

**MEDICAL EXPENDITURE PANEL SURVEY
MEDICAL PROVIDER COMPONENT
EVENT FORM
FOR
OFFICE-BASED PROVIDERS
FOR
REFERENCE YEAR 2022**

Specifications for RCD

VERSION #	V	GENERATION OF CHANGES	DATE TO AHRQ
.0	1	Updates made for 2022 data collection – highlights in yellow	12/20/22

PROGRAMMERS: This document details the specifications for the **Office-Based Medical Event Form**.

Overall functionality requirements we would like for the system controlling the event forms are as follows:

- Show an “overall” progress indicator on the screen.
- Set up FUNCTION KEYS for each of the following commands:
 - (1) Don’t Know
 - (2) Refused

The function keys would be available for any question unless specified otherwise in the question by question specifications.

NOTE: 2018 Update: The response option of “Retrievable” was removed from all Event Forms.

- To assist the DCS/abstractors if they need to jump around a form, among forms, and among patients for a given provider:
 - o Within an event form, in addition to post-logic, include pre-logic to the area we are skipping to, so the interviewer wouldn’t be able to access a group of questions without answering the gateway question. For example, the “Capitated Basis” section should not allow entry unless the question in “Reimbursement Type” (C3) = 2.
 - o Incorporate edit trails (e.g., if need to go back and revise answer).
 - o Include in the screen header some sort of progress status on how many patients for a given provider have been completed out of the total (e.g., Done with 2 of 3 patients).
 - o Allow the DCS/abstractors to see a list of the event forms completed for a given patient (with event dates) in case they need to go back to revise some information in one of the forms.

Question By Question Specifications

The QxQ specifications have been broken out throughout the rest of this document by section and include the screen layout, programmer notes, and edit specifications from Westat.

NOTE: Westat EDIT SPECS:

Westat editors wrote BLUE SHEETS to the TRC (telephone research center) for data items that needed collection, clarification, or correction. The TRC is our contact with the respondent in the provider's office.

Westat editors wrote YELLOW SHEETS for problematic items that needed managerial review.

NOTE:

The following are a list of CRITICAL ITEMS and ADDITIONAL DATA RETRIEVAL ITEMS in the event form, which were pulled from (1) the CHEAT SHEET provided by AHRQ with the edit specs (*cheat sheet rev2 DRG after 10-1-07.doc* found in [\\RTINTS27\MEPS\00_ADMIN\04_DOCUMENTS\MATERIALS FROM AHRQ AND WESTAT\11_14_2008\DOCS_RECEIVED_ELECTRONICALLY\MPC_EDIT_SPECX.ZIP](#)) and (2) the following memo [\\RTINTS27\MEPS\01_BASE_YEAR\11_DATA_COLLECTION\00_DCT_COMMON\REQUESTS FOR CLIENT\FROM CLIENT\CRITICAL DATA ITEMS MEMO 01051997.PDF](#).

CRITICAL ITEMS

LOCATION OF SERVICE

The location where the doctor provided service was be recorded.

DATE OF VISIT

At least month and year must be recorded.

SERVICES PROVIDED (review event type)

FOR OBD – At least one procedure code or description must be recorded.

REIMBURSEMENT

Fee for service or capitated must be circled.

SOURCE OF PAYMENTS

The amount paid by each source must be recorded, *OR* the total payments and the contributing source must be recorded. This includes OTPAYMOS and OTPAYMOSTXT.

OTHER GLOBAL FEE DATES - GFEE DATE

SECTION 1 – OMB

DCS: IN GENERAL, PRESS <F6> FOR DON'T KNOW AND <F7> FOR REFUSAL. AT ANY POINT, PRESS <F2> FOR SHORTCUT TO ALL DK/RF RESPONSES. USE UP/DOWN ARROWS OR PAGE UP/DOWN TO MOVE THROUGH RESPONSES. PRESS END BUTTON TO JUMP TO THE LAST OPEN QUESTION.

READ THIS ALOUD ONLY IF REQUESTED BY RESPONDENT:

OMB Statement:

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.

OMB No. [#]; Exp. Date [DATE]

1. CONTINUE

SECTION 2 – VISIT DATE

[Page 1 – VISIT DATE (1 of 1)]

SCREEN LAYOUT

B1. What is the (first/next) date of service in your records during this period, for (PATIENT NAME)?

DCS: ENTER A DATE IN FORMAT MM/DD/YYYY. INCLUDE LEADING 0's FOR SINGLE DIGIT MONTHS AND DAYS

ENC_DATE
MONTH/DAY/YEAR

PROGRAMMER NOTES

(first/next) - If first event form for patient fill: "first" ELSE fill: "next".

(PATIENT NAME) should fill with patient's first name and patient's last name from Housing Component data file.

ENC_DATE – value for month (MM) should be 1 through 12; value for day (DD) should only valid numbers (1-28 for all months; 29-30 for all months except month 2; 31 allowed only for months 1, 3, 5, 7, 8, 10, and 12; value 29 allowed for month 2 only in leap years); value for year (YYYY) should be 2022.

DK/REF – CONTINUE TO B3

EDIT SPECS FROM WESTAT

DATA ITEM	SPECIFICATIONS	ACTION, if specification not met
B1- Date of visit	Month, day and year is needed.	Blue Sheet if all are blank. Blue Sheet if month or day is blank.

CRITICAL ITEM (Month and Year)		<p>Blue Sheet if year is blank and can't be determined.</p> <p>Add year 2022, if year is blank, but book is in the middle of a series of books in 2022.</p>
	Year must be 2022.	<p>Blue Sheet if not 2022 and correct year can't be determined to be 2022.</p> <p>Change year to 2022, if wrong, but book is in the middle of a series of books in 2022.</p>
	<p>Month and Day are acceptable as DK or RF. Year is acceptable as DK or RF after TRC verifies on Blue Sheet. If month or year is DK or RF, RC code for Pair is 60 – critical item is missing.</p>	<p>Change DK to – 8. Change RF to – 7. Blue Sheet, asking if at least the year can be determined. Note: Day is not a critical item.</p>
	<p>Duplicate dates need managerial review.</p> <p>More than one book with same DOS (Date of Service). Book DOS is same as Global Fee or Repeat Visit in this book or another book. Global Fee or Repeat Visit DOS in this book is same as DOS in another book.</p>	<p>Yellow Sheet.</p>

SECTION 2 – LOCATION OF SERVICES RECEIVED

NOTE: this section was previously after the global fee section

[Page 2 – LOCATION OF SERVICES RECEIVED (1 of 1)]

SCREEN LAYOUT

B3. Did (PATIENT NAME) receive the services on (VISIT DATE) in a:

Physician's Office;	=1	RCSR
Hospital as an Inpatient;	=2	
Hospital Outpatient Department;	=3	
Hospital Emergency Room	=4	
Telehealth	=6	
Drive-through	=7	
Somewhere else?	=5	
IF SOMEWHERE ELSE:		
Where was that?		RCSPC_OTHR

PROGRAMMER NOTES

The "somewhere else" option should be set up so a response can be entered in as text. Allow 50 characters.

(PATIENT NAME) should fill with patient's first name and patient's last name from Housing Component data file.

(VISIT DATE) should fill with **ENC_DATE** from B1.

DK/REF NOT ALLOWED

2017 Update: Remove the dropdown options for response option "Somewhere else" but keep the text box. Maintain the text box in case of necessity.

EDIT SPECS FROM WESTAT

DATA ITEM	SPECIFICATIONS	ACTION, if specification not met
QB3 - Where event took place	1, 2, 3, 4, or 5 must be circled.	Blue Sheet.
	Only one response can be chosen.	Blue Sheet.
	If 5 (Somewhere Else) is answered, there must be an answer on the SPECIFY line.	Blue Sheet.
	Answer on the SPECIFY line needs review.	Check Decision Log. If answer is on the Decision Log, accept. If the answer is not on Decision Log, Yellow Sheet.
	Procedure must be compatible with event type (location of event).	Compare procedure to location of event. Yellow Sheet , if not compatible. See "edit specs from Westat" below B5a titled "Procedures That Need Special Handling".

	If there is a Global Fee, this question is skipped.	Cross out, if there is an answer here, and there is a global fee. Review the IF GLOBAL FEE, RECORD TYPE line. If it is blank and there is a global fee, the answer to this question can be transferred to the GLOBAL FEE, RECORD TYPE line.
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SECTION 3 – GLOBAL FEE

NOTE: This section was previously before the Location of Services Received section

NOTE: See end of section for edit specs from Westat for questions B2a, B2b, B2c, and B2d.

[Page 3 – GLOBAL FEE]

SCREEN LAYOUT

B2a. Was the visit on (VISIT 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 **GLOFEE**

EXPLAIN IF NECESSARY: Examples would be a surgeon’s fee covering surgery as well as pre- and post-operative care, or an obstetrician’s fee covering normal delivery as well as pre- and post-natal care.

IF THERE IS A GLOBAL FEE DO NOT SELECT YES. PLEASE READ:

Due to the complexity of the charges and payments for these events, I’m required to request a hardcopy of the billing and payment records. Would you be able to send in the billing and payment records for this patient?

IF POC INDICATES THEY WILL SEND IN THE RECORDS PROVIDE THEM WITH THE FAX AND/OR ADDRESS AND ASK THAT THEY INCLUDE THE REFERENCE # ON THE MATERIALS:

FAX: 1-866-309-4556

ADDRESS:
MEPS-MEDICAL PROVIDER COMPONENT
1 NORTH COMMERCE CENTER
5265 CAPITAL BOULEVARD
RALEIGH, NC 27616

IF SENDING IN RECORDS: SELECT PREVIOUS AND BREAKOFF FROM THE EF, COLLECT DATA FOR ANY OTHER PAIRS, AND COMPLETE A ROC DETAILING THE SITUATION WITH THIS PAIR.

IF NOT SENDING IN RECORDS: SELECT YES AND CONTINUE DATA COLLECTION

PROGRAMMER NOTES

[IF GLOFEE=2, GO TO B4a]

(VISIT DATE) should fill with ENC_DATE from B1.

DK/REF – GO TO B4a

SCREEN LAYOUT

B2b. What other dates of service were covered by this global fee? Please include dates before or after 2022 if they were included in the global fee.

ADMINISTER B2c FOR EACH DATE OF SERVICE COVERED BY THE GLOBAL FEE

B2c. Did (PATIENT NAME) receive the services on this date in a:

- Physician' s Office (TYPE=MV)
- Hospital as an Inpatient (TYPE=SH)
- Hospital Outpatient Department (TYPE=SO)
- Hospital Emergency Room (TYPE=SE)
- Somewhere else (TYPE=96)
- IF SOMEWHERE ELSE: Where was that?

B2d. Do you expect (PATIENT NAME) will receive any future services that will be covered by this same global fee?

YES=1, NO=2 **GFEEFUTS**

CHK_GFEE
ARE THESE GLOBAL FEE DATES ACCURATE?

YES = 1 **CHK_GFEE**
NO = 2

MONTH/DAY/YEAR	TYPE	IF TYPE=96 SPECIFY:
GFEEDATE	GFTYPE	GFTYPE_OTH
GFEEDATE	GFTYPE	GFTYPE_OTH
GFEEDATE	GFTYPE	GFTYPE_OTH
GFEEDATE	GFTYPE	GFTYPE_OTH
GFEEDATE	GFTYPE	GFTYPE_OTH
GFEEDATE	GFTYPE	GFTYPE_OTH
GFEEDATE	GFTYPE	GFTYPE_OTH
GFEEDATE	GFTYPE	GFTYPE_OTH

PROGRAMMER NOTES

B2b AND B2c- [SYSTEM WILL SET UP AS A LOOP, SO NO LIMIT ON NUMBER OF DATES]

GFEEDATE – value for month (MM) should be 1 through 12; value for day (DD) should only valid numbers (1-28 for all months; 29-30 for all months except month 2; 31 allowed only for months 1, 3, 5, 7, 8, 10, and 12; value 29 allowed for month 2 only in leap years); value for year (YYYY) may be 2021, 2022, or 2023.

B2b and B2c is a question loop that will require:

- (1) A GROWING TABLE/GRID to display responses already collected.
- (2) A question to appear after each iteration of the questions that reads: Are there any more dates? YES=1 NO=2
- (3) If 96 (“Somewhere else”) is entered for GFTYPE, provide a text box for the DCS/abstractor to enter the “specify” option (GFTYPE_OTH). Text box allows 50 characters.

At B2c and B2d, (PATIENT NAME) should fill with patient’s first name and patient’s last name from Housing Component data file.

B2b - DK/REF – CONTINUE TO B2c

B2c - DK/REF – CONTINUE TO B2d

B2d - DK/REF – CONTINUE TO B4a

2019 UPDATE: CHK_FEE – Grid displaying summary of global fee dates displaying after B2d and requiring confirmation (or correction) replaces dynamic grid that previously displayed at items B2b and B2c. If CHK_FEE = NO, display hard check: PLEASE GO BACK AND MAKE CORRECTIONS.

