ATTACHMENT 91

MEDICAL EXPENDITURE PANEL SURVEY

MEDICAL PROVIDER COMPONENT

EVENT FORM

FOR

HOSPITAL PROVIDERS

COMBINED MEDICAL AND BILLING RECORDS

REFERENCE YEAR 2017

OMB STATEMENT

DCS: READ THIS ALOUD ONLY IF REQUESTED BY RESPONDENT.

PRESS NEXT TO CONTINUE IN THIS EVENT FORM

PRESS BREAKOFF TO DISCONTINUE

(Public reporting burden for this collection of information is estimated to average 3 minutes per response, the estimated time required to complete the survey. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: AHRQ Reports Clearance Officer Attention: PRA, Paperwork Reduction Project (0935-0118) AHRQ, 5600 Fishers Lane, Rockville, MD 20857.)

SECTION 1 – MEDICAL RECORDS – LOCATION OF SERVICES

OMB Statement

A1.	The (first/next) time (PATIENT NAME) received services during calendar year 2017, 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 SOMEWHERE ELSE: Select one

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

A2a.	What were the admit and discharge dates of the inpatient stay? REFERENCE PERIOD – CALENDAR YEAR 2017	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)

A2c. What was the date of this visit? REFERENCE PERIOD – CALENDAR YEAR 2017	MONTH DAY YEAR

SECTION 4 – MEDICAL RECORDS – SBD

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. 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.	YES, SEPARATELY BILLING DOCTORS FOR THIS EVENT.....1 **NO** SEPARATELY BILLING DOCTORS FOR THIS EVENT.....2

SECTION 5 – MEDICAL RECORDS – SBD SUBROUTINE

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	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

A4a. I need the diagnoses for (this stay/this visit). I would prefer the ICD-10 codes or DSM-5 codes, if they are available.

IF CODES ARE NOT USED, RECORD DESCRIPTIONS.

RECORD UP TO FIVE ICD-10 CODES OR DESCRIPTIONS

	ICD-10 CODE	DESCRIPTION

SBDPR1: A diagnosis that you mentioned often involves a (FILL SPECIALTY). We did not record such persons in the earlier questions about separately billing doctors. Did you not mention them for this patient event because they were residents or interns?

IF SPECIALTY RECORDED IN COMMENTS, ANSWER "NO" HERE.

YES=1
NO=2

SBDPR2: Do your records indicate that a (FILL SPECIALTY) was associated with this patient event?

IF SPECIALTY RECORDED IN COMMENTS, ANSWER "NO" HERE.

YES=1
NO=2

SBDPR3: PROBE WHY THERE WAS NO SBD OF THE EXPECTED TYPES FOR THIS EVENT

IF SPECIALTY RECORDED IN COMMENTS, NOTE THAT HERE.

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SECTION 9 – PATIENT ACCOUNTS – GLOBAL FEE

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? 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.

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

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 2017 if they were included in the global fee.

MONTH DAY YEAR TYPE
SPECIFY:

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

Outpatient Department
Emergency Room
Somewhere else

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

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. **CODE DESCRIPTION CHARGE**

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

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.

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 ICD10-CM CODES WITH FORMAT # #. # OR # #. # # FOR THIS QUESTION.

CODE DESCRIPTION

C2a.

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

[**IF ADFROMER=1**]
Please do not 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?

FULL ESTABLISHED CHARGE OR CHARGE EQUIVALENT:

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

C2b

[**IF ADFROMER=1**]
Were the emergency room charges included with the full established charge?

YES=1, NO=2

C2c **[IF MREVTYPE (A1) = 5]** Were the ancillary charges included with the full established charge?	YES=1, NO=2

SECTION 12 – PATIENT ACCOUNTS – REIMBURSEMENT TYPE

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

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

IF NO, CORRECT ENTRIES ABOVE AS NEEDED.

TOTAL PAYMENTS **$**

BOX 2

DO TOTAL PAYMENTS EQUAL TOTAL CHARGES?

YES, AND ALL PAID BY PATIENT OR PATIENT'S FAMILY	**-1 (GO TO LSPCHECK)**
YES, OTHER PAYERS	**- 2 (GO TO C5a)**
NO, PAYMENTS < CHARGES	**- 3 (GO TO PLC1)**
NO, PAYMENTS > CHARGES	**- 4 (GO TO** ADJEXTRA**)**

SECTION 14 – PATIENT ACCOUNTS – VERIFICATION OF PAYMENT

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?

YES, FINAL PAYMENTS RECORDED IN C4 AND C5 =1
NO =2

IF NO, GO BACK AND CORRECT ENTRIES AS NEEDED.

SECTION 15 – PAYMENTS LESS THAN CHARGES *(new section, UNDERPAYMENT)*

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
e. Person is an eligible veteran	YES=1 NO=2

SECTION 16 – PATIENT ACCOUNTS – DIFFERENCE BETWEEN PAYMENTS AND CHARGES

C6_Additional, Question C6_additional

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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'sFamily?	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?)

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

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

SECTION 18 – PATIENT ACCOUNTS – CAPITATED BASIS

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

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:

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

a. Patient or Patient's Family;	YES=1, NO=2
b. Medicare;	YES=1, NO=2
c. Medicaid;	YES=1, NO=2
d. Private Insurance; or	YES=1, NO=2
e. Something else? (IF SOMETHING ELSE: What was that?)	YES=1, NO=2

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

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.

RECORD PAYMENTS FROM ALL THAT APPLY

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

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?)	$

1. What is the name of the PA form received from the provider?

   Form Name

   ID

2. Rate the quality and completeness of the following billing information provided with this form:

Global Fee	COMPLETE=1, PARTIAL=2, MISSING = 3, N/A = 4
CPT4/Services and Charges	COMPLETE=1, PARTIAL=2, MISSING = 3, N/A = 4
Reimbursement Type	COMPLETE=1, PARTIAL=2, MISSING = 3, N/A = 4
Source of Payment by Reimbursement Type	COMPLETE=1, PARTIAL=2, MISSING = 3, N/A = 4
Total Payment by Reimbursement Type	COMPLETE=1, PARTIAL=2, MISSING = 3, N/A = 4
Adjustments by Reimbursement Type	COMPLETE=1, PARTIAL=2, MISSING = 3, N/A = 4
Expecting Additional Payment by Payment Source (including copayment or additional payment information)	COMPLETE=1, PARTIAL=2, MISSING = 3, N/A = 4
Lump Sum Payment	COMPLETE=1, PARTIAL=2, MISSING = 3, N/A = 4

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** FINISH SCREEN**)**

SECTION 19 – FINISH SCREEN

PRESS VALIDATE TO COMPLETE THIS EVENT FORM.