MEDICAL EXPENDITURE PANEL SURVEY

MEDICAL PROVIDER COMPONENT

EVENT FORM

FOR

SEPARATELY BILLING DOCTORS

FOR

REFERENCE YEAR 2022

Specifications for RCD

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

PROGRAMMERS: This document details the specifications for the **SBD 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:
  - 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.

  - Incorporate edit trails (e.g., if need to go back and revise answer).

  - 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).

  - 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. **FOR SBDs, THE NUMBER OF EVENTS SHOULD BE PRELISTED (FROM THE INFORMATION PROVIDED BY HOSPITALS/INSTITUTIONS) SO THE DCS/ABSTRACTOR CAN SEE HOW MANY EVENTS THEY HAVE COMPLETED AND HOW MANY THEY HAVE LEFT TO COMPLETE.**

    Once the DCS/abstractors finish with one patient they are taken back to a summary screen listing all patients for that provider, so they can click on the next patient.

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:
The variable names have been included where radio buttons or text boxes should appear. The variables in RED FONT were new for base year (2009). The variables in GREEN FONT were new for Option Year 1 (2010). The

variables in PURPLE FONT are new for Option Year 2 (2011). The variables in BLUE FONT are those that were used by 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

SERVICES PROVIDED (review event type)
FOR SBD – 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.

GLOBAL FEE
The field GFEEDATE is critical.

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.

DCS: 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 – INTRODUCTION

[PAGE 1 – INTRODUCTION (1 of 1)]

SCREEN LAYOUT

Again we are asking about [PATIENT NAME] who received health care services from someone in this practice during [an inpatient stay from BEGIN DATE to END DATE/a long term stay from BEGIN DATE to END DATE/an institution visit from BEGIN DATE to END DATE].

Within this stay, when did you have your [FILL_FIRSTNEXT] encounter with this patient?

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

MM/DD/YYYY **ENC_DATE**

PROGRAMMER NOTES

FUNCTIONALITY

Administer ENC_DATE when MREVTYPE =1 or 5 or 6 (hospital inpatient or hospital long-term care or institution event).

ENC_DATE: Display empty field; the user will enter MM/DD/YYYY on his/her own.

FILLS

[PATIENT NAME] should fill with [PATIENT_FIRST_NAME] [PATIENT_LAST_NAME] from Housing Component data file.

FILL (an inpatient stay from BEGIN DATE to END DATE/a long term stay from BEGIN DATE to END DATE/an institutional stay) should fill based on the following logic:

IF MREVTYPE (A1 of Hospital Event Form) = 1 fill "an inpatient stay from BEGIN DATE to END DATE"

IF MREVTYPE (A1 of Hospital Event Form) = 5 fill "a long term stay from BEGIN DATE to END DATE"

IF MREVTYPE (A1 of Institution Event Form) =6 fill "an institution visit from BEGIN DATE to END DATE"

(DATE) should fill based on the following logic:

IF MREVTYPE (A1 of Hospital Medical Event Form) = 1 or 5, fill “from INPATBEG_DAT to INPATEND_DAT” (A2a of Hospital Medical Event Form)

For Institution fill “from EVTBEG_DATE to EVTEND_DATE” from A1 of Institution Event Form.

Again we are asking about [PATIENT NAME] who received health care services from someone in this practice during [an outpatient visit on DATE/an emergency room visit on DATE/a visit on DATE].

1. Continue **OUT_NODECHECK**

PROGRAMMER NOTES

FUNCTIONALITY

Display OUTNODECHECK when MREVTYPE=2, 3, or 4 (hospital outpatient, hospital ER, hospital somewhere else).

No data entry needed; user will press Next to continue.

FILLS

[PATIENT NAME] should fill with [PATIENT_FIRST_NAME] [PATIENT_LAST_NAME] from Housing Component data file.

[an outpatient visit/an emergency room visit/an inpatient stay] should fill based on the following logic:

IF MREVTYPE (A1 of Hospital Event Form) = 2 fill “an outpatient visit on [DATE]”

IF MREVTYPE (A1 of Hospital Event Form) = 3 fill “an emergency room visit on [DATE]”

IF MREVTYPE (A1 of Hospital Event Form) = 4 fill “a visit on [DATE]”

[DATE] should fill based on the following logic:

IF MREVTYPE (A1 of Hospital Medical Event Form) = 2, 3, or 4, fill “EVNTBEGM EVNTBEGD, EVNTBEGY” (A2C_OUTPAT_DATE of Hospital Medical Event Form). Spell out the month.