EDIT SPECS FROM WESTAT

DATA ITEM	SPECIFICATIONS	ACTION, if specification not met
QB2a – Global fee or not	Cannot be blank; either 1 or 2 must be circled.	If there is a global fee date, Circle 1 (YES) if blank. If there is a global fee date and 2 (NO is answered, change to 1 (YES). If blank, circle 2 (No), if there is no indication of a Global Fee.
	DK or RF need managerial review.	Yellow Sheet.
	If NO, other global fee questions are skipped.	Go to QB3.
	ALL GLOBAL FEES NEED YELLOW SHEETS. If YES, and rest of Global Fee section is filled in, send for managerial review.	Yellow Sheet.
	If YES, Global Fee section must be filled in.	Blue Sheet.
	If YES, Box 2 must be answered GLOBAL FEE SITUATION (1).	Check Box 2. Circle 1, if blank or if another answer is given.
IF GLOBAL FEE, RECORD TYPE [NOTE: This is to the right of the date in QB1.]	Cannot be blank.	If QB3 is answered, transfer answer here. If QB3 is not answered, Blue Sheet.
	Main Global Fee Event Type must be MV, SH, SO, or SE.	If HS, change to SH. If OP, change to SO. If ER, change to SE. Yellow Sheet , if another answer is given.
	Not answered if there is no Global Fee.	Cross out answer given, if QB2a is NO.
	Procedure must be compatible with event type (location of Main Global Fee event).	Compare procedure to Global Fee Main Event type. Yellow Sheet , if not compatible. See “edit specs from Westat” below B5a titled “Procedures That Need Special Handling”.
QB2b Global Fee dates Global Fee dates are not critical items. RC code will remain 63.	Year 2021, 2022, and 2023 are acceptable as Global Fee dates.	Blue Sheet.
	Year cannot be DK or RF.	Blue Sheet to verify that the year is not available.
	Month or Day can be DK or RF, if year is given.	Change DK to –8. Change RF to –7.
	Entire Date or series of dates may not be DK or RF. (TRC indicates that there were global fee dates, but the DOS were unknown.)	Blue Sheet asking if we can get at least the year.
	If date is a duplicate of any event book date, any other global fee date or any repeat visit date, it needs managerial review.	Yellow Sheet.
QB2c Global Fee event types	Each global fee date must have an event type; type cannot be blank.	Blue Sheet.
	Type must be MV, SH, SO, SE or 96.	If HS, change to SH. If OP, change to SO. If ER, change to SE. If 96, Yellow Sheet , if the Other/Specify answer is not on the Decision Log.
QB2c – Global Fee event type, cont	If 96 (Somewhere else) is answered, there must be an answer on the SPECIFY line. Answer may be in the form of a comment outside the line.	Blue Sheet, if 96 is answered and Specify line is blank.
	Answer on the SPECIFY LINE needs review. Sometimes the answer is written outside the line, as a comment. It may be added to the line if the Decision Log instructs.	Check Decision log for all Specify answers. If it is on the Decision log, follow directions given there. If the answer is not there, Yellow Sheet.
	Type may be DK or RF.	Change DK to – 8. Change RF to –7.

Global Fee Counter	If Global Fee is YES, Office Use Only Box must be filled.	Count the number of global fee dates and enter them as a two-digit, zero-filled number.
	If Global Fee is NO, Office Use Only box will be skipped.	Leave Office Use Only box blank.
QB2d – Future Global Fee dates expected	1 or 2 must be circled. May not be blank.	If blank and there is no indication that there will be future service, circle 2 for NO.
	Should not be DK or RF.	Circle 2 for NO.
	If YES, needs managerial review.	Yellow Sheet.

Decision Log for QB2c

[PROGRAMMER NOTE: Include all "Problems" in a drop down menu at the other specify entry and program the required "decision" behind the scenes]

Problem	Decision / Categorization
Location of event	
Mental Health Clinic	Code GF as MV
Clinic, Free-standing clinic	Code GF as MV
Health Department	Code GF as MV
Urgent care, Urgi Center	Code GF as MV
X-ray, Imaging CTR, Radiology, MRI clinic	Yellow Sheet
Lab or Laboratory, Pathology Dept	Yellow Sheet
Dialysis	Yellow Sheet
Planned Parenthood	Code GF as MV
Surgi Center, Ambulatory Care Center	Yellow Sheet

SECTION 4 - DIAGNOSES

[Page 5 – DIAGNOSES (1 of 1)]

SCREEN LAYOUT

B4a. I need the diagnoses for (this visit/these visits). I would prefer the ICD-10 codes, or the 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
ICDCND#	ICDPDS#
ICDCND#	ICDPDS#
ICDCND#	ICDPDS#
ICDCND#	ICDPDS#
ICDCND#	ICDPDS#

Always a letter

Always a number

Letter or number

PROGRAMMER NOTES

[SYSTEM WILL ALLOW FOR A MAXIMUM OF 5 ICD-10 CODES AND/OR DESCRIPTIONS TO BE COLLECTED]

This is a question loop that will require:

- (1) A HISTORY BOX to display responses already collected.
- (2) A question to appear after each iteration of the questions that reads: Any More Diagnoses? YES=1 NO=2

(this visit/these visits) - If B2a=YES fill: "these visits" ELSE fill: "this visit".

DK/REF – CONTINUE TO B5a

Description field (ICDPDS) = up to 100 characters.

For ICDCND, display "ENTER CODE" on screen. For ICDPDS, display "ENTER DESCRIPTION" on screen.

2019 UPDATE: Addition of onscreen ICD-10 graphic to emphasize correct code format. Logic also added to restrict code entries to only accurate formats.

- o Code is 3-7 characters.
- o First character is always a letter.
- o Second character is always a number.
- o Characters 3-7 can be letter or number.

- 2020 UPDATE: Values entered into ICDCND are checked against a dictionary of valid ICD-10 and DSM-5 codes. Entry is allowed for valid codes. If entry of an invalid code is attempted, a hard check message is displayed, "The code you entered is not in our database. Please verify your entry. If the entry is correct, leave ICDCND empty and move to ICDPDS field to enter a description instead."

EDIT SPECS FROM WESTAT

DATA ITEM	SPECIFICATIONS	ACTION, if specification not met
QB4a – Diagnosis	Must have at least one Diagnosis, in text or code.	Blue Sheet.
	DK and RF are acceptable answers.	Change DK to –8. Change RF to –7. Code PL-IV as 60, critical item is DK or RF.

CRITICAL ITEM		If one Diagnosis is given and another is DK, cross out the DK and keep the Diagnosis given.																							
	Diagnosis descriptions must be valid, clear, and legible.	Blue Sheet																							
	Diagnosis descriptions may be the identification of a disease or illness. Symptoms are acceptable for Diagnosis. Procedures are acceptable for Diagnosis.	Accept the name of a disease. Accept symptoms such as cough or nausea. Accept procedures such as lab work, screening mammogram, flu shot, employment physical, or school physical. Do not accept "Follow-up" without any other information. Blue Sheet , asking Follow-up for what.																							
USED FOR DETERMINING SBDs	Abbreviations in the Description field should be standard medical abbreviations.	Review abbreviations. Check reference list in manual. Check medical dictionary. Ask team leader to check website. Yellow Sheet , if not found, and team leader is not available.																							
	There should be only 1 diagnosis per line. If there are 5 or more codes, the order of the codes must be maintained.	If two codes are listed on the same line, rewrite one of the codes. If there are 4 or less Diagnoses, write the code on the last line. If there are 5 or more Diagnoses, write the code on the next line and rewrite all other codes, keeping them in order.																							
	<table border="1"> <thead> <tr> <th>Change</th> <th>To</th> <th>Change</th> <th>To</th> </tr> </thead> <tbody> <tr> <td>650 652</td> <td>650</td> <td>650</td> <td>650</td> </tr> <tr> <td>V27.1</td> <td>652</td> <td>652</td> <td>V27.1</td> </tr> <tr> <td>V25.2</td> <td>V27.1</td> <td>V27.1</td> <td>V25.2</td> </tr> <tr> <td>V25.09</td> <td>V25.2</td> <td>V25.2</td> <td>652</td> </tr> <tr> <td></td> <td>V25.09</td> <td></td> <td></td> </tr> </tbody> </table>	Change	To	Change	To	650 652	650	650	650	V27.1	652	652	V27.1	V25.2	V27.1	V27.1	V25.2	V25.09	V25.2	V25.2	652		V25.09		
Change	To	Change	To																						
650 652	650	650	650																						
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V25.2	V27.1	V27.1	V25.2																						
V25.09	V25.2	V25.2	652																						
	V25.09																								
The code field and the description field cannot be used on the same line. CODE DESCRIPTION 650 A mixture of codes and descriptions are acceptable if they are on different lines. CODE DESCRIPTION 650 _____ Normal Delivery	Look up the diagnosis code in the ICD-10 reference book. If they are on the same line, and the code's definition exactly matches the text description, cross out the text and keep the code. Do not look up codes if they are on different lines. If there are 5 or more Diagnoses, write the code on the next line and rewrite all other codes, keeping them in order																								
A diagnosis may only appear in the book once. Note: different numbers after the decimal mean that a diagnosis is not a duplicate. Keep both. 547.11 and 547.1 are not duplicates 698 and 698.0 are not duplicates	Cross out a duplicate diagnosis.																								
Descriptions cannot go over 100 characters.	Take to a team leader to shorten, or write a Yellow Sheet , if a team leader is not available.																								
Some sequential events will have ongoing treatments for a condition. Pre-natal care Dialysis Physical or Occupational Therapy If diagnosis is given in some books, but DK or RF in other books, managerial review is needed.	Yellow Sheet , if diagnosis is given in some books, but is DK or RF in other books.																								
Diagnosis Counter	Office Use Only box must be filled in. The Office Use Only box is only used on the booklet page, not on the Continuation Sheet.	Count the number of diagnoses and enter as a 2-digit, zero-filled number. Diagnosis of DK or RF = Diagnosis count of 01.																							

CHEAT SHEET RANGES FOR DIAGNOSES (ICD-10)

Codes are between 3 and 7 characters, ranging from A00 to Z99.

ICD-10-CM Code Structure

ICD-10 diagnosis codes have between 3 and 7 characters:



SECTION 5 – SERVICES/CHARGES

NOTE: See end of section for edit specs from Westat for questions B5a, B5b, and C2.
 [Page 6 – SERVICES/CHARGES (1 of 1)]

SCREEN LAYOUT

B5a. I need to know what services were provided during (this visit/these visits). I would prefer the CPT-4 codes, if they are available.

CPT-4 CODE DESCRIPTION
MCPT# **MCPTDS#**

What was the full established charge, or charge equivalent, for this service?

\$MCPTCH#

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

IF CPT-4 CODE BEGINS WITH W, X, Y OR Z, ENTER A DESCRIPTION INSTEAD.

B5b. ASK FOR EACH CPT-4 CODE OR DESCRIPTION: 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?

IF PROVIDER APPLIED THE CHARGE FOR THIS SERVICE TO SOME OTHER SERVICE ON THIS DATE, ENTER -4.

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 is missing] Is that correct?
 IF INCORRECT, CORRECT ENTRIES SHOWN ABOVE AS NEEDED

TOTLCHRGOK
 YES = 1
 NO = 2

OTHERMCPT#

PROGRAMMER NOTES

2021 UPDATE: Check MCPT fields for any of the following codes or modifiers:

- HCPCS/CPT4 codes: G0425, G0426, G0427, G0406, G0407, G0408, G2012, G2010, 99421, 99422, 99423, G2061, G2062, G2063
- 2022 UPDATE: Add the following HCPCS/CPT4 codes: 99441, 99442, 99443, 98966, 98967, 98968
- Modifiers: 95, GQ, GT

Determine YES or NO if any of the codes or modifiers listed immediately above are in MCPT fields. If NO, no soft check is displayed at this point. If YES: check item B3 RCSR.V. Does RCSR.V = 1 (Physician's Office)? If NO, no soft check is displayed at this point. If YES, display a soft check message:

ONE OR MORE CODES/MODIFIERS INDICATES TELEHEALTH, BUT THE LOCATION OF SERVICE SELECTED IS NOT TELEHEALTH.
CONFIRM THE CURRENT LOCATION OF SERVICE AND CONTINUE OR CLICK THE GOTO BUTTON TO CHANGE THE LOCATION OF SERVICE TO TELEHEALTH.

2022 UPDATE: Modifiers added in MCPT must be 2 characters. After the first 5 characters in an MCPT field, any additional entry within that same field must be 0 characters or 2 characters.

2020 UPDATE: Values entered into MCPT are checked against a dictionary of valid CPT-4 and HCPCS codes. Entry is allowed for valid codes. If entry of an invalid code is attempted, a hard check message is displayed, "The code you entered is not in our database. Please verify your entry. If the entry is correct, leave MCPT empty and move to MCPTDS field to enter a description instead."

2016 UPDATE: REQUESTING EVENT FORM CHANGE IN WHAT IS CONSIDERED AN ERROR FOR B5a/b GRID. [The following only occurs during re-abstraction: If an event includes a duplicated CPT code and associated charge that needs to be deleted, the deletion creates errors for all CPTs/charges listed after it, even if their CPTs or values do not change. This happens when the deleted item is not the last in the list/grid. For example, if the second CPT and associated charge in the list is deleted, the system marks that removal as an error. Then it shifts every CPT and charge "below" that one in the grid. Each one of those shifts counts as an error. Requesting Event Form change in what is considered an error.]

Design Note for C2

In the summary of charges that displays on screen, "I show the total charge as [TOTLCHRG]" distinguish different types of reserve codes, by displaying phrases "Don't Know" or "Refused" instead of the generic word "missing."

If there is even one reserve code entered in the MCPTCH fields, then end the currently displayed phrase with "...although there are some charges that are missing." Do not cite "total." For example:

"I show the charge as \$30, although one or more charge is missing. Is that correct?"

"I show the charge as zero, although one or more charge is missing. Is that correct?"

If all the entries in the SOP fields are reserve codes, then display:

"I show the total charge as undetermined."

Design Note for C2

C2. I show the total charge as [TOTLCHRG]. Is that correct?

CHARGES

Services charge: CPT-4 CODE: [MCPT_1] / DESC: [MCPTDS_1] charge = \$[MCPTCH_1]

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.

.

Services charge: CPT-4 CODE: [MCPT_N] / DESC: [MCPTDS_N] charge = \$[MCPTCH_N]

Programmer:

At least one entry of MCPTCH must be something other than -4. Entries of dollars, DK, RF all count as valid entries in the presence of -4. If a user answers A6_Anymore ("Any more procedures") as "No" and the sole entry is -4 or all entries are -4, then administer a hard check message: "At least one charge must have a value other than -4."

When a user answers A6_Anymore ("Any more procedures") as "No", and one or more MCPTCH entries equals DK, RF, administer a soft check message: "ONE OR MORE CHARGES WAS RECORDED AS DON'T KNOW OR REFUSED. PRESS OK TO CONTINUE, OR CANCEL TO CHANGE AN ANSWER."

B5b: 0 is UNALLOWABLE. Must have a positive value, -4, DK or REF response.

IF C2=NO DISPLAY HARD CHECK ("IF INCORRECT, CORRECT ENTRIES AS NEEDED") AND SEND USER BACK TO B5b MCPTCH[1].

Validation: If OUT_TOTLCHRG>10000 administer soft-check "You have entered a charge over \$10,000."

B5a - [SYSTEM WILL SET UP AS A LOOP, SO NO LIMIT ON CPT-4 CODES REQUIRED]

B5a and B5b is a question loop that will require:

- (1) A HISTORY BOX to display responses already collected.
- (2) A question to appear after each iteration of the questions that reads: Any more services? YES=1 NO=2

B5a – (this visit/these visits) - If B2a=YES fill: "these visits" ELSE fill: "this visit".

B5a – MCPTDS = Up to 100 characters allowed.

B5b, IF NO CHARGE – (s) – If B5a has one response fill: " " ELSE fill: "s".

B5b, IF NO CHARGE – (this/these) – If B5a has one response fill "this" ELSE fill: "these".

B5b, VERIFY – (Is this/Are these) - If B5a has one response fill: "Is this" ELSE fill: "Are these".

B5b, VERIFY – (s) - If B5a has one response fill: " " ELSE fill: "s".

B5b, VERIFY – (this/these) - If B5a has one response fill: "this" ELSE fill: "these".

B5b & C2 - DOLLAR AMOUNTS SHOULD BE FORMATTED TO INCLUDE COMMAS and DECIMAL POINTS

C2 – System should compute and display total charges from preceding charges reported in \$MCPTCH#. That total is referred to in spec as \$TOTLCHRG and will be a fill in the C2 question. The answer for the user is Yes or No. However if the user answers "No" then a hard check error message should be administered, "IF INCORRECT, CORRECT ENTRIES AS NEEDED." This live message will replace the fixed interviewer instruction in ALL CAPS.

B5a - DK/REF – CONTINUE TO B5b

B5b - DK/REF – CONTINUE TO C2

2019 UPDATE: TOTLCHRGOK – Grid displaying summary of CPT-4 codes/descriptions and associated charge amounts, along with summary of total charge amount, and requiring confirmation (or correction). This screen replaces dynamic grid that previously displayed at items B5a and B5b.

EDIT SPECS FROM WESTAT

DATA ITEM	SPECIFICATIONS	ACTION, if specification not met	
QB5a PROCEDURES	There must be at least one procedure, written as a text description, as a CPT code or as a HCPC.	Blue Sheet , if procedure is missing.	
PROCEDURE IS A CRITICAL ITEM	DK and RF are acceptable answers.	Change DK to -8. Change RF to -7. Give an RC code of 60 (critical item missing).	
	Descriptions of procedures must be clear, valid, and legible.	Blue Sheet.	
	Abbreviations in the Description field should be standard medical abbreviations.	Review abbreviations. Check reference list in manual. Check medical dictionary. Ask team leader to check website. Yellow Sheet , if not found, or team leader not available.	
	Descriptions cannot be longer than 100 characters.	Ask a team leader to shorten it or Yellow Sheet.	
	CPT and HCPC codes must fall within valid ranges (see Cheat Sheet).	Blue Sheet.	
	HCPCs cannot begin with W, X, Y, or Z because these are local codes, not national codes.	Blue Sheet , asking for text description.	
	CPT and HCPC Modifiers must be valid. Valid modifiers include: 2 numbers 2 letters 1 letter + 1 number 1 letter	Keep all valid modifiers. Cross out all invalid modifiers. Note: Modifiers with X may be a multiplication sign – see below.	
	Only one procedure per line. Procedures cannot be followed by a multiplication mark (For example: 85025 x5). Multiplication marks should not be confused with modifiers.	Blue Sheet , saying that there can only be one procedure per line.	
	Only one valid modifier is acceptable for each CPT code.	Cross out the second modifier.	
	Modifiers must be separated from the main code by a hyphen.	Change a decimal point to a hyphen.	
	Multiple listings of the same procedure may need managerial review.	Yellow Sheet if the same procedure is listed more than twice.	
	Multiple visits may need review	Check CPT codes in the 99201–99499 range.	
		Accept Office Visit or OP codes w/consultation codes (if the event type is compatible).	
		Accept Office Visit or OP codes w/ preventive medicine codes.	
Yellow Sheet multiple inpatient care codes in the same book. These may appear as initial inpatient care, subsequent inpatient care and inpatient discharge code in the same book.			
	Yellow Sheet multiple Office Visit or OP codes in the same book.		
Procedures should be consistent with the location of the event (event type).	Compare procedure to QB3 or to the Global Fee Main Event type.		

	See "edit specs from Westat" below B5a titled "Procedures That Need Special Handling".	Yellow Sheet , if not consistent.
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PROCEDURES THAT NEED SPECIAL HANDLING

PROCEDURES	Specification	Action
Body part with no procedure	Body part alone is not a valid procedure.	Blue Sheet.
Body part with indication of Radiology	Body parts with descriptives for Radiology are acceptable. For example, 2 views, P/A, LAT, v	Accept.
Abbreviations	Standard medical abbreviations are allowed. Shorthand abbreviations are not accepted.	Look up in list of abbreviations and in med dictionary. Let a team leader look up on a website. Yellow Sheet , if a team leader is not available.
CPT code with description	Should not have a code and a description on the same line. 71020 Chest X-ray	Look up code. If the code and text match, cross out text. If code and text do not match, Blue Sheet to ask if they are one procedure or two, and to get the second charge if appropriate.
CPT code with units	Should not have a code and text. Cross out the text. 99284 J2001	Cross out text.
CPT code with multiplication mark	Not allowed. 71020 (x2)	Blue Sheet , saying that there can only be one procedure per line.
State tax	Valid if it is not the only service in the book. No identifying information is allowed.	Yellow Sheet , if it is the only procedure. Cross out state name, if given.
Handling 99000 - 99002	Valid if it is not the only service in the book. Needs further review if used alone.	Yellow Sheet , if it is the only procedure.
Administrative fee	Valid if it is not the only service in the book. Needs further review if used alone.	Yellow Sheet , if it is the only procedure.
Surcharge	Needs further review if used alone. Valid if it is not the only service in the book. No identifying information is allowed.	Yellow Sheet , if it is the only procedure. Cross out state name, or other identifying information, if given.
Ambulance, ambulance mileage	Needs further review.	Yellow Sheet.
Reports, copy of reports, insurance reports	Valid if it is not the only service in a book.	Yellow Sheet , if it is the only procedure.
99080 S9981, S9982	Valid if it is not the only service in a book.	Yellow Sheet , if it is the only procedure.
Rxpickup; Pharmacy	Valid if it is not the only service in a book.	Yellow Sheet , if it is the only procedure.
Canceled appointment, no show charge	Needs managerial review.	Yellow Sheet.
Follow up, no charge	We take charge equivalents.	Blue Sheet. Is this part of the Global Fee? If not, can we get a Charge Equivalent?
Service with no charge or comment that Dr did not charge.	We take charge equivalents.	Blue Sheet , asking for a Charge Equivalent.
99024 (Follow-up visit included in a Global Fee)	A Global Fee f/u visit should appear as a GF date in the book with the main GF charge, not as a separate book.	Blue Sheet. Should this be part of a global fee?
99500 – 99600 (Home Care services)	If there are Home Care services the Patient Data Form must be reviewed. Did we expect Home Care events?	Accept, if no Home Care Events were reported on Patient Data Form. Blue Sheet if Home Care events were reported, asking that they be collected.
Delivery 59400 – 59412, 59510-	Valid for HS event. Verification needed for MV, OP, or ER.	Blue Sheet to verify that event took place in physician's office or OP dept or ER.

59525, 59610 – 59622		
Neonatal inpatient care 99295 – 99299, 99433, 99436	Valid for HS event. Verification needed for MV, OP, or ER.	Blue Sheet to verify that event took place in physician's office or OP or ER.
Surgeries in Physician's Office	Surgeries may be acceptable in an MV event, depending on the complexity of the surgery and the type of physician's office. Providers that are Eye Centers or Surgi-Centers can do surgeries on an outpatient basis.	Look up CPT codes, or ask a team leader. If surgery is \$1000.00 or less, and can be done on an outpatient basis, accept. If surgery is more than \$1000.00, Yellow Sheet . If any questions, Yellow Sheet .
Procedure doesn't match the location given.	Compare QB3 to QB5a for the type of service and the location of the service (event type).	Yellow Sheet , if procedure doesn't match event type.
Text description says Office Visit but not an MV or OP event.	Expect that an Office Visit would occur as an event in the Physician's Office or in a Hospital Outpatient setting.	Yellow Sheet if the procedure is written as "Office Visit" but event is ER or HS.
Inpatient event with CPT codes for Path and/or Rad services.	Office-Based cases should not have the hospital charges.	Yellow Sheet .
Inpatient event with room charge, or room and board, or supplies	Office-Based cases should not have the hospital charges.	Yellow Sheet .
Proc is DK or RF / Charge is DKor RF/ Payments are DK	If procedures and charges and payments are DK or RF, book needs managerial review.	Yellow Sheet .

CHEAT SHEET RANGES FOR PROCEDURES (CPT-4 and HCPC)

[Modifiers are separated by a hyphen – may be 2 numbers or 2 letters, a number and a letter, or one letter.]

CPT4 – 5 DIGITS:

Anesthesiology

00100 to 01999, 99100, 99116, 99135 & 99140

Surgery

10021 - 19499

20000 - 29999

30000 - 39599 (36400 - 36425 are not surgery)

40490 - 49999

50010 - 59899 (59020 & 59025 are not surgeries)

60000 - 69990

93501 - 93545, 93580 - 93581

Radiology

70010 - 79999

938 __, 939 __

Pathology and Laboratory

80048 - 89356

36400 - 36425, 36540

also HCPC G0001

Medicine

90281 - 99602 [HH = 99500 – 99602]

Evaluation and Management

99201 - 99499 [ER = 99281 – 99288]

HCPC – 'ALPHA' + 4 DIGITS STARTING WITH A, B, C, D, E,G, H, J, K, L, M, P, Q, R, S, T, V

[Do not accept W, X, Y, Z – Blue Sheet for text description]

DATA ITEM	SPECIFICATIONS	ACTION, if specification not met
QB5b Charges	Every procedure must have a charge.	Blue Sheet , if missing. Yellow Sheet , if missing, but there is a comment explaining why.

Charge is not a Critical Item.	Only one procedure per charge, unless indicated by the TRC	If two procedures are combined into one charge, see below.
	Sometimes charges for more than one procedure are combined into one. There is a note that says charges cannot be broken out. Two or more procedures are connected by brackets. The code – 4 may be used to indicate that a charge is included in the charge on the line above it. The code – 4 is only used for charges. The code – 4 can only be used if it is certain that there are two procedures (and therefore two charges are needed).	The combined charge should be on the line next to the first of the bracketed procedures. Write the code –4 on the subsequent line in the field for the charge. The line for a charge cannot be blank if a procedure is given. If a single procedure is written on more than one line, circle it to show that it is one procedure. The matching charge lines will have a charge on the first line and will be blank on the second line. Blue Sheet , if unsure.
	DK or RF is an acceptable answer.	Change DK to – 8. Change RF to – 7. Since charges are not critical items, the Receipt Code remains 63 unless another critical item is missing. If all Individual Charges are DK or RF and there is a Total Charge given, Yellow Sheet .
	\$0.01 charge and other illogically-low charges need managerial review to determine if we should ask for a charge equivalent or full established charge.	Yellow Sheet .
	\$0.00 charge, N/C charges, or comments indicating that the doctor did not charge for this service need managerial review. NOTHING IS FREE. This may indicate a service covered by a global fee. If not a global fee service, we may need to ask for a charge equivalent.	Blue Sheet for Charge Equivalent, unless a Global Fee is indicated. If a Global Fee is indicated, Yellow Sheet .
	QC2 - Total Charge	Total Charge must be written by the TRC.
	Total Charge should equal sum of Individual Charges.	If there is only one charge, compare to Total. Blue Sheet if not the same.
	Calculator tape should be run to verify Total if there are multiple charges.	Run calculator tape. If tape doesn't match book, write NOT OK. If tape matches book, write OK. Initial the tape.
	If the Total Charge written by the TRC is less than sum of the Individual Charges, a correction can be made if the difference is 10% or less. Compare the amount of the difference and the Total Charge as written by the TRC. Note that changes can affect the answers to Box 1, QC5a, and QC6.	If the difference is 10% or less than the Total, correct the Total Charge. Blue Sheet , if the difference is greater than 10%. Change Box 1 to the appropriate answer. Blue Sheet , if QC6 was skipped, but now must be answered.
	If the Total Charge written by the TRC is greater than the sum of the Individual Charges, the TRC must make any corrections.	Blue Sheet .
	DK or RF is acceptable.	If Total Charge, and Total Pay, and Procedures are all DK or RF, Yellow Sheet .

	If one charge is DK or RF, Total Charge should be DK or RF.	Yellow Sheet.
	\$0.00 is not acceptable. Nothing is Free.	Yellow Sheet.

SECTION 6 – SOURCES OF PAYMENT

NOTE: See end of section for edit specs from Westat for questions C4 and C5.

