ATTACHMENT 87

MEDICAL EXPENDITURE PANEL SURVEY

MEDICAL PROVIDER COMPONENT

EVENT FORM

FOR

HOSPITAL PROVIDERS

COMBINED MEDICAL AND BILLING RECORDS

REFERENCE YEAR 2014

OMB HYPERLINK ON FIRST SCREEN

DCS: READ THIS ALOUD ONLY IF REQUESTED BY RESPONDENT.

PRESS NEXT TO CONTINUE IN THIS EVENT FORM

PRESS BREAKOFF TO DISCONTINUE

SECTION 1 – MEDICAL RECORDS – LOCATION OF SERVICES

[PAGE 1 – MEDICAL RECORDS - LOCATION OF SERVICES (1 of 1)]
SCREEN LAYOUT

A1. The (first/next) time (PATIENT NAME) received services during calendar year 2014, were the services received:

CODE ONLY ONE

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

IF INPATIENT: What was the inpatient venue?

IF SOMEWHERE ELSE: Select one

SECTION 2 – MEDICAL RECORDS – EVENT DATE – INPATIENT/LTC (ADMIT/DISCHARGE DATES)

[PAGE 3 – MEDICAL RECORDS - EVENT DATE – INPATIENT/LTC (1 of 1)]

A2a. What were the admit and discharge dates of the inpatient stay?

REFERENCE PERIOD – CALENDAR YEAR 2014

ADMIT:

	MONTH	DAY	YEAR

DISCHARGE:

	MONTH	DAY	YEAR

NOT YET DISCHARGED...................1

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

YES=1, NO=2

SECTION 3 – MEDICAL RECORDS – EVENT DATE – OUTPATIENT/ER/OTHER (VISIT DATE)

[PAGE 4 – MEDICAL RECORDS - EVENT DATE – OUTPATIENT/ER/OTHER (1 of 1)]

A2c. What was the date of this visit?

	MONTH	DAY	YEAR

REFERENCE PERIOD – CALENDAR YEAR 2014

SECTION 4 – MEDICAL RECORDS – SBD

[PAGE 5 – MEDICAL RECORDS - SBD (1 of 2)]

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

YES, SEPARATELY BILLING DOCTORS FOR THIS EVENT..1

NO SEPARATELY BILLING DOCTORS FOR THIS EVENT..2

THERE MAY BE MORE THAN ONE TYPE OF EACH DOCTOR, SO PROBE FOR MULTIPLE SURGEONS, RADIOLOGISTS, ANETHESIOLOGISTS, AND OTHER SEPARATELY BILLING MEDICAL PROFESSIONALS.

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

SECTION 5 – MEDICAL RECORDS – SBD SUBROUTINE

[PAGE 6 – MEDICAL RECORDS - SBD (2 of 2)]

EF1 I need to collect information about the doctors whose services for this event might not be included in the charges on the hospital bill. I would like to record the group name, doctor name, and National Provider ID, if available.

Physician 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?

SCREEN LABEL	DISPLAY ORDER	HATTERAS STORED VALUE
Active Physician/Providing Direct Care	1	6
Referring Physician	2	1
Copied Physician	3	2
Follow-up Physician	4	3
Department Head	5	4
Primary Care Physician	6	5
Some Other Physician	7	7

None of the above	8	8
DON'T KNOW	9	9

(IF OTHER DESCRIBE)

What other type of physician?

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

SECTION 6 – MEDICAL RECORDS – DIAGNOSES

[PAGE 7 – MEDICAL RECORDS - DIAGNOSES (1 of 1)]

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.   ICD-9 CODE   DESCRIPTION

IF CODES ARE NOT USED, RECORD
DESCRIPTIONS.

RECORD UP TO FIVE ICD-9 CODES OR
DESCRIPTIONS

SECTION 7 – MEDICAL RECORDS – SUMMARY/CONCLUSION

MEDICAL RECORDS - SUMMARY/CONCLUSION (1 of 1)]

A4c.

PRESS "BREAKOFF" TO CLOSE THIS MEDICAL RECORDS SECTION. CMS WILL ASK WHETHER YOUR MEDICAL RECORDS RESPONDENT HAS ADDITIONAL EVENTS FOR THIS PATIENT.

PRESS "NEXT" WHEN YOU ARE READY TO BEGIN PATIENT ACCOUNTS SECTION.

SECTION 8 – PATIENT ACCOUNTS – INTRODUCTION

[PAGE 8 – PATIENT ACCOUNTS - INTRODUCTION (1 of 1)]

I have information from Medical Records that (PATIENT NAME) received health care services (FILL DATE)

NOTE: IF THE ONLY EVENT OF THIS TYPE KNOWN BY PATIENT ACCOUNTS IS WITHIN A DAY OR TWO OF WHAT WAS REPORTED BY MEDICAL RECORDS, ANSWER YES BELOW.