ENC_DATE

YYYY: value for year may be 2021, 2022, or 2023.

OUT_NODECHECK

YYYY: value for year may be 2021, 2022, or 2023.

SECTION 3 – GLOBAL FEE

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

[Page 2 – GLOBAL FEE (1 of 2)]

SCREEN LAYOUT

GLOBAL FEE

B2a.	Was the visit on [FILL_VISITDATE] covered by a global fee, that is, was it included in a charge that covered services received on other dates as well? EXPLAIN IF NECESSARY: 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.	YES=1, NO=2	**GLOFEE**

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 B5a]

[VISITDATE] should fill based on the following logic:
IF MREVTYPE = 2, 3, or 4, fill with A2c_OUTPAT_DATE" (A2c of Hospital Medical Event Form).

IF MREVTYPE=1, 5, or 6 then fill with date the user recorded in ENC_DATE, aka Encounter screen for the inpatient path in this event form.

DK/REF – GO TO B5a

[Page 3 – GLOBAL FEE (2 of 2)]

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.

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

		IF TYPE=96
MONTH/DAY/YEAR	TYPE	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**

B2c. Did (PATIENT NAME) receive the services on GLOBAL FEE DATE in a:

Physician's Office (TYPE=MV);
Hospital as an Inpatient (TYPE=SH);
Hospital Outpatient Department (TYPE=SO);
Hospital Emergency Room (TYPE=SE); or
Somewhere else (TYPE=96)?

- IF SOMEWHERE ELSE: Where was that?

RECORD RESPONSE UNDER "TYPE"

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, NO=2 **CHK_GFEE**

PROGRAMMER NOTES

B2a – (VISITDATE) should fill based on the following logic:

if MREVTYPE = 2, 3, or 4, fill with A2c_OUTPAT_DATE" (A2c of Hospital Medical Event Form).

if MREVTYPE=1, 5, or 6 then fill with date the user recorded in ENC_DATE, aka Encounter screen for the inpatient path in this event form.

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

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 HISTORY BOX 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, that same line of text including date and type will repopulate (as is) but also provide a text box for the DCS/abstractor to enter the "specify" option.
(4) The "specify" option should be set up so a response can be selected from a drop down menu, or entered in as text.

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 B5a

[After B2d, GO TO B5a]

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?	1 or 2 must be circled; cannot be blank.	If there is a global fee date, circle 1 for YES. If there is nothing to indicate a Global Fee, circle 2 for NO.
	If Global Fee is 1 (YES), QB2b, QB2c and QB2d must be answered.	**Blue Sheet**, if Global Fee is answered YES, but other questions are not answered.
	Global Fees need Managerial Review.	**YELLOW SHEET ALL GLOBAL FEES.**
	If Global Fee = YES, the Node on the cover of this book will be a STEM.	On the Patient Data Form (PDF), code the Node for the main Global Fee event as Global Fee = S.
	C3 OVERLAP cases (collected in the Office-Based [OBD] Sample) should be Global Fee = N (No Global Fee).	On the PDF, code all Nodes that overlap an OBD case as Global Fee = N.
QB2b and QB2c – Global Fee dates with types of visits Fill in the Global Fee COUNTER with the number of Global Fee dates. Global Fee Date is not a Critical Item. If date is DK or RF, PL-IV	Month, day and year are needed. Allow years 2021, 2022 and 2023.	**Blue Sheet,** if month or day or year is missing. Change DK in month or day to – 8. Change RF in month or day to – 7. **Yellow Sheet,** if year is DK or RF.
	Type must be given if Global Fee date is given. Allowable types are MV, SH, SO, SE, or 96. For Type = 96, the "Other/Specify" answer must be present and categorized by checking the Decision Log.	**Blue Sheet,** if type is missing. Change type if wrong abbreviation is used. (See correct abbreviations at left.) If 96, **Yellow Sheet** "Other/Specify" type of visit, if not already on the Decision Log.
	A Global Fee date and event type in QB2b and c that matches a Node date and event type on the PDF is a Global Fee Leaf. The TRC codes the Leaf as C1/99.	Code the Node as Global Fee = L. All 99 codes need a **Yellow Sheet.**
	Leaf Nodes need a Pointer with the NodeID of the Stem of its Global Fee.	**Code the Leaf Node on the PDF with the NodeID of the Global Fee STEM.**