[Page 7 – REIMBURSEMENT TYPE (1 of 1)]

SCREEN LAYOUT

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

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

FEEORCAP

EXPLAIN IF NECESSARY:

Fee-for-service means that the practice 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.

DK/REF NOT ALLOWED

IF C3 = 2 (CAPITATED BASIS) GO TO C7A

PROGRAMMER NOTES

2019 UPDATE: When a user answers FEEORCAP as 2 (“CAPITATED BASIS), a soft check message displays: “Capitated basis means that the patient was enrolled in a prepaid managed care plan where reimbursement is not tied to specific visits. This is extremely rare outside of California. Please review and correct if needed, or suppress and continue.”

EDIT SPECS FROM WESTAT

DATA ITEM	SPECIFICATIONS	ACTION, if specification not met
QC3 Fee for Service or Capitated?	1 or 2 must be circled. This critical item can usually be determined by looking at the skip pattern of the payment questions.	If blank, answer 1 or 2, by looking at the skip pattern used for the payment questions.
CRITICAL ITEM	Answer must be consistent with the skip pattern used in payments section. If Fee for Service, then QC4, Box 1, and QC6 must be answered. If Capitated, then QC7a – f Capitated Section must be answered.	If answered incorrectly, circle the answer that matches the skip pattern, and cross out incorrect response.
	Should be the same in all books for a patient, unless there is an explanation.	Yellow Sheet , if there is no explanation about a change in insurance which caused the change among books.

SECTION 7 – SOURCES OF PAYMENT

NOTE: See end of section for edit specs from Westat for questions C4 and C5.

[Page 8 – SOURCES OF PAYMENT (1 of 1)]

SCREEN LAYOUT

	SOURCE	PAYMENT AMOUNT
C4. From which of the following sources has the practice 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/these visits).	a. Patient or Patient's Family;	\$PATPAYM
	b. Medicare;	\$CAREPAYM
	c. Medicaid;	\$AIDPAYM
IF NONE, ENTER ZERO (0).	d. Private Insurance;	\$PINSPAYM
[DCS ONLY] IF NAME OF INSURER, PUBLIC, OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance?	e. VA/ChampVA;	\$VAPAYM
	f. Tricare;	\$CHAMPAYM
[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.	g. Worker's Comp	\$WORKPAYM
	h. Something else? IF SOMETHING ELSE: What was that?	\$OTHRPAYM
	OTPAYMOS OTPAYMOSTXT	
C5. [I show the total payment as TOTLPAYM / I show the payment as undetermined. / I show the payment as TOTLPAYM , although one or more payments is missing] Is that correct?	YES=1, NO=2	
IF NO, CORRECT ENTRIES ABOVE AS NEEDED.		

PROGRAMMER NOTES

When a user answers MoreSources_1 ("Any more payments") as "No", and one or more entries among PATPAYM, CAREPAYM, AIDPAYM, PINSPAYM, VAPAYM, CHAMPAYM, WORKPAYM equals DK, RF administer a soft check message: "One or more payments was recorded as Don't Know or Refused. Please review and correct if needed, or suppress and continue."

2019 UPDATE: Each C4 item a-g (PATPAYM to WORKPAYM) appears on its own screen, along with the entire C4 question text and DCS instructions. Each screen has the word "SOURCE:" before the source (Medicare, Private Insurance, etc.) being asked about on a given screen. The differences among screens is only the source being asked about.

Require an entry in each source of payment (SOP) field PATPAYM to WORKPAYM. Require an entry in OTHRPAYM if MoreSources = 1. The following are allowed entries: 0, integer, integer with 2 decimal places, DK, REF.

In the summary of charges that displays on screen C5, "I show the total payment as [TOTLPAYM]" distinguish different types of reserve codes, by displaying phrases "Don't Know" or "Refused" instead of the generic word "missing."

If there is even one reserve code entered in the SOP fields, then end the currently displayed phrase with "...although one or more payments are missing." Do not cite "total." For example:

"I show the payment as \$30, although one or more payments is missing. Is that correct?"

"I show the payment as zero, although one or more payments is missing. Is that correct?"

TOTLPAYM counts entries of DK or REF in the individual SOPs as "0".

This variable that is recorded on screen C5 is called TOTLPAYMOK, it saves values of Yes or No. It is a critical item.

FILL INSTRUCTIONS:

1. All SOP >=0 (e.g., 0, integer dollars, dollars + cents)

- a. Text: I show the total payment as TOTLPAYM.
- 2. All SOP <0 (e.g., DK, REF, whose numeric values are -1, -2)

- a. Text: I show the total payment as undetermined.

- 3. Mixed entries (e.g., a zero or dollar amount along with one or more DK/REF)

- a. Text: I show the payment as TOTLPAYM, although one or more payments is missing.

Even if all the individual payments recorded in C4 are DK or REF and the value of TOTLPAYM=0, then we collect either

- 1. Reasons for payment < > charges (e.g., PLC1 and the appropriate screens for C6)
- 2. Confirmation that payment = charge (C5a).

If a particular SOP was coded as "Don't Know" or "Refused" then display the appropriate phrase instead of the generic word "missing."

(VISIT DATE) should fill with ENC_DATE from B1.

C4 - [SYSTEM WILL SET UP "SOMETHING ELSE" AS A LOOP, SO NO LIMIT REQUIRED]

C4 – (this visit/these visits) - If B2a=YES fill: "these visits" ELSE fill: "this visit".

C4h - The OTPAYMOSTXT variable was added to record free-form text for the "Other, Specify" option. Interviewers will be able to record responses in the text box that do not occur in the listed options. Field = 50 characters.

C4h is a question loop that will require:

- (1) A HISTORY BOX to display responses already collected.
- (2) A question to appear after each iteration of the question that reads: Any more sources? YES=1 NO=2
- (3) The "something else" option should be set up so a response can be selected from among response options, or entered in as text.

C4h – Include the following options for the "Other Specify";

- Auto or Accident Insurance
- Indian Health Service
- State Public Mental Plan
- State/County/Local program
- Other

C5 – System should compute and display total payments from preceding charges reported in fields \$PATPAYM# through \$OTHRPAYM. The dollars total is referred to in spec as \$TOTLPAYM and will be a fill in the C5 question. The answer for the user is Yes or No. However if the user answers "No" then a hard check error message should be administered, "IF INCORRECT, CORRECT ENTRIES AS NEEDED" and return user to previous screen.

C4 - DK/REF – CONTINUE TO C5

C5 - DK/REF – CONTINUE TO BOX 1

DOLLAR AMOUNTS SHOULD BE FORMATTED TO INCLUDE COMMAS and DECIMAL POINTS

Design Note #1 for C5

C5.

CHARGES

Services charge: CPT-4 CODE: [MCPT_1] / DESC: [MCPTDS_1] charge = \$[MCPTCH_1]

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Services charge: CPT-4 CODE: [MCPT_N] / DESC: [MCPTDS_N] charge = \$[MCPTCH_N]

PAYMENTS

Patient or family	[\$PATPAYM]
Medicare	[\$CAREPAYM]
Medicaid	[\$AIDPAYM]
Private insurance	[\$PINSPAYM]
ChampVA/VA	[\$VAPAYM]
TRICARE	[\$CHAMPAYM]
Workers comp	[\$WORKPAYM]
Other	[\$OTHRPAYM_1]
Other	[\$OTHRPAYM_2]
.	
.	
.	
Other	[\$OTHRPAYM_N]

[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?

EDIT SPECS FROM WESTAT

DATA ITEM	SPECIFICATIONS	ACTION, if specification not met
<p>QC4 -Payment sources/amounts</p> <p>CRITICAL ITEM is source of payments plus Total Payments.</p> <p>The amount of Individual Payments is not a critical item.</p> <p>See QC4 – QC6 Consistency notes on page 3-9.</p>	Must be completed if Reimbursement Type = Fee-For-Service.	Blue Sheet , if blank.
	Every source of payment must have an amount, either \$0.00 or greater than \$0.00.	Enter \$0.00 for blank sources if Total Payments is given and sum of other Individual Payments equals the Total.
		Blue Sheet for blank Individual Payment if Total Payments is missing, or if sum of other sources does not equal Total.
	DK or RF are acceptable.	Change DK to –8. Change RF to – 7.
	If OTHER is answered, there must be an answer on the SPECIFY line.	Blue Sheet if missing.
		If the answer is written outside of the answer line, circle the answer.
	Answer on the SPECIFY line needs review. Sometimes the answer is written outside the line, as a comment.	If the answer is written outside of the Specify line, and it is on the Decision Log, circle the answer to indicate that it should be Caded. Yellow Sheet if it is not on the Decision Log.
	“HMO” is not acceptable as a SPECIFY answer. “Public” is not acceptable as a SPECIFY answer. The name of an insurance co. is not acceptable as a SPECIFY answer. Note: the same insurance company may provide private insurance and also administer Medicare and/or Medicaid payments.	Blue sheet , asking which type of insurance. Note: the same insurance company can provide private insurance and also administer Medicare and/or Medicaid payments.
	Expect that an answer on line h OTHER/SPECIFY will have a comparable answer in QC6 line h. For example, STATE PROGRAM in QC4 will have STATE PROGRAM ADJUSTMENT in QC6. Exceptions: Provider w/o or small bal adj in QC6 will not have a comparable answer in QC4. If there is no payment in QC4 line h, there may still be an adjustment in QC6.	Yellow Sheet if there is not a comparable answer in both questions.
	Adjustments and write-offs should not be included in payments.	Blue Sheet if comments or answer to line (h) indicate that adjustments or write-offs have been included.
	If payment by patient is \$1.00 or less, expect that the insurance type will be a public type – Medicare, Medicaid, state program, etc.	Yellow Sheet if the insurance is not government insurance.
	If a payment is made by VA, expect that the answer to QC6 will be Eligible Veteran or an OTHER/SPECIFY answer that will reflect military service.	Yellow Sheet.
	Comments may need review.	Compare comments about sources to the answers given in C4. Yellow Sheet if comments don't agree with the answer to QC4. Yellow Sheet all comments that are not included in the answer to QC4.
Payments by three or more insurance types need managerial review.	Look at the payment sources in all books for a patient. Yellow Sheet , if three or more insurance types.	
Lump payments need special handling.	See Lump payment instruction sheet, on page 24.	
	Total Payments cannot be blank.	Blue Sheet , if it can't be determined.

<p>QC5- Total Payments</p> <p>CRITICAL ITEM is source of payments plus Total Payments.</p>		If blank and all Individual Payments are filled in with a value or with \$0.00, fill in the Total Payments.
	<p>Calculator tape should be run to verify Total if there are multiple payments. Do not use the TRC's tape.</p>	<p>Run calculator tape or review tape if run by Editing assemblers. If tape doesn't match book, write NOT OK. If tape matches book, write OK. Initial tape.</p>
	<p>Total Payments should equal sum of Individual Payments.</p>	<p>Review calculator tape. Initial tape, compare to Total.</p> <p>If there is only one payment and it doesn't agree with Total, Blue Sheet.</p>
	<p>If the Total Payments written by the TRC is less than sum of the Individual Payments, a correction can be made if the difference is 10% or less.</p> <p>Compare the amount of the difference and the Total Payment as written by the TRC.</p> <p>Note that changes can affect the answers to Box 1 and QC6.</p>	<p>If the difference is 10% or less than the Total, correct the Total Payment.</p> <p>Blue Sheet, if the difference is greater than 10%.</p> <p>Change Box 1 to the appropriate answer.</p> <p>Blue Sheet, if QC6 was skipped, but now must be answered.</p>
	<p>If the Total Payments written by the TRC are <u>greater than</u> the sum of the Individual Payments, the TRC must make any corrections.</p>	<p>Blue Sheet, asking if we are missing a payment or service.</p>
	<p>DK or RF is an acceptable answer.</p>	<p>Change DK to – 8; Change RF to – 7. Code PL-IV as 60, critical item missing.</p>
	<p>Booklets with DK or RF for Procedures and Charges and Payments need special review.</p>	<p>Yellow Sheet if all three fields are DK or RF.</p>
	<p>Total Payments greater than Total Charge need managerial review.</p>	<p>Yellow Sheet all overpayments.</p>

Decision Log for QC4

[PROGRAMMER NOTE: Include all “Problems” in a drop down menu at the other specify entry and program the required “decision” behind the scenes. May require implementing instructional boxes for the DCS/abstractor. For example, if the DCS selects “vocational rehabilitation” an instruction box should pop up asking the DCS to probe for source of funding: federal, state, county, other gov't, private, etc.]

Problem	Decision / Categorization
State (or Federal, or County, or City) Plan ---- Plan may be Fund, Program, Grant ----- type of plan may be given ----- REMOVE Name of State if it is present	Code by indicating source of funds, then type of plan if given If program isn't also mentioned in QC6, Yellow Sheet, unless total charges = total payment
Examples:	
Nevada State Disability (SRS)	Code in 'Other' as State Disability
State Breast Cancer Program	Code in 'Other' as State Breast Cancer Program
Maryland Indigent Program	Code in 'Other' as State Indigent Program
Federal Grant	Code in 'Other' as Federal Grant
Cook County Indigent Fund	Code in 'Other' as County Indigent Fund
State Program	Code in 'Other' as State Program
Comment indicates one of the above, but it is not indicated in QC4 (line h)	Yellow Sheet
Comment indicates the name of an insurance company for QC4.	Ignore the name of an insurance company if we have the type of insurance payer.
QC4 (line h) 'Specify' answer is name of an insurance company	Blue Sheet to determine source of funding: Federal, State, County, Other gov't, Private etc
Children's Special Services	Blue Sheet to determine source of funding: Federal, State, County, Other gov't, Private etc
Vocational Rehabilitation	Blue Sheet to determine source of funding: Federal, State, County, Other gov't,

	Private etc
Welfare	Blue Sheet to determine source of funding: Federal, State, County, Other gov't, Private etc
Hospital	Yellow Sheet
Grant	Blue Sheet to determine source of funding: Federal, State, County, Other gov't, Private etc
Grant - DK who is funding it	Code in 'Other' as GRANT - DK FUNDING
Breast Cancer Program	Blue Sheet to determine source of funding: Federal, State, County, Other gov't, Private etc
Indigent Program or Fund for Indigents	Blue Sheet to determine source of funding: Federal, State, County, Other gov't, Private etc
Local	Blue Sheet to determine who is funding it , I.e. State, County, City, Other gov't, etc
MediCal (in California)	Code as Medicaid (C4c)
Employer	Yellow Sheet
Verbiage about car/auto accident paid or auto/car insurance paid	Code in Other as Auto Insurance
Military	Blue Sheet for more specific information
Indian Health	Code in Other as Indian Health Service
CHDP; CHIP	Accept, but cross out any state or county name
WIC	Accept, but cross out any state or county name
AARP (American Association of Retired Persons)	Code as Private Insurance (QC4d)
Prepaid Mental Health Plan - State Plan	Code In Other as State Public Mental
HMO	Blue Sheet to find out Insurance Type: Medicare, Medicaid, Priv Ins., Other; Ask for source of payment.

LUMP SUM – PENDING FURTHER RTI DISCUSSION

DATA ITEM	SPECIFICATIONS	ACTION, if specification not met
QC4 – QC5 LUMP SUM INFORMATION	<p>The DCS supplies information needed to process the lump. This is usually in the form of a label on page 2 of the first book of a lump.</p> <p>Information supplied by the DCS should include: Book numbers that are included in the lump Total Charge of those books Total Payments of the lump Sources of Payments and payment by each source</p>	Blue Sheet , if info is missing.
		Run calculator tape of charges in all books of the lump to verify Total Charge. Staple and initial tape.
		Blue Sheet if calculator tape doesn't match info written by TRC.
		Total Payments are not necessary if the Individual Payments are given.
		If source of payment is not given, it may be possible to determine it by QC4.
		If it can't be determined, Blue Sheet .
	Repeat visits charges may be involved in the lump in books # 6 and higher.	Check for repeat visits when adding charges. Each repeat visit will have the same charge as QB5b in the booklet where the repeat visit is listed. It should be part of the Total Charge.
	The Lump Payment information needs to be flagged for the Receipt Staff.	Place a Post-It note on the outer edge of the first page of the lump. Write "LUMP" and the books involved.
		Place a neon-green LUMP sticker on the front cover of the case above the bottom line of the grid.
		If space permits, write the name of the patient and the books in the lump on the green sticker.

QC4 – QC5 LUMP SUM INFORMATION	QC6 should be the same in all books of the lump.	<p>Blue Sheet, if answers are given but are not consistent.</p> <p>If all books are blank, Blue Sheet.</p> <p>If answered in the first book of the lump, but missing from the subsequent books of the lump, transfer the answer to all books of the lump.</p>
	<p>Box 1 should be the same in all books of the lump.</p> <p>If total lump charges = total lump payments, then Box 1 should be answered 1 in all books of the lump.</p> <p>If total lump charges don't equal total lump payments, then Box 1 should be answered 2 (NO) in all books of the lump.</p>	<p>Answer if blank.</p> <p>Correct Box 1 if wrong. This may change the skip pattern. Review QC6, if necessary.</p>
	<p>If lump payments = lump charges, and there is only one source of payments, the lump won't have to go for computer calculation.</p>	<p>Enter the payment amount equal to the charges on the line for the payment source, and on the line for Total Payments.</p> <p>If there is more than one payer, the lump will have to be processed in the usual way.</p>

BOX 1

DO TOTAL PAYMENTS EQUAL TOTAL CHARGES?

If totChrgFlag = 1 and totPayFlag = 1 (*This means no reserve codes were used for any charge and payment variables*)

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 - 3 (GO TO ADJEXTRA)

IF totChrgFlag =2 AND totPayFlag =2 (*This means only reserve codes were used for charge and payment variables – no values recorded*) –

-GO TO PLC1 (*payments less than charges discrepancy questions*)

IF totChrgFlag =2 AND totPayFlag =3 (*This means only reserve codes were used for charges and a mix of values and reserve codes was used for payment variables*)

- GO TO PLC1 (*payments less than charges discrepancy questions*)

IF totChrgFlag =3 AND totPayFlag =2 (*This means a mix of values and reserve codes were used for charges and only reserve codes were used for payment variables*)

- GO TO PLC1 (*payments less than charges discrepancy questions*)

IF totChrgFlag =3 AND totPayFlag =3 (*This means there is a mix of values and reserve codes for charge and payment variables*)

- GO TO PLC1 (*payments less than charges discrepancy questions*)

IF totChrgFlag =1 AND totPayFlag =2 OR totPayFlag =3, AND TOTLPAYM < TOTLCHRG (*This means, if we have all the charges, but the payments are either all reserve codes, or have at least 1 reserve code, and the total payment is less than the total charge*)

- GO TO PLC1 (*payments less than charges discrepancy questions*)

IF totChrgFlag =1 AND totPayFlag =3, AND TOTLPAYM > TOTLCHRG (*This means, if we have all the charges, and the payments have at least 1 reserve code, BUT the total payment is MORE than the total charge*)

- GO TO ADJEXTRA (*payments more than charges discrepancy questions*)

[PROGRAM BEHIND THE SCENES – SHOULD NOT APPEAR ON SCREEN. VARIABLE NAME=CPAYBOX]

PROGRAMMER NOTES

DESCRIPTION OF PROGRAMMING REQUIRED FOR BOX 1

IF C2=C5 AND ONLY C4 OPTION WITH A RESPONSE IS 'a' (patient or patient's family - PATPAYM), GO TO BOX 2.

IF C2=C5 AND C4 OPTIONS b, c, d, e, f, g, or h HAVE A RESPONSE, GO TO C5a.

IF C2≠C5, GO TO C6.

IF C2 OR C5 = DK/REF, GO TO BOX 2, ELSE FOLLOW INSTRUCTIONS FOR BOX 1

EDIT SPECS FROM WESTAT

<p>BOX 1 – Total Payments = Total Charges or not</p>	<p>1 (YES), 2 (YES) or 3 (NO) must be circled.</p>	<p>Compare Total Charge to Total Payments.</p>
	<p>DK or RF is not acceptable.</p>	<p>Circle 3 (NO). Blue Sheet for answer to QC6, if skipped.</p>

	<p>If 1 (YES) or 2 (YES) is circled, there should be equal dollar values greater than \$0.00. If Total Charge and Total Payments are \$0.00, DK or RF, they are not equal. QC6 must be answered.</p>	<p>If Total Charges and Total Payments are \$0.00, Yellow Sheet for Total Charges = \$0.00.</p> <p>Change DK or RF to 3 (NO). Answer QC6 as – 8 (DK).</p>
	<p>Cannot be blank.</p>	<p>If blank, circle the correct answer.</p> <ul style="list-style-type: none"> • Compare Total Payments to Total Charges. • Look at the Source of Payments.
	<p>Should be consistent with Total Charges, Total Payments, and Source of Payments.</p>	<p>If answered 1 and it should be 2 or 3, change to the correct answer.</p> <p>If answered 3, and should be 1 or 2, change to the correct answer.</p> <p>An answer changed to 2 will follow the skip pattern to QC5a. If that is blank, write a Blue Sheet.</p>

	<p>The skip pattern to QC5a cannot be lost. QC5a is flagged to record the number of times it is answered.</p> <p>QC5a sends the DCS back to QC4 to look at the payments again. Changes to QC4 will NOT generate a change in Box 1.</p>	<p>Do NOT change the answer 2 (YES) to another answer, even if it is now no longer consistent with QC4 or QC5.</p>
	<p>Comments may need special review.</p>	<p>Yellow Sheet.</p>
	<p>FOLLOW THE SKIP PATTERN</p>	

SECTION 8 – VERIFICATION OF PAYMENT

[Page 9 – VERIFICATION OF PAYMENT (1 of 1)]

SCREEN LAYOUT

EQPAYOK 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 =2
NO =2

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

PROGRAMMER NOTES

[IF EQPAYOK=1 GO TO BOX 2, IF EQPAYOK=2 DISPLAY HARD CHECK: "IF INCORRECT, RETURN TO C4 AND CORRECT PAYMENT ENTRIES AS NEEDED."]

payment(s) - If C4 has one response fill: " " ELSE fill: "s".

charge(s) - If B5b has one response fill: " " ELSE fill: "s".

AMOUNT(S) – If C4 has one response fill: " " ELSE fill: "s".

DK/REF – CODE AS 2 (NO) FIRST TIME THROUGH (GOES BACK TO C4), IF NOTHING CHANGES AND END UP BACK AT C5a, GO TO BOX 2.

EDIT SPECS FROM WESTAT

DATA ITEM	SPECIFICATIONS	ACTION, if specification not met
QC5a Verification of 100% payments by Other sources.	QC5a asks the DCS to verify a 100% Total Payment when at least one source of the payment is an insurance program other than the patient. The skip pattern of Box 1 jumps over this question, unless Box 1 is answered 2.	If QC5a is blank, and Box 1 is 2 (YES, other payer), Blue Sheet for an answer to QC5a. If QC5a is answered, and Box 1 is answered 1 or 3, cross out the answer.

SECTION 9 – PAYMENTS LESS THAN CHARGES (new section, UNDERPAYMENT)

[Page 10 – SOURCES OF PAYMENT (1 of 1)]

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 | DISADJ |
| b. You are expecting additional payment | YES=1 NO=2 | MOREPAY |
| c. This was charity care or sliding scale | YES=1 NO=2 | SLIDSCA2 |
| d. This was bad debt | YES=1 NO=2 | BADDEB2 |
| e. Person is an eligible veteran | YES=1 NO=2 | ELIGVET2 |

PROGRAMMER NOTE:

2020 UPDATE: If MOREPAY = 1 and BADDEB2 = 1, display a soft check after BADDEB2 that reads: "YOU HAVE INDICATED EXPECTING ADDITIONAL PAYMENT AND BAD DEBT AS REASONS PAYMENTS ARE LESS THAN CHARGES. PLEASE CONFIRM WITH THE POC BY ASKING: **"If the patient or other payer were to try to make a payment on this bill, would you be able to accept it?"** IF YES = Expecting Additional Payment from Patient. IF NO = Bad Debt. IF POC INDICATES BOTH ARE YES, SUPPRESS AND CONTINUE."

2016 UPDATE: Create a new Section with single form called UNDERPAYMENT to contain DISADJ, MOREPAY, SLIDSCA2, BADDEB2, and ELIGVET2, spec'd above as PLC1a-d.

ELIGVET2 – allow DK/REF

If MOREPAY=1 then show C6_additional.

If [DISADJ=1 and MOREPAY=1] or [DISADJ=2 and MOREPAY=2 and SLIDSCA2=2 and BADDEB2=2] then show C6_additional.

2019 UPDATE: Each PLC1 item a-e (DISADJ to ELIGVET2) appears on its own screen, along with the entire PLC1 question text. The differences among screens is only the reason payments are less than charges being asked about.

ELIGVET2: Display onscreen instruction: "DCS: IF THE POC IS CONFUSED BY THE QUESTION, ANSWER THE QUESTION 'NO'."

SECTION 10 – DIFFERENCE BETWEEN PAYMENTS AND CHARGES

[Page 11 –DIFFERENCE BETWEEN PAYMENTS
AND CHARGES (1 of 1)]

SCREEN LAYOUT

C6_Additional, Question C6_additional

Expecting additional payment

Are you expecting additional payment from:	i. Patient or Patient's Family?	YES=1, NO=2	EPAYPAT
	j. Medicare?	YES=1, NO=2	EPAYCAR
	k. Medicaid?	YES=1, NO=2	EPAYAID
	l. Private Insurance?	YES=1, NO=2	EPAYPINS
	m. VA/ChampVA?	YES=1, NO=2	EPAYVA
	n. Tricare?	YES=1, NO=2	EPAYCHAM
	o. Worker's Comp?	YES=1, NO=2	EPAYWORK
	p. Something else?	YES=1, NO=2	EPAYOTH
	IF SOMETHING ELSE: What was that?		EPAYOTOS EPAYOTOSTXT

ADJEXTRA

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

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

YES=1, NO=2

PROGRAMMER NOTES

2016 UPDATE:

At C6_Additional

If Additional pymt expected (MOREPAY) selected as a reason at PLC1, require a selection (1,DK,RF) at C6_Additional. If all are 2, administer a hardcheck. If Sliding Scale and Bad Debt options are shown, include them in the check, otherwise, exclude them.

```
if ( [MOREPAY] == "1" && [EPAYPAT] == "2" && [EPAYCAR] == "2" && [EPAYAID] == "2" && [EPAYPINS] == "2" && [EPAYVA] == "2" && [EPAYCHAM] == "2" && [EPAYWORK] == "2" && [EPAYOTH] == "2" && ([SHOW_SLIDSCA] == "No" || [SLIDSCA] == "2") && ([SHOW_BADDEB] == "No" || [BADDEB] == "2" ) )  
HardCheck("ADDITIONAL PAYMENT UNSPECIFIED: You must select at least one reason for underpayment.");
```

```
if ( [MOREPAY] == "1" && [EPAYPAT] == "2" && [EPAYCAR] == "2" &&
[EPAYAID] == "2" && [EPAYPINS] == "2" && [EPAYVA] == "2" &&
[EPAYCHAM] == "2" &&
[EPAYWORK] == "2" && [EPAYOTH] == "2" ) )
HardCheck("ADDITIONAL PAYMENT UNSPECIFIED: You must select at
least one reason for underpayment.");
```

```
if ( [MOREPAY] == "1" && [EPAYPAT] == "2" && [EPAYCAR] == "2" &&
[EPAYAID] == "2" && [EPAYPINS] == "2" && [EPAYVA] == "2" &&
[EPAYCHAM] == "2" &&
[EPAYWORK] == "2" && [EPAYOTH] == "2" ) )
HardCheck("ADDITIONAL PAYMENT UNSPECIFIED: You must select at
least one reason for underpayment.");
```

```
if ( [ELIGVET2] == "2" && [EPAYPAT] == "2" && [EPAYCAR] == "2" &&
[EPAYAID] == "2" && [EPAYPINS] == "2" && [EPAYVA] == "2" &&
[EPAYCHAM] == "2" &&
[EPAYWORK] == "2" && [EPAYOTH] == "2" ) )
HardCheck("PAYMENT UNSPECIFIED: You must select at least one reason
for underpayment.");
```

(VISIT DATE) should fill with ENC_DATE from B1.

After C6 - [GO TO BOX 2]

(less than/more than) - If C5 < C2 fill: "less than", else if C5 > C2 fill: "more than".

DK/REF – GO TO BOX 2

IF C5 < C2 then show C6 Adjustments or Discount response options a-h, and C6 Expecting additional payment options i-p. If C5 > C2 then show C6 Payments more than charges.

DO NOT SHOW Q6_Exceeded if any selection on form UNDERPAYMENT (e.g., any entry of 1 or “YES”)

C6h, C6p, C6v should each be set up as a question loop that will require:

- (1) A HISTORY BOX to display responses already collected.
- (2) A question to appear after each iteration of the question that reads: Any more expected payments? YES=1 NO=2
- (3) The “something else” option should be set up so a response can be selected from a list, or entered in as text. Allow up to 50 characters text entry.

C6p - EPAYOTOSTXT variable was added to record free-form text for the “Other, Specify” options. Interviewers will be able to record responses in the text box that do not occur in the listed options. DCS instruction onscreen for EPAYOTOSTXT reads “PLEASE SPECIFY OTHER.” EPAYOTOSTXT field is 50 characters.

C6p – Include the following options in listed options for the “Other Specify”;

- Auto or Accident Insurance
- Indian Health Service
- State Public Mental Plan
- State/County/Local Program

Other

ALSO ALLOW SYSTEM TO PULL UP NAME OF SOURCE SPECIFIED IN C4H.

2019 UPDATE: Each C6_additional item i-p (EPAYPAT to EPAYOTH) appears on its own screen, along with the entire C6_additional question text. The differences among screens is only the source of additional expected payment being asked about.

2019 UPDATE: IF PLC1 ITEMS DISADJ, MOREPAY, SLIDSCA2, BADDEB2, AND ELIGVET2 ALL = 2, AND C6_ADDITIONAL ITEMS EPAYPAT, EPAYCAR, EPAYAID, EPAYPINS, EPAYVA, EPAYCHAM, EPAYWORK, AND EPAYOTH ALL =2, DISPLAY HARDCHECK: "YOU MUST SELECT AT LEAST ONE REASON PAYMENTS ARE LESS THAN CHARGES. RETURN TO PLC1 ITEMS AND/OR C6_ADDITIONAL ITEMS AND SELECT THE REASON(S)."

2019 UPDATE: IF ADJEXTRA = 2, DISPLAY A HARD CHECK: "IF THE ANSWER IS 'NO,' PLEASE GO BACK TO C5 (VERIFY TOTAL PAYMENTS) TO RECONFIRM CHARGES AND PAYMENTS AS NEEDED."

EDIT SPECS FROM WESTAT

DATA ITEM	SPECIFICATIONS	ACTION, if specification not met
<p>QC6 a – r Reason for PAYMENTS LESS THAN CHARGES</p> <p>See QC4-QC6 CONSISTENCY notes below.</p>	If payments are less than charges, there must be a YES (1) answer on lines a – r.	Blue Sheet , if there is no YES answer, and payments are less than charges.
	The answer must be consistent with the source of payments on QC4.	Check the answer with the QC4 – QC6 CONSISTENCY reference sheet below labeled “QC4 and QC6 Consistency Notes”.
	YES (1) or NO (2) must be circled for each choice. Since YES (1) may be answered for more than one choice, only the TRC can answer NO (2).	Blue Sheet if missing for any choice. Blue Sheet if both YES (1) and NO (2) are circled for a choice.
	Since more than one answer can be YES, only the TRC can write NO for an answer if payments are less than charges.	Blue Sheet if only YES answer is circled, and NO answers are blank, and the payments are less than charges. Let the TRC fill in the NO answers.
	If there is a YES answer in PAYMENTS MORE THAN CHARGES section, all choices in the PAYMENTS LESS THAN CHARGES SECTION should be NO (2).	Blue Sheet if there is a YES answer in both PAYMENTS LESS and PAYMENTS MORE sections. Circle NO (2) for all answers in the PAYMENTS LESS section, if all answers are blank and there is a YES (1) answer in the PAYMENTS MORE section.
	If OTHER is answered, there must be an answer on the SPECIFY line (QC6 line h or line p). Sometimes the answer is written outside the line, as a comment.	Check Decision log for all Specify answers. If it is on the Decision log, follow directions given there. If the answer is not there, Yellow Sheet .
	Answer on the SPECIFY line (QC6 line h or line p) needs review.	Blue Sheet if Specify answer is missing. If the answer is written outside of the Specify line, circle the answer if it is on the Decision Log to indicate that it should be Caded. Yellow Sheet if it is not on the Decision Log.
<p>DATA ITEM QC6 a – r Reason for PAYMENTS LESS THAN CHARGES</p> <p>See QC4-QC6 CONSISTENCY notes QC6 a – r Reason for PAYMENTS LESS THAN CHARGES</p> <p>See QC4-QC6 CONSISTENCY notes</p>	QC6 line h answers should also be reflected in QC4 unless total pay was \$0.00. State program paid; State program adj. Exceptions: Provider w/o or sm ball adj	Yellow Sheet .
	Provider write-off and Small balance write-off are acceptable answers on line h.	Accept.
	Courtesy Discount (line d) may need review.	If the only payer is an insurance, Yellow Sheet .
	If there are three insurance types, managerial review is needed.	If the sources of payment include three or more insurance types, Yellow Sheet . This may be indicated by the answers to QC4 and QC6 in all books for a patient.
	Adjustments are acceptable with no payment from that source in QC4.	Accept, unless it looks like wrong answer was circled. For example, QC4 says Medicare paid \$0.00; QC6 says Medicare adjustment or limit.
	Comments may need review.	Check the Decision Log. Follow instructions. It may be permissible to move the comment to QC6 (line h or p).
	If Comments say “in collections” expect that the answer to QC6 will be Expecting Patient Payment or Bad Debt.	Accept if QC6 is answered “Expecting Payment from Patient” and/or “Bad Debt.” Otherwise, Yellow Sheet .
	Books should be compared for consistency.	“In collections” cannot be an answer on the Specify line. If “Expecting Payment from Patient” and/or “Bad Debt” answers are given, cross out “in collections” and change line p to 2 (NO). If these are not answered, Yellow Sheet . Review all books for a patient. It is not necessary for books to be identical, but if it looks like the wrong answer was given in a book, Blue Sheet .

	There should not be an adjustment in the expecting payments section (line p).	Blue Sheet if the answer to this question is not a payer source.
<p>QC6 s – v Reason for PAYMENTS MORE THAN CHARGES</p> <p>See QC4-QC6 CONSISTENCY notes</p>	OVERPAYMENTS NEED REVIEW	Yellow Sheet.
	If payments are more than charges, there must be a YES (1) answer on lines s-v	Blue Sheet.
	More than one YES answer is acceptable.	Blue Sheet if the NO answers are missing and payment is more than charges.
	The answer must be consistent with the source of payments on QC4.	Check the answer with the QC4 – QC6 CONSISTENCY notes on page 3-9, or on page 4-28.
	YES (1) or NO (2) must be circled for each choice. Since YES (1) may be answered for more than one choice, only the TRC can answer NO (2).	Blue Sheet if missing and payment is less than charge.
		Blue Sheet if only YES answer is circled, and the NO answers are blank, if payments are more than charges. Let the TRC fill in the NO answers.
	If there is a YES answer in PAYMENTS LESS THAN CHARGES section, all choices in the PAYMENTS MORE THAN CHARGES SECTION should be NO (2). Review the payments and charges. Are payments less or more than charges?	Blue Sheet if there is a YES answer in both PAYMENTS LESS and PAYMENTS MORE sections. If Payments are Less than Charges, <u>and</u> answers in the PAYMENTS MORE section are all blank, <u>and</u> there is a YES (1) answer in the PAYMENTS LESS section, Circle NO (2) for all answers in the PAYMENTS MORE section.
	If OTHER is answered, there must be an answer on the SPECIFY line (QC6 line v). Sometimes the answer is written outside the line, as a comment.	Check Decision log for all Specify answers. If it is on the Decision log, follow directions given there. If the answer is not there, Yellow Sheet.
	Answer on the SPECIFY line (QC6 line v) needs review.	Blue Sheet if Specify answer is missing. If the answer is written outside of the Specify line, and it is on the Decision Log, circle the answer to indicate that it should be Caded. Yellow Sheet if it is not on the Decision Log.
	If there are three insurance types, review is needed.	If the sources of payment include three or more insurance types, Yellow Sheet. This may be indicated by the answers to QC4 and QC6 in all books, looked at together.
OTHER/SPECIFY answers in QC6 line v should be reflected in an OTHER/SPECIFY answer in QC4. State program paid; State program adj	Yellow Sheet.	

QC4 AND QC6 CONSISTENCY NOTES

PAYER IN QC4	ANSWER TO QC6
Medicare	<p>Accept any of these alone: Medicare Adjustment, Contractual Arrangement, Expecting Payment from any source, Charity, or Bad Debt.</p> <p>Accept Medicare Adjustment plus any of the following: Medicaid Adjustment, Contractual Arrangement, Courtesy Discount, Expecting Payment from any source, Charity or Bad Debt.</p> <p>If Insurance Write-Off is answered, Yellow Sheet.</p> <p>If the only answer is an adjustment or limit or arrangement other than Medicare, look for an indication* that this other source is involved. If no indication, Blue Sheet.</p>

Medicaid	<p>Accept any of these alone: Medicaid Adjustment; Expecting Payment from any source, Charity, or Bad Debt.</p> <p>Accept Medicaid Adjustment plus any of the following: Medicare Adjustment, Contractual Arrangement, Courtesy Discount, Expecting Payment from any source, Charity or Bad Debt.</p> <p>If Insurance Write-Off is answered, Yellow Sheet.</p> <p>If the only answer is any adjustment or limit or arrangement other than Medicaid, look for an indication* that the other source is involved. If no indication, Blue Sheet.</p>
Private Insurance	<p>Accept any of these alone: Contractual Arrangement; Expecting Payment from any source, Charity, or Bad Debt.</p> <p>Accept Contractual Arrangement plus any of the following: Medicare Adjustment, Medicaid Adjustment, insurance w/o, Courtesy Discount, Expecting from any source, Charity or Bad Debt.</p> <p>If only answer is any adjustment or limit other than Private Insurance, look for indication* that the other source is involved. If no indication, Blue Sheet.</p>
TRICARE, Champus, ChampVA	<p>Accept anything that is acceptable for Private Insurance, and/or accept Eligible Veteran or OTHER/SPECIFY: Tricare Adjustment or Champus Adjustment.</p> <p>May be the primary insurance or secondary to other kinds of insurance.</p>
VA or Indian Health	<p>Usually says "ELIGIBLE VETERAN" or OTHER/SPECIFY: "ELIGIBLE..." There may be no payment or payment by any source.</p> <p>If there is a payment by another source, QC6 may refer to that source, either alone or in addition to Eligible Veteran (or Other/Specify "Eligible..." answer.</p> <p>If Insurance Write-Off is answered, Yellow Sheet.</p> <p>Accept Courtesy Discount, Charity and Bad Debt in addition to "Eligible..." or other insurance adjustment.</p>
Workers' Comp	<p>Should say "Workers' Comp Adjustment." If missing, Blue Sheet.</p> <p>Accept Courtesy Discount, Charity and Bad Debt in addition to Workers' Comp Adjustment.</p> <p>If Insurance Write-Off is answered, Yellow Sheet.</p> <p>Expect that no other insurance will be involved. If Workers' Comp is given with any other insurance, Yellow Sheet.</p>

*Look for INDICATIONS OF ADDITIONAL SOURCES OF PAYMENT in:

- QC4 (payers) in other books
- Comments
- Expecting Payment section

Additional instruction copied and pasted from Westat's hardcopy edit manual for OB.

QC4 AND QC6 "OTHER/SPECIFY"

Answers in "Other/Specify" should be reflected in both QC4 and QC6.

If there is an "Other/Specify" answer in QC4 that is not also indicated in QC6, **Yellow Sheet**.

If there is no payment on QC4 (line h), cross out the Other/Specify answer on that line.

If there is an "Other/Specify" answer in QC6 that is not also indicated in QC4, **Yellow Sheet**.

Exceptions: If Other/Specify answer in QC6 is Hosp or Provider Write Off, there will not be a corresponding answer in QC4.

If Total payment = Total charges, there will not be a corresponding answer in QC6.

CHECK DECISION LOG FOR COMMENT REVIEW

Some comments should be moved to QC6 (line h) Other/Specify. Look up comments on the Decision Log.

Examples: "Insurance denied," "Medicare denied," "Billing error," "Billed late," "Procedure not covered by Medicaid"

COMPARE QUESTIONS BETWEEN BOOKS

Look for indications that the wrong answer was circled by mistake.

OTHER/SPECIFY WRITE-OFFS

OBD cases -- Accept the phrase "Provider write-off."

Hospital cases -- Accept the phrase "Hospital write-off"

Accept "Small Balance Write-off" or "Small Balance Adjustment"

COURTESY DISCOUNT

If there is only an insurance as QC4 payer, and QC6 is only Courtesy Discount, **Yellow Sheet**.

THREE OR MORE INSURANCE TYPES

Yellow Sheet.

AN ADJUSTMENT WITHOUT A PAYMENT FROM THAT SOURCE

Accept an answer that indicates an Adjustment with \$0.00 payment by that source, as long as there is no other evidence of an inconsistency.

DECISION LOG FOR QC6

[PROGRAMMER NOTE: Include all "Problems" in a drop down menu at the other specify entry and program the required "decision" behind the scenes. May require implementing instructional boxes for the DCS/abstractor. For example, if the DCS selects "insurance was never billed" an instruction box should pop up asking the DCS to probe to include type of insurance if know, such as **MEDICARE NEVER BILLED**]

Problem	Decision / Categorization
Payment Less than Charges	If instructions say to add an answer to line h or line p, change the YES/NO answer to 1 and cross out the answer 2. If instructions say to delete an answer from line h or line p, change the YES/NO answer to 2 and cross out the answer 1.
Underpayment exists in Q(C4) by a State (or Federal, or County, or City) Plan ---- Plan may be Fund, Program, Grant ----- type of plan may be given ----- REMOVE Name of State if it is present	Code in 'OTHER' as (name of source given in Q(C4h)).
Examples:	
Nevada State Disability	State Disability.
State Breast Cancer Program	State Breast Cancer Program.
Maryland Indigent Program	State Indigent Program.
Federal Grant	Federal Grant.
Cook County Indigent Fund	County Indigent Fund.
State Program	State Program.
Zero total payment in Q(C4) but comment about a State (or Federal, or County, or City) Plan ---- Plan may be Fund, Program, Grant ----- type of plan may be given ----- REMOVE Name of State if it is present	If TRC says Charity care, accept as is. otherwise Yellow Sheet
Comment says that insurance was never billed	Code in 'Other' (line h) as NEVER BILLED. Include type of insurance, if known, such as MEDICARE NEVER BILLED
Comment says Insurance denied payment.	Code in 'Other' (line h) as INSURANCE DENIED. Include type of insurance, if known, such as MEDICARE DENIED.
Comment mentions billing error.	Code in 'Other' (line h) as Billing Error. Include type of insurance if known, such as: MEDICARE DENIED: BILLING ERROR
Comment mentions untimely filing, billed late.	Code in 'Other' (line h) as Billed Late. Include type of insurance if known, such as MEDICARE DENIED: BILLED

	LATE.
Comment mentions Insurance denied, with an amount, such as Private Insurance denied \$52.50.	Code in 'Other' (line h) as INSURANCE DENIED. Include type of insurance, if known, such as PRIV INS DENIED. Do not include the amount.
Comment mentions that the insurance doesn't cover a procedure.	Code in 'Other' (line h) as INSURANCE DENIED: PROCEDURE NOT COVERED. Include type of insurance, if known, such as MEDICAID DENIED: PROCEDURE NOT COVERED.
Comment mentions that insurance doesn't cover if no pre-authorization	Code in 'Other' (line h) as INSURANCE DENIED: NO PRE-AUTHORIZATION. Include type of insurance, if known, such as TRICARE DENIED: NO PRE-AUTHORIZATION
Comment mentions nurse visit not covered	Code in 'Other' (line h) as INSURANCE DENIED: NURSE VISIT. Include type of insurance, if known, such as MEDICAID DENIED: NURSE VISIT
Comment says patient paid the deductible.	Do not code in 'Other' (line h). If there is an adjustment or limit answered, or payment is expected from any source, accept as is. If there is no adjustment or limit, or expectation of future payment, Yellow Sheet.
Comment says insurance made an adjustment.	Do not code in 'Other' (line h). If there is an adjustment or limit answered, or payment is expected from any source, accept as is. If there is no adjustment or limit, or expectation of future payment, Yellow Sheet.
Comment mentions Collection Agency or " in Collections"	Do not code in 'Other' line h or line p. Accept answers EXPECTING PATIENT PAYMENT and/or BAD DEBT. Otherwise, Yellow Sheet.
Collection Agency or "in collections" is Other/Specify answer (line h or line p)	Cross out "in collections," etc. as the 'Specify' answer (line h or line p). Accept answers EXPECTING PATIENT PAYMENT and/or BAD DEBT. Otherwise Yellow Sheet.
Small balance w/o (Small balance write off)	Code in Other as Small Balance W/O
Small balance Adj (Small balance adjustment)	Code in Other as Small balance Adj
Military	Blue Sheet for more specific information
Dependent of active duty military / Active duty military dependent	Code in 'other' as Eligible Active Duty Fam Mem
Active duty armed forces member / Active duty military	Code in 'Other' as Eligible Active Duty
Active duty family member	Code in 'Other' as Eligible Act Duty Fam Mem
Retired veteran / Retired military	Code in 'Other' as Eligible Retiree
Retired veteran's family member	Code in 'Other' as Eligible Retiree Fam Mem
Retired Military Dependent	Code in 'Other' as Eligible Retiree Fam Mem
Veteran's family member	Code in 'Other' as Eligible Veteran Fam Mem
Indian Health	Code in 'Other' as Eligible Native American
Clerical fee; administrative fee	YELLOW SHEET
Grant - DK who is funding it	Code in 'Other' as Grant - DK who is funding it.
HMO	Blue Sheet for type of insurance: Medicare, Medicaid, or Private, other
Comments say No payments due to Federal Vaccines given/ Fed gov't supplied vaccines	Code in 'Other' (line h) as Federal Vaccine Program.
Payment More than Charges	Yellow Sheet ALL OVERPAYMENTS
Tricare (or Champus) payment exceeds charges	Accept Private Insurance adjustment or, in 'OTHER', as Tricare (or Champus) Adjustment
Overpayment exists in Q(C4) by a State (or Federal, or County, or City) Plan ---- Plan may be Fund, Program, Grant ----- type of plan may be given ----- REMOVE Name of State if it is present	Code in 'OTHER' as <u>(name of source given in Q(C4h))</u> .
Examples:	
Nevada State Disability	Code in 'Other' (line v) as State Disability.
State Breast Cancer Program	Code in 'Other' as State Breast Cancer Program.
Maryland State Indigent Program	Code in 'Other' as State Indigent Program.
Federal Grant	Code in 'Other' as Federal Grant.
Cook County Indigent Fund	Code in 'Other' as County Indigent Fund.
State Program	Code in 'Other' as State Program.
Comment mentions Patient Credit, Patient	Yellow Sheet.

Overpayment; Patient has a balance	
------------------------------------	--

SECTION 11 – LUMP SUM PAYMENTS

[Page 12 – LUMP SUM PAYMENT (1 of 3)]

SCREEN LAYOUT new form “LSP_CHECK”

LSPCHECK WAS ANY LUMP SUM ASSOCIATED WITH THE SOURCES OF PAYMENT?

YES

NO

PROGRAMMING NOTE:

ELSE GO TO BOX 1 LOGICS.

IF (all source of payment fields PATPAYM to WORKPAYM and OTHRPAYM have entries of 0.00) or (TOTLPAYM is 0.00 or missing)

AND a-e = NO (DISADJ, MOREPAY, SLIDSCA2, BADDEB2, ELIGVET2) AND i-p = NO (EPAYPAT, EPAYCAR, EPAYIAD, EPAYPINS, EPAYVA, EPAYCHAM, EPAYWORK, EPAYOTH) AND (LSPCHECK=”No”) display a hard error at LSPCHECK, “PAYMENT VALIDATION FAILED: No payment source or reason(s) identified. Return to Sources of Payment or Payments NE Charges, or record Lump Sum Payment here.” This hard error will require user to correct one of those conditions or break off the event form

DK/REF: GO TO RIV1

SECTION 12 – CAPITATED BASIS

NOTE: See end of section for edit specs from Westat for questions C7a, C7b, C7c, C7d, C7e, and C7f.

[Page 15–CAPITATED BASIS (1 of 4)]

SCREEN LAYOUT

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?

- a. Medicare?
- b. Medicaid?
- c. Private Insurance?
- d. VA/ChampVA?
- e. Tricare?
- f. Worker's Comp?
- g. Something else?
IF SOMETHING ELSE:
What was that?

YES=1, NO=2 **COVCARE**
YES=1, NO=2 **COVAID**
YES=1, NO=2 **COVPINS**
YES=1, NO=2 **COVVA**
YES=1, NO=2 **COVCHAM**
YES=1, NO=2 **COVWORK**
YES=1, NO=2 **COVOTHR**

COVOTOS
COVOTOSTXT

C7b. Was there a co-payment for (this visit/these visits)? YES=1, NO=2 **ANYCOPAY**

PROGRAMMER NOTES

C7a – (this visit/these visits) - If B2a=YES fill: "these visits" ELSE fill: "this visit".

C7a(g) - The COVOTOSTXT variable was added to record free-form text for the "Other, Specify" option. Interviewers will be able to record responses in the text box that do not occur in the listed options. COVOTOSTXT field allows up to 50 characters. Screen reads: "OTHER INSURANCE PLAN..." "PLEASE SPECIFY OTHER".

C7a(g) is a question loop that will require:

- (1) A HISTORY BOX to display responses already collected.
- (2) A question to appear after each iteration of the question that reads:
Any more plans? YES=1 NO=2
- (3) The "something else" option should be set up so a response can be selected from listed options, or entered in as text.

C7a(g) – Include the following options in listed options for the "Other Specify";
Auto or Accident Insurance
Indian Health Service
State Public Mental Plan
State/County/Local program
Other

C7b – (this visit/these visits) - If B2a=YES fill: "these visits" ELSE fill: "this visit".

C7b - [IF ANYCOPAY=2 GO TO C7e]

C7a - DK/REF – CONTINUE TO C7b

C7b - DK/REF – GO TO C7e

2021 UPDATE: IF C7a a-g (COVCARE, COVAID, COVPINS, COVVA, COVCHAM, COVWORK, COVOTHR) all equal 2 (NO), display soft check:
YOU HAVE INDICATED CAPITATED PAYMENT, BUT ENTERED 'NO' FOR ALL INSURANCE TYPES. PLEASE CHECK THE RECORDS AGAIN AND/OR PROBE WITH THE POC TO DETERMINE THE INSURANCE PLAN(S) TYPE THAT COVERED THIS EVENT, AND CHANGE THE ANSWER FOR THAT ITEM. OR CLICK 'SUPPRESS' TO CONTINUE.

2019 UPDATE: Each C7a item a-g (COVCARE to COVOTHR) appears on its own screen, along with the entire C7a question text. The differences among screens is only the payer type (Medicare, Medicaid, etc.).

[Page 16–CAPITATED BASIS (2 of 4)]

SCREEN LAYOUT

C7c. How much was the co-payment?

\$COPAYAMT

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?
- b. Medicare?
- c. Medicaid?
- d. Private Insurance?
- e. Something else?
(IF SOMETHING ELSE:
What was that?)

YES=1, NO=2 **CPAYPAT**
 YES=1, NO=2 **CPAYCARE**
 YES=1, NO=2 **CPAYAID**
 YES=1, NO=2 **CPAYPINS**
 YES=1, NO=2 **CPAYOTHR**

CPAYOTOS
CPAYOTOSTXT

PROGRAMMER NOTES

C7c – If the amount of copayment is unusually high or low, administer different softchecks. Specifically, if 0 < COPAYAMT < 5 administer soft message: “You have entered a copayment under \$5.00. Press OK to continue, or Cancel to correct.” Additionally, if COPAYAMT > 200, administer soft message “You have entered a copayment over \$200.00. Press OK to continue, or Cancel to correct.”

C7c - DOLLAR AMOUNTS SHOULD BE FORMATTED TO INCLUDE COMMAS and DECIMAL POINTS

C7d(e) - The CPAYOTOSTXT variable was added to record free-form text for the “Other, Specify” option. Interviewers will be able to record responses in the text box that do not occur in the listed options.

C7d(e) is a question loop that will require:

- (1) A HISTORY BOX to display responses already collected.
- (2) A question to appear after each iteration of the question that reads:
Any more payers? YES=1 NO=2
- (3) The “something else” option should be set up so a response can be selected from listed options, or entered in as text.

C7d(e) – Include the following options in listed options for the “Other Specify”;
Auto or Accident Insurance
Indian Health Service
State Public Mental Plan
State/County/Local program
Other

C7d(e) CPAYOTOSTXT screen text: “OTHER SOURCE OF CO-PAYMENT...” “PLEASE SPECIFY OTHER”.

CPAYOTOSTXT field allows up to 50 characters.

YES=1, NO=2 **OTHPAY**

C7c - DK/REF – CONTINUE TO C7d
C7d - DK/REF – CONTINUE TO C7e

2019 UPDATE: Each C7d item a-e (CPAYPAT to CPAYOTHR) appears on its own screen, along with the entire C7d question text. The differences

SCREEN LAYOUT

C7f. From which of the following other sources has the practice 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/these visits).

RECORD PAYMENTS FROM APPLICABLE PAYERS.

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

SOURCE

- a. Patient or Patient's Family?
 - b. Medicare?
 - c. Medicaid?
 - d. Private Insurance?
 - e. VA/ChampVA?
 - f. Tricare?
 - g. Worker's Comp?
 - h. Any more sources?
(IF SOMETHING ELSE:
What was that?)
- OTHOTOS**
OTHOTOSTXT

PAYMENT AMOUNT

- \$OTHPAT**
- \$OTHCARE**
- \$OTH AID**
- \$OTH PINS**
- \$OTHVA**
- \$OTHCHAM**
- \$OTHWORK**

- \$OTHOTHR**

PROGRAMMER NOTES

C7f: Each of the fields requires a non-blank entry, as was done for C4 sources of payment. Entries of 0, DK, RF are allowed here.

(VISIT DATE) should fill with ENC_DATE from B1.

(this visit/these visits) - If B2a=YES fill: "these visits" ELSE fill: "this visit".

C7f(h) - The OTHOTOSTXT variable was added to record free-form text for the "Other, Specify" option. Interviewers will be able to record responses in the text box that do not occur in the listed options. Field allows up to 50 characters.

C7f(h) OTHOTOSTXT screen text: "OTHER PAYMENT SOURCE..." "PLEASE SPECIFY OTHER".

(h) is a question loop that will require:

- (1) A HISTORY BOX to display responses already collected.
- (2) A question to appear after each iteration of the question that reads:
Any more sources? YES=1 NO=2
- (3) The "something else" option should be set up so a response can be selected from listed options, or entered in as text.

(h) – Include the following options in listed options for the "Other Specify";
Auto or Accident Insurance
Indian Health Service
State Public Mental Plan
State/County/Local program
Other

EDIT SPECS FROM WESTAT

DATA ITEM	SPECIFICATIONS	ACTION, if specification not met
Capitated Section Completed if QC3 is Capitated (2).	Entire Capitated Section cannot be DK or RF.	Blue Sheet , to verify that Reimbursement type is Capitated.
	DK or RF is acceptable for individual answers in the Capitated Section, as long as entire section is not DK or RF.	Accept DK or RF. Change to -7 or -8. Yellow Sheet , if questionable.
QC7a – Capitated – what kind of insurance	Must be completed if Reimbursement Type in QC3 = Capitated Basis	Blue Sheet , if no answers are YES (1).
	More than one answer of YES is acceptable.	Blue Sheet , if the NO (2) answers are not circled, and there is a YES (1) answer.
	Answers should agree in all books for a pair.	Yellow Sheet , if answers differ in books for a pair.
	If SOMETHING ELSE is answered, there must be an answer on the SPECIFY line.	Blue Sheet if missing.
	Answer on the SPECIFY line needs review.	Check Decision log. If it is on the Decision log, follow directions given there. If the answer is not there, Yellow Sheet .
	“HMO,” “Public,” or the name of an insurance company is not acceptable as a SPECIFY answer.	Blue sheet , asking which type of insurance. Note: the same insurance company can provide private insurance and also administer Medicare and/or Medicaid payments. If “HMO, DK type” Yellow Sheet .
QC7b – Any Co-pay	1 or 2 circled must be circled.	If blank and there is no indication of a co-payment, circle NO (2).
QC7c - Co-payment amount	If QC7b is YES, there must be an amount.	Blue Sheet .
	Co-pay range is typically > 0 and <=\$50.	Yellow Sheet .
	Co-pay amount is typically a whole dollar number.	Yellow Sheet .
	DK or RF is acceptable.	Change DK to – 8. Change RF to – 7.
	If payment by patient is \$1.00 or less, expect that the insurance type will be a public type – Medicare, Medicaid, state program, etc.	Yellow Sheet if there is another insurance type indicated.
QC7d - Co-payment payer	If QC7b is YES, there must be a co-payer source.	Blue Sheet .
	Sources other than patient or patient’s family need review.	Yellow Sheet if source of co-pay is not patient or patient’s family.
	Answers of more than one source need review.	Yellow Sheet .
	Answer on the SPECIFY line needs review.	Check Decision log. If it is on the Decision log, follow directions given there. If the answer is not there, Yellow Sheet .
	“HMO,” “Public,” or the name of an insurance company is not acceptable as a SPECIFY answer.	Blue Sheet , asking which type of insurance. Note: the same insurance company can provide private insurance and also administer Medicare and/or Medicaid payments.
QC7e Capitated Secondary Payment?	Must be answered 1 (YES) or 2 (NO).	If blank and nothing indicates that there is a Capitated Secondary payment, Circle 2 (NO).
	Capitated Secondary Payments need review.	Yellow Sheet if YES.

QC7f – Source(s) and amount of payment for CAPITATED SECONDARY PAYMENT	If QC7e is YES (1), a payment amount must be filled in for at least one source.	Blue Sheet , if there is no amount given.
	If there is an amount, the Capitated Secondary Payment needs special review.	Yellow Sheet all Capitated Secondary Payments.
	DK or RF is acceptable.	Change DK to –8 and RF to –7; Yellow Sheet as a Capitated Secondary Payment.
	If question is not skipped (QC7e is YES), all sources of payment must have a dollar value.	If there is a dollar amount for one source, fill in \$0.00 for all the other sources. Do not leave any lines blank, unless the question is skipped (when QC7e is NO).
	Answer on the SPECIFY line (h) needs review.	Check Decision log. If it is on the Decision log, follow directions given there. If the answer is not there, Yellow Sheet .
	“HMO,” “Public,” or the name of an insurance company is not acceptable as a SPECIFY answer.	Blue Sheet , asking which type of insurance. Note: the same insurance company can provide private insurance and also administer Medicare and/or Medicaid payments.
Note: There is no Total Payments field for this question.	If the TRC has written the Total Secondary Capitated Payment on the last line (for Other/Specify payment), cross it out.	

Decision Log for C7a, C7d, and C7f (same as Decision Log for QC4)

[PROGRAMMER NOTE: Include all “Problems” in a drop down menu at the other specify entry and program the required “decision” behind the scenes. May require implementing instructional boxes for the DCS/abstractor. For example, if the DCS selects “vocational rehabilitation” an instruction box should pop up asking the DCS to probe for source of funding: federal, state, county, other gov’t, private, etc.]

Problem	Decision / Categorization
State (or Federal, or County, or City) Plan ---- Plan may be Fund, Program, Grant ----- type of plan may be given ----- REMOVE Name of State if it is present	Code by indicating source of funds, then type of plan if given If program isn't also mentioned in QC6, Yellow Sheet, unless total charges = total payment
Examples:	
Nevada State Disability (SRS)	Code in 'Other' as State Disability
State Breast Cancer Program	Code in 'Other' as State Breast Cancer Program
Maryland Indigent Program	Code in 'Other' as State Indigent Program
Federal Grant	Code in 'Other' as Federal Grant
Cook County Indigent Fund	Code in 'Other' as County Indigent Fund
State Program	Code in 'Other' as State Program
Comment indicates one of the above, but it is not indicated in C7a (line g)/C7f (line h)	Yellow Sheet
Comment indicates the name of an insurance company for C7a/C7f.	Ignore the name of an insurance company if we have the type of insurance payer.
C7a (line g)/C7f (line h) 'Specify' answer is name of an insurance company	Blue Sheet to determine source of funding: Federal, State, County, Other gov't, Private etc
Children's Special Services	Blue Sheet to determine source of funding: Federal, State, County, Other gov't, Private etc
Vocational Rehabilitation	Blue Sheet to determine source of funding: Federal, State, County, Other gov't, Private etc
Welfare	Blue Sheet to determine source of funding: Federal, State, County, Other gov't, Private etc
Hospital	Yellow Sheet
Grant	Blue Sheet to determine source of funding: Federal, State, County, Other gov't, Private etc
Grant - DK who is funding it	Code in 'Other' as GRANT - DK FUNDING
Breast Cancer Program	Blue Sheet to determine source of funding: Federal, State, County, Other gov't, Private etc
Indigent Program or Fund for Indigents	Blue Sheet to determine source of funding: Federal, State, County, Other gov't, Private etc
Local	Blue Sheet to determine who is funding it , I.e. State, County, City, Other gov't, etc

MediCal (in California)	Code as Medicaid (C7a (line b)/C7f (line c))
Employer	Yellow Sheet
Verbiage about car/auto accident paid or auto/car insurance paid	Code in Other as Auto Insurance
Military	Blue Sheet for more specific information
Indian Health	Code in Other as Indian Health Service
CHDP; CHIP	Accept, but cross out any state or county name
WIC	Accept, but cross out any state or county name
AARP (American Association of Retired Persons)	Code as Private Insurance (C7a (line c)/C7f (line d))
Prepaid Mental Health Plan - State Plan	Code In Other as State Public Mental
HMO	Blue Sheet to find out Insurance Type: Medicare, Medicaid, Priv Ins., Other; Ask for source of payment.

BOX 2

BOX 2
[PROGRAM BEHIND THE SCENES – SHOULD NOT APPEAR ON SCREEN. VARIABLE NAME=GOTORVIS]
IF FEEORCAP = 1 ASK LSPCHECK AND RIV1 SCREEN
IF FEEOR CAP = 2 GO TO RIV1 SCREEN

AFTER VALIDATION USER RETURNS TO CMS AND IS ASKED “ANYMORE EVENTS?”

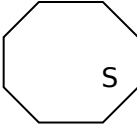
PROGRAMMER NOTES

DK/REF – Not Applicable here

EDIT SPECS FROM WESTAT

DATA ITEM	SPECIFICATIONS	ACTION, if specification not met
BOX 2 Global fee? Or an event that may have a repeat visit?	1, 2, or 3 must be circled.	If blank, answer as below.
	If 1=GLOBAL FEE SITUATION is circled, there must be a Global Fee. This answer will appear whenever there is a Global Fee, regardless of the book number.	Check Q B2a. Correct the answer, if wrong. If 1, there cannot be a repeat visit with a Global Fee. Skip to QB8.
	If 2=RECORDED 5 OR FEWER EVENTS is circled, there cannot be a Global Fee. This answer will appear in book numbers 1-5, in every book without a Global Fee.	Correct the answer, if wrong. If 2, there cannot be a repeat visit in books 1-5. Skip to QB8.
	If 3=RECORDED 6 OR MORE EVENTS is circled, there cannot be a Global Fee. This answer will appear in book number 6 or higher, in every book without a Global Fee.	Correct the answer, if wrong. If 3, QB6a must be answered.

EDIT SPECS FROM WESTAT

DATA ITEM	SPECIFICATIONS	ACTION, if specification not met
QB8 - All events covered?	1 or 2 must be circled.	
	In a booklet that is NOT the last booklet for a patient, the answer must be NO (2) – not all events are covered.	If <u>not the last</u> booklet, change blank to NO (2). If <u>not the last</u> booklet, change YES (1) to NO (2).
		ONLY THE DCS CAN SAY THAT ALL EVENTS ARE COLLECTED.
	In the last booklet for a patient, the TRC must say that all events are collected	If NO,(2) in the <u>last booklet</u> , write a Blue Sheet. DO NOT CHANGE NO TO YES. IF BLANK in the <u>last event booklet</u> , review QB9a: If QB9a is blank, Blue Sheet. OR If QB9a is answered, circle 1 in QB8, because TRC has indicated that this is the last book by answering QB9a.

QB9a – Did we get the number of events we expected? If not, why not?	This question is only answered in the last book for a patient.	If not last book, but this question is answered, cross out.
	If last book, cannot be blank.	Review the total number of events collected from the provider. Count each event booklet, plus each 2022 global fee date, plus each repeat visit date. Compare the total events collected with the total events expected on the Patient Data Form. Determine answer to QB9a and circle appropriate response.
	If 1 is circled, The provider gave us the same number of Total Events that the patient gave us, or the provider gave us more than the patient gave us.	Compare events collected (event booklets, 2022 Global Fee dates, and Repeat visit dates) to total events on Patient Data Form. Also compare for HS and HC event types. Blue Sheet , if we didn't get as many events as we expected.
	If 2 is circled, The provider gave us less events than the patient reported. An explanation must be recorded by the TRC.	Blue Sheet , if events are missing and no explanation given. If 2 is circled, but a review of the PDF shows that we have collected enough events, change answer to 1, unless it looks like an event is missing. Blue Sheet , if the explanation looks like an event was not collected, or if there is a missing HS or HC event.
	ALL EXPLANATIONS NEED MANAGERIAL REVIEW.	Yellow Sheet , if events are missing and explanation is given. If events are not missing, but an explanation is given, cross out explanation, unless the explanation looks like an event was not collected. Yellow Sheet if there is a possible missing event.
	Reported Home Care events need special handling. Missing Home Care events need a NIRF, an HC dead code on the PL-IV, and TRC approval.	If the Patient Data Form says that Home Care events were expected, review the books in the case. If no Home Care books for the patient, Blue Sheet . Request HC events, even if the total number of events is adequate. If there are Home Care books, verifiers should give the case to a Home Care editor.

RIV1

IS THIS EVENT A REPEATED IDENTICAL VISIT (RIV) EVENT? THAT IS, ARE THERE 10 OR MORE ADDITIONAL EVENTS IDENTICAL TO THIS EVENT, EXCEPT FOR THE DATE OF SERVICE?

IF IN DOUBT, ANSWER NO.

1=YES – THIS EVENT HAS AT LEAST 10 REPEATED IDENTICAL VISITS ASSOCIATED WITH IT.

2=NO

RIV2

RECORD THE DATES OF SERVICE FOR WHICH ALL DATA ARE IDENTICAL TO THIS (FILL DATE OF CURRENT EVENT) EVENT, EXCEPT FOR THE DATE OF SERVICE.

PROGRAMMER NOTES

If RIV1 = NO, go to FINISH SCREEN.

RIV2: Require minimum of 10 dates, maximum of 200. After 10 dates, a blank followed by an Enter goes to FINISH SCREEN.

RIV1 – DK/REF not allowed for RIV1, but are allowed for RIV2.

2022 UPDATE: Add soft check when YES is selected for RIV1. Soft check reads:

- MARK THIS ITEM AS YES ONLY IF ABSTRACTING AND THE EVENT IS AN RIV. IF COMPLETING BY PHONE, OR IF THE EVENT IS NOT AN RIV, CLOSE THIS MESSAGE AND CHANGE ANSWER TO NO. OTHERWISE, SUPPRESS AND CONTINUE.

FINISH SCREEN

ENTER 1 TO FINALIZE CASE.

PROGRAMMER NOTES

At this screen, users will enter 1 and Enter to finalize the event form.