YES, RECORDS FOUND FOR THIS EVENT	=1
NO, RECORDS NOT FOUND FOR THIS EVENT	=2
NO, OTHER RECORDS PROBLEM	=3

SECTION 9 – PATIENT ACCOUNTS – GLOBAL FEE

[PAGE 9 – PATIENT ACCOUNTS - GLOBAL FEE (1 of 4)]

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?   YES=1, NO=2

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.

[PAGE 10 – PATIENT ACCOUNTS - GLOBAL FEE (2 of 4)]

A5b. Did the global fee for this date cover any services received while the patient was an inpatient?   YES=1, NO=2

[PAGE 11 – PATIENT ACCOUNTS - GLOBAL FEE (3 of 4)]

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

ADMIT:

	MONTH	DAY	YEAR

DISCHARGE:

	MONTH	DAY	YEAR

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

1 YES
2 NO

A5d. What were the other dates on which services covered by
this global fee were provided? Please include dates before
or after 2014 if they were included in the global fee.

MONTH   DAY   YEAR

Did (PATIENT NAME) receive services on this date in an:

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

A5f. [ABS ONLY] You've described different dates of service
covered by a global fee. Do you know if there were
additional doctors providing services whose charges
weren't included in the hospital bill?

YES=1, NO=2

SECTION 10 - PATIENT ACCOUNTS – SERVICES/CHARGES – OUTPATIENT/ER/OTHER
[Page 13 – PATIENT ACCOUNTS - SERVICES/CHARGES – OUTPATIENT/ER/OTHER (1 of 2)]

CODE   DESCRIPTION   CHARGE

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, DESCRIBE SERVICES AND PROCEDURES
PROVIDED. ENTER UP TO 8 CHARACTERS.

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

A6b. What was the full established charge for this service, before any adjustments or
discounts?

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 service?

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

C2. [I show the total charges as OUT_TOTLCHRG / I show the charge as undetermined.
/ I show the charge as OUT_TOTLCHRG, although one or more charges are
missing] Is that correct?

IF INCORRECT, CORRECT ENTRIES SHOWN ABOVE AS NEEDED

C2. [I show the total charges as _____ / I show the payment as undetermined. / I show the payment as
_____, although one or more payments are missing] Is that correct? IF INCORRECT, CORRECT ENTRIES
SHOWN 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?

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

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

SECTION 11 – PATIENT ACCOUNTS – SERVICES/CHARGES – INPATIENT/LTC

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:

DRG NOT RECORDED:............................1

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

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

YES=1, NO=2

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.

CODE   DESCRIPTION

IF CPT-4 CODES ARE NOT USED, DESCRIBE SERVICES AND PROCEDURES PROVIDED. ENTER UP TO 8 CHARACTERS.

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

IT IS ACCEPTABLE TO ENTER ICD9-CM CODES WITH FORMAT # #. # OR # #. # # FOR THIS QUESTION.

C2a.

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

Please do <u>not</u> include any emergency room 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, YOU MAY REPORT THE COMBINED TOTAL.

NOTE: WE NEVER ENTER $0 FOR A CHARGE

FULL ESTABLISHED CHARGE OR CHARGE EQUIVALENT:

C2b   YES=1, NO=2

Were the emergency room charges included with the full established charge?

C2c   YES=1, NO=2

   [IF (A1) = 5]

Were the ancillary charges included with the full established charge?

SECTION 12 – PATIENT ACCOUNTS – REIMBURSEMENT TYPE

[Page 21 – PATIENT ACCOUNTS - REIMBURSEMENT TYPE (1 of 1)]

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

FEE-FOR-SERVICE BASIS =1
CAPITATED BASIS   =2

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, this is also called Per Member Per Month.

IF IN DOUBT, CODE FEE-FOR-SERVICE.

SECTION 13 – PATIENT ACCOUNTS – SOURCES OF PAYMENT

[Page 22 – PATIENT ACCOUNTS - SOURCES OF PAYMENT (1 of 1)]

C4. From which of the following 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 (DATE) and now for this (visit/these visits).

RECORD PAYMENTS FROM ALL THAT APPLY

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

[DCS ONLY] 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.

IF ANY OF THE PAYMENTS IS A LUMP SUM THAT IS NOT YET ALLOCATED, ENTER F8 IN THE APPROPRIATE FIELD(S).

SOURCE	PAYMENT AMOUNT
	$
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 _____ / I show the payment as undetermined. / I show the payment as _____, although one or more payments are missing] Is that correct? / [THE TOTAL PAYMENT IS _____ . IS THAT CORRECT?

TOTAL PAYMENTS   **$**

IF NO, CORRECT ENTRIES ABOVE AS NEEDED.

SECTION 14 – PATIENT ACCOUNTS – VERIFICATION OF PAYMENT
[Page 23 – PATIENT ACCOUNTS - VERIFICATION OF PAYMENT (1 of 1)]

C5a.   I recorded that the payment(s) you received equal the charge(s). I would like to make sure that I have
=2
           this recorded correctly. I recorded that the total
payment is [TOTAL   PAYMENT FROM C5].

Does this total payment include any other amounts such as adjustments or
discounts, or is this the final payment?

   YES, FINAL PAYMENTS RECORDED IN C4 AND C5 =1 _
   NO

IF NO, GO BACK AND CORRECT ENTRIES AS NEEDED.

SECTION 15 – PAYMENTS LESS THAN CHARGES *(now UNDERPAYMENT)*

 [Page 24 – SOURCES OF PAYMENT (1 of 1)]

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

   IF THE ONLY PAYMENT FOR THIS EVENT WAS A LUMP SUM, ANSWER "NO" TO ALL OPTIONS.

   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

ELIGVET2**.**

It appears that the total payments were less than the total charges. Is that because the person is an eligible
veteran?

DCS: IF THE POC IS CONFUSED BY THE QUESTION, ANSWER THE QUESTION "NO"

YES=1, NO=2

SECTION 16 – PATIENT ACCOUNTS – DIFFERENCE BETWEEN PAYMENTS AND CHARGES

[Page 25– PATIENT ACCOUNTS - DIFFERENCE BETWEEN PAYMENTS AND CHARGES (1 of 1)]

Are you expecting additional payment from:

IF ONLY PAYMENT FOR THIS EVENT WAS A LUMP SUM, ANSWER "NO" TO ALL OPTIONS

Expecting additional payment

i.   Patient or Patient's Family?   YES=1, NO=2
j.   Medicare?   YES=1, NO=2
k. Medicaid?   YES=1, NO=2
l.   Private Insurance?   YES=1, NO=2
m. VA/Champva?   YES=1, NO=2
n. Tricare?   YES=1, NO=2
o. Worker's Comp?   YES=1, NO=2
p. Something else?   YES=1, NO=2
    (IF SOMETHING ELSE: What was that?)

C6p – "Other Specify";

Auto or Accident Insurance

CHDP/CHIP

Indian Health Service

State Public Mental Plan

State/County/Local Program

Other

ADJEXTRA

It appears that the total payments were more than the total charges. Is that correct?

DCS: IF THE ANSWER IS "NO" PLEASE GO BACK TO C5 (VERIFY TOTAL PAYMENTS) TO RECONFIRM CHARGES AND PAYMENTS AS NEEDED.

YES=1, NO=2

SECTION 17 – LUMP SUM PAYMENTS
[PAGE 26 – LUMP SUM PAYMENTS (1 of 4)]

CHECK   WAS THIS EVENT COVERED BY A LUMP SUM?
        YES
        NO

SECTION 18 – PATIENT ACCOUNTS – CAPITATED BASIS

[Page 30– PATIENT ACCOUNTS - CAPITATED BASIS (1 of 4)]

CAPITATED BASIS

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

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

a. Medicare;	YES=1, NO=2
b. Medicaid;	YES=1, NO=2
c. Private Insurance;	YES=1, NO=2
d. VA/Champva;	YES=1, NO=2
e. Tricare;	YES=1, NO=2
f. Worker's Comp; or	YES=1, NO=2
g. Something else?	YES=1, NO=2
(IF SOMETHING ELSE: What was that?)	

C7a(g) – "Other Specify";

Auto or Accident Insurance

CHDP/CHIP

Indian Health Service

State Public Mental Plan

State/County/Local Program

Other

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

YES=1, NO=2

C7c.   How much was the co-payment? $

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

        a. Patient or Patient's Family;   YES=1, NO=2

        b. Medicare;   YES=1, NO=2

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

        c. Medicaid;   YES=1, NO=2

        d. Private Insurance; or   YES=1, NO=2

        e. Something else?   YES=1, NO=2
           (IF SOMETHING ELSE:
           What was that?)

C7d(e) – "Other Specify" menu

        Auto or Accident Insurance

        CHDP/CHIP

        Indian Health Service

        State Public Mental Plan

        State/County/Local Program

        Other

C7e.   Do your records show any other payments for   YES=1, NO=2
      (this visit/these visits/this stay)?

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
      (DATE) and now for this visit.

SOURCE	PAYMENT AMOUNT
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?)	
	$

      RECORD PAYMENTS FROM ALL THAT APPLY

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

(h) – "Other Specify" menu

        Auto or Accident Insurance

        CHDP/CHIP

        Indian Health Service

        State Public Mental Plan

        State/County/Local Program

        Other

SECTION 19 – FINISH SCREEN

PRESS VALIDATE TO COMPLETE THIS EVENT FORM.