can still be coded as 63.	Global Fee dates that are leaves must have the Leaf NodeID identified at QB2c on the line labeled IF TYPE 96, SPECIFY.	Write the NodeID of the leaf Node on the Specify line.
	• The days within a hospital inpatient Node (HS event type) are not Global Fee dates. • If the Node event date covers an inpatient stay and there are Global Fee dates included within the same stay, cross them out. • If no Global Fee dates remain, change QB2a to NO (2) and cross out QB2d.	

Decision Log for QB2b

[PROGRAMMER NOTE: Decision log is taken from OBD as there is no Decision Log for SBD]

[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	
Observation	Code GF as SO
Ambulatory Surgery Center	Code GF as SO
SurgiCenter	Code GF as SO
Independent Radiology Clinic, Imaging CTR, X-Ray	Code GF as SO
Independent Pathology Clinic. Laboratory, Clinical Lab	Code GF as SO
Independent Facility	Code GF as SO
Ambulance	Yellow Sheet
SNF	Code GF as SH
Rehab Center	Code GF as SH
Hospital Free Standing Clinic/ Hospital Satellite Clinic	Code GF as SO
Long Term Care Unit	Code GF as 96 and keep as Specify answer
Institution	Code GF as 96 and keep as Specify answer

SECTION 4 – SERVICES/CHARGES

NOTE: See end of section for edit specs from Westat for questions B5a, B5b, and C2

[Page 4 – SERVICES/CHARGES (1 of 2)]

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.

IF CPT-4 CODES ARE NOT USED, RECORD DESCRIPTIONS OF SERVICES AND PROCEDURES PROVIDED. ENTER UP TO 8 CHARACTERS. IF 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?

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

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

VERIFY: (Is this/Are these) the full established charge(s) or "list price" for (this/these) service(s)? IF NOT, RECORD FULL ESTABLISHED CHARGES

IF PROVIDER APPLIED THE CHARGE FOR THIS SERVICE TO SOME **OTHER** SERVICE ON THIS DATE, ENTER -4. NOTE: WE NEVER ENTER $0 FOR A CHARGE

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

	CPT-4 CODE	DESCRIPTION	What was the full established charge, or charge equivalent, for this service?
a.	**MCPT#**	**MCPTDS#**	$**MCPTCH#**
b.	**MCPT#**	**MCPTDS#**	$**MCPTCH#**
c.	**MCPT#**	**MCPTDS#**	$**MCPTCH#**
d.	**MCPT#**	**MCPTDS#**	$**MCPTCH#**
e.	**MCPT#**	**MCPTDS#**	$**MCPTCH#**
f.	**MCPT#**	**MCPTDS#**	$**MCPTCH#**
g.	**MCPT#**	**MCPTDS#**	$**MCPTCH#**
h.	**MCPT#**	**MCPTDS#**	$**MCPTCH#**
i.	**MCPT#**	**MCPTDS#**	$**MCPTCH#**
j.	**MCPT#**	**MCPTDS#**	$**MCPTCH#**
k.	**MCPT#**	**MCPTDS#**	$**MCPTCH#**

TOTAL CHARGES $**TOTLCHRG**

OTHERMCPT#

PROGRAMMER NOTES

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 B5b

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

CHARGES
Services charge: CPT-4 CODE: [MCPT_1] / DESC: [MCPTDS_1] charge = $[MCPTCH_1]
.
.
.
Services charge: CPT-4 CODE: [MCPT_N] / DESC: [MCPTDS_N] charge = $[MCPTCH_N]
Inpatient charge: Total amount = $[IN_TOTLCHRG]

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.”

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

Validation: If OUT_TOTLCHRG>20000 administer soft-check “You have entered a charge over $20,000. Please review and correct if needed, or suppress and continue.”
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".

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".

B5a – MCPTDS# field length is up to 100 characters.

B5b & C2 - DOLLAR AMOUNTS SHOULD BE FORMATTED TO INCLUDE COMMAS and DECIMAL POINTS
B5a - DK/REF – CONTINUE TO B5b
B5b - DK/REF – CONTINUE TO C2

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
QB 5a PROCEDURE PROCEDURE IS A **CRITICAL ITEM**	Procedure cannot be blank.	**Blue Sheet,** if procedure is missing
	DK and RF are acceptable answers.	Give a Receipt 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
	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	**Yellow Sheet,** if there is a modifier with one number. **Blue Sheet,** if there is any other problem with a modifier that would make it invalid.
	Only one valid modifier is acceptable for each CPT code.	Cross out the second modifier. If in doubt ask a team leader.
	Modifiers must be separated from the main code by a hyphen.	Change a decimal point to a hyphen.
	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.
	Multiple listings of the same procedure may need managerial review.	**Yellow Sheet** if the same procedure is listed more than twice.
	Descriptions cannot be longer than 100 characters.	**Yellow Sheet** or ask a team leader to shorten it.
	Multiple visits may need review. Multiple inpatient codes (initial inpatient care, subsequent inpatient care, and discharge codes) are acceptable for an HS Node in an SBD case.	**Yellow Sheet** multiple Office Visit or OP codes in the same book.
		Accept multiple inpatient codes.
	Procedures should be consistent with the location of the event (event type).	Compare the procedure to the event type on the pair label on the cover of the booklet.
		Yellow Sheet, if not consistent.

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 code and text do not match, **Blue Sheet**, asking if they are one procedure or two. If the code and text match, cross out text.
CPT code with units	Allowed for anesthesia codes and J-code HCPCs 01320 – 2 units J2001 2 units	Keep if anesthesia or J-code. Circle as one answer. **Blue Sheet** if any other code, saying that there can be only one procedure per line.
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. Cannot stand alone. Needs further review. No identifying information is allowed.	**Yellow Sheet,** if it is the only procedure**.** Cross out state name, if given.
Handling	Valid if it is not the only service in the book. Cannot stand alone. Needs further review.	**Yellow Sheet**, if it is the only procedure.
Administrative fee	Valid if it is not the only service in the book. Cannot stand alone. Needs further review.	**Yellow Sheet,** if it is the only procedure**.**
Surcharge	Cannot stand alone. Needs further review. 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 only procedure.
99080, S9981, S9982	Valid if it is not the only service in a book.	**Yellow Sheet** if only procedure.
Rx pickup; Pharmacy	Valid if it is not the only service in a book.	**Yellow Sheet** if 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 for a procedure.	We take charge equivalents.	**Blue Sheet, asking for a Charge Equivalent.**
ER event with OBSERVATION, 99217-99220, 99234-99236	Observation is usually an OP event.	**Blue Sheet to ask if we are missing an OP event. Address Blue Sheet to TRC SPVR.**
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. It should not have a separate book.	**Blue Sheet. Should this be part of a global fee?**

99500 – 99602 (Home Health services)	Home Health services are not expected in SBD cases.	**Yellow Sheet.**
99050, 99052, 99054, 99058 99100, 99116, 99135, 99140	These codes indicate additional charges for after hours care/emergency care/holiday services/ or additional charge for elder care. Valid if it is not the only procedure in the event book.	**Yellow Sheet if only procedure. Accept if there are other procedures.**

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 Charge is not a Critical Item.	Every procedure must have a charge.	**Blue Sheet,** if missing. **Yellow Sheet,** if missing, but there is a comment explaining why.
	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 indicated that a charge is included in the charge on the line above it. The code – 4 is only used for charges.	The combined charge should be on the line next to the first of the bracketed procedures. Write the code –4 on the subsequent lines in place of the charge. These lines cannot be blank.

	The code – 4 can only be used if it is certain that there are two procedures (and therefore two charges are needed).	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**.
	\$0.00 charges, \$0.01 charge, illogically-low charge need managerial review to determine if we should ask for a charge equivalent or full established charge.	**Yellow Sheet.**
	N/C charges, or comments indicating that the doctor did not charge for this service, need managerial review. This may indicate a service covered by a global fee, or, if not a global fee service, we may need to ask for a charge equivalent.	**Yellow Sheet.**

DATA ITEM	**SPECIFICATIONS**	**ACTION, if specification not met**
QC2 - Total Charge	Total Charge must be written by the TRC.	**Blue Sheet**.
	Total Charge should equal sum of Individual Charges.	Review Calculator tape. Initial tape.
		If there is only one charge, compare to Total. **Blue Sheet** if not the same.
	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 and QC6.	If the difference is 10% or less than the Total, correct the Total Charge. **Blue Sheet, i**f 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**.
	Calculator tape must be run to verify Total if there is more than one charge.	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 the tape.

	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 5 – REIMBURSEMENT TYPE

[Page 5 – REIMBURSEMENT TYPE (1 of 1)]

SCREEN LAYOUT

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

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

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

FEEORCAP

PROGRAMMER NOTES

[IF FEEORCAP=2 GO TO C7a]

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

Implement a soft check every time FEEORCAP=2. Should read: "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."

DK/REF – NOT ALLOWED

EDIT SPECS FROM WESTAT

DATA ITEM	SPECIFICATIONS	ACTION, if specification not met
QC3 Fee for Service or Capitated? **CRITICAL ITEM**	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.
	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 6 – SOURCES OF PAYMENT

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

[Page 6 – SOURCES OF PAYMENT (1 of 1)]

SCREEN LAYOUT

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 (FILL_VISITDATE) and now for (this visit/these visits).

IF NONE, ENTER ZERO (0).

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

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.

SOURCE	PAYMENT AMOUNT
a. Patient or Patient's Family;	$**PATPAYM**
b. Medicare;	$**CAREPAYM**
c. Medicaid;	$**AIDPAYM**
d. Private Insurance;	$**PINSPAYM**
e. VA/ChampVA;	$**VAPAYM**
f. Tricare;	$**CHAMPAYM**
g. Worker's Comp; or	$**WORKPAYM**
h. Something else? (IF SOMETHING ELSE: What was that?) **OTPAYMOS** **OTPAYMOSTXT**	$**OTHRPAYM**
TOTAL PAYMENTS	**$TOTLPAYM**

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?

PROGRAMMER NOTES

When 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."

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 and OTHRPAYM. The following are allowed entries: 0, integer, integer with 2 decimal places, F6/DK, F7/REF.

In the summary of charges that displays above the sentence, "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 payment is missing. Is that correct?"

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

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

This variable that is recorded on this screen 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.”

[VISITDATE] should fill based on the following logic:

IF MREVTYPE = 2, 3, or 4, fill with A2c_OUTPAT_DATE” (A2c of Hospital Medical Event Form).
IF MREVTYPE=1, 5, or 6 then fill with date the user recorded in ENC_DATE, aka Encounter screen for the inpatient path in this event form.

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 options listed. Field = 75 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 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 C4 (specifically C_4OTHERPAYMENTS)

CHARGES (if outpatient)

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

.
.
.

Services charge: CPT-4 CODE: [MCPT_N] / DESC: [MCPTDS_N] charge = $[MCPTCH_N]
Outpatient charge: Total amount = $OUT_TOTLCHRG]

CHARGES (if inpatient)

Inpatient charge: Total amount = $[IN_TOTLCHRG]

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**]

Programmer:

Each iteration of OTHRPAYM will appear on its own screen and require entry of dollars.

Design Note #2 for C5

C5.

CHARGES

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

.

.

.

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
QC4 -Payment sources/amounts **CRITICAL ITEM** is source of payments plus Total Payments. The amount of Individual Payments is not a critical item. See QC4 – QC6 Consistency notes.	Must be completed if Reimbursement Type = Fee-For-Service.	**Blue Sheet**, if blank.
	Expect patient payment if there is an insurance payment that is not Medicaid.	**Yellow Sheet,** if there is no Patient Payment, and the book doesn't indicate one of the exceptions on the Patient Payment memo.
	Every source of payment must have $$ value or $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 also missing, or if sum of other sources does not equal Total.
	DK or RF are acceptable for payments, but need further review if procedures and charges are also DK and RF.	Change DK to –8. Change RF to – 7.
		Yellow Sheet, if procedures, charges and payments are all DK or RF.
	If OTHER is answered, there must be an answer on the SPECIