GO BACK TO C4)

.

UNDERPAYMENT

PLC1. It appears that the total payments were less than the total charge. Is that because …

a. There were adjustments or discounts YES=1 NO=2

b. You are expecting additional payment YES=1 NO=2

c. This was charity care or sliding scale YES=1 NO=2

d. This was bad debt YES=1 NO=2

[IF a=1 GO TO C6_ADJUSTMENTS.

IF b=1 GO TO C6_ADDITIONAL.

IF a=1 AND b=1 GO TO BOTH C6_ADJUSTMENTS AND C6_ADDITIONAL.

IF (a=2 AND b=2 AND c=2 AND D=2) GO TO C6_ADJUSTMENTS, C6_ADDITIONAL, AND C6 EXCEEDED.

IF BOTH c=1 and d=1 WITH NO OTHER SELECTION, GO TO LSPCHECK.

IF BOTH c=1 OR d=1 WITH NO OTHER SELECTION, GO TO LSPCHECK.]

C6. It appears that the total payments were (less than/more than) the total charges. What is the reason for that difference? Please include all adjustment activity that has taken place between (VISIT DATE) and now for (this visit/these visits). Was it a

CODE 1 (YES) FOR ALL REASONS MENTIONED.

C6 ADJUSTMENTS

	YES	NO
Adjustment or discount		
a. Medicare limit or adjustment;.....	1	2
b. Medicaid limit or adjustment;.....	1	2
c. Contractual arrangement with insurer or managed care organization;.....	1	2
d. Courtesy discount;.....	1	2
e. Insurance write-off;.....	1	2
f. Worker's Comp limit or adjustment;.....	1	2
g. Eligible veteran; or.....	1	2
h. Something else?……..	1	2

(IF SOMETHING ELSE: What was that?)

_____

C6 ADDITIONAL

Are you expecting additional payment from:

i. Patient or Patient's Family;.....	1	2
j. Medicare;.....	1	2
k. Medicaid;.....	1	2
l. Private Insurance;.....	1	2
m. VA/Champva;.....	1	2
n. Tricare;.....	1	2
o. Worker's Comp; or	1	2
p. Something else?……..	1	2

(IF SOMETHING ELSE: What was that?)

_____

C6 EXCEEDED *(Note: this is displayed only if all responses to PLC1 are "No.")*

q. **Charity care or sliding scale;**.....	1	2
r. **Bad debt;**.....	1	2

C6 OVERPAYMENT
PAYMENTS MORE THAN CHARGES:

s. Medicare adjustment;.....	1	2
t. Medicaid adjustment;.....	1	2
u. Private insurance adjustment; or.....	1	2
v. Something else?……..	1	2

(IF SOMETHING ELSE: What was that?)

_____

(GO TO LSPCHECK)

LSPCHECK

WAS THIS EVENT COVERED BY A LUMP SUM?

YES	1 (GO TO LSPREVIEW)
NO	2 (GO TO BOX 3 IF A1= 2, 3, OR 4)
	(GO TO FINISH SCREEN IF A1= 1 OR 5)

LSPREVIEW

WAS CURRENT MEDICAL EVENT COVERED BY A PAYMENT NOT ALREADY DEPICTED HERE?

YES, I NEED TO RECORD A NEW PAYMENT	1 (GO TO LSP DETAIL)
NO, PAYMENT ALREADY SHOWN ABOVE	2 (GO TO BOX 3 F A1= 2, 3, OR 4)
	(GO TO FINISH SCREEN IF A1= 1 OR 5)

[PREVIOUSLY REPORTED LUMP PAYMENTS, PAYER, AND AMOUNT WILL LIST ABOVE RESPONSE OPTIONS.]

LSP DETAIL

LSP1. How much was that payment? Amount_____

LSP2. Who made the payment?

a. Patient or Patient's Family;

b. Medicare;

c. Medicaid;

d. Private Insurance;

e. VA/Champva;

f. Tricare;

g. Worker's Comp; or

h. Something else?
(IF SOMETHING ELSE: PLEASE SPECIFY)
_____

LSP3. Where else was the payment applied? I will record the date and total charge of those other events where payment was applied.

Month: ___

Day: ___

Year: ____

Charge: _____

Were there any other events where this payment was applied?

YES	1 (GO BACK TO LSP3)
NO	2 (GO TO LSPANYMORE)

LSP ANYMORE

Were there any other events where this payment was applied?

YES	1 (GO BACK TO LSP1)
NO	2 (GO TO BOX 3 IF A1= 2, 3, OR 4)
	(GO TO FINISH SCREEN IF A1= 1 OR 5)

CAPITATED BASIS

C7a. What kind of insurance plan covered the patient for (this visit/these visits)? Was it:

[DCS ONLY] IF NAME OF INSURER, PUBLIC, OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance?

OTHER SPECIFY: PROBE FOR SOURCE OF FUNDS AND TYPE OF PLAN.

	YES	NO
a. Medicare;.....	1	2
b. Medicaid;.....	1	2
c. Private Insurance;.....	1	2
d. VA/Champva;.....	1	2
e. Tricare;.....	1	2
f. Worker's Comp; or.....	1	2
g. Something else?.....	1	2

(IF SOMETHING ELSE: What was that?)

_____

C7b. Was there a co-payment for (this visit/these visits/any part of this stay)?

YES..... 1
NO..... 2(GO TO C7e)

C7c. How much was the co-payment?

$_____._____

C7d. Who paid the co-payment? Was it:

[DCS ONLY] IF NAME OF INSURER, PUBLIC, OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance?

	YES	NO
a. Patient or Patient's Family;.....	1	2
b. Medicare;.....	1	2
c. Medicaid;.....	1	2
d. Private Insurance; or.....	1	2
e. Something else? ……	1	2

(IF SOMETHING ELSE: What was that?)

_____

C7e. Do your records show any other payments for (this visit/these visits/this stay)?

YES..... 1
NO..... 2(GO TO BOX 3)

C7f. From which of the following other sources has the facility received payment for (this visit/these visits/this stay) and how much was paid by each source? Please include all payments that have taken place between (VISIT DATE) and now for this visit.

RECORD PAYMENTS FROM ALL APPLICABLE PAYERS

[DCS ONLY] IF NAME OF INSURER, PUBLIC, OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance?

a. Patient or Patient's Family;. . $_____._____
b. Medicare;..... $_____._____
c. Medicaid;..... $_____._____
d. Private Insurance;..... $_____._____
e. VA/Champva;..... $_____._____
f. Tricare; $_____._____
g. Worker's Comp; or..... $_____._____
h. Something else?
(IF SOMETHING ELSE: What was that?)
_____ $_____._____

BOX 3

GLOBAL FEE SITUATION (A5a=YES).....1 **(GO TO FINISH SCREEN)**

RECORDED 5 OR FEWER EVENTS .....2 **(GO TO FINISH SCREEN)**

RECORDED 6 OR MORE EVENTS .....3 **(GO TO A7a)**

REPEATING IDENTICAL VISITS

A7a. Were there any other visits for this patient during 2010 for which the services and charges were identical to the services and charges for the visit on (DATE OF THIS EVENT)?

EXPLAIN, IF NECESSARY: We are referring here to **repeating identical visits**. These usually occur when the patient has a condition that requires very frequent visits, such as once- or twice-a-week physical therapy.

YES.. 1
NO ....2 (GO TO FINISH SCREEN)

A7b. During 2010 how many other visits were there for which the services and charges were identical to those on (DATE OF THIS EVENT)?

OF VISITS_____________

A7c. Please tell me the dates of those other visits.

[SYSTEM WILL SET UP AS A LOOP, SO NO LIMIT ON NUMBER OF DATES REQUIRED]

MO/DAY/YR	MO/DAY/YR	MO/DAY/YR
___/___ 20___	___/___ 20 ___	___/___ 20 ___
___/___ 20___	___/___ 20 ___	___/___ 20 ___
___/___ 20___	___/___ 20 ___	___/___ 20 ___
___/___ 20___	___/___ 20 ___	___/___ 20 ___
___/___ 20___	___/___ 20 ___	___/___ 20 ___
___/___ 20___	___/___ 20 ___	___/___ 20 ___
___/___ 20___	___/___ 20 ___	___/___ 20 ___
___/___ 20___	___/___ 20 ___	___/___ 20 ___
___/___ 20___	___/___ 20 ___	___/___ 20 ___
___/___ 20___	___/___ 20 ___	___/___ 20 ___

(GO TO A11)

RECONCILIATION SCREEN:
[DCS ONLY] PROBE: (Patient Name) reported (NUMBER) events at (FACILITY) during 2010, but I have only recorded (NUMBER) visits. Do you have any information in your records that would explain this discrepancy?

DON'T KNOW…………………………………1
UNACCESSIBLE ARCHIVED RECORDS….2
ACCESSIBLE ARCHIVED RECORDS…….. 3
COLLECT CONTACT INFORMATION FOR PERSON WITH RECORDS
OTHER (SPECIFY):……………………………4

____

____

(GO TO NEXT PATIENT. IF NO MORE PATIENTS, THANK RESPONDENT AND END.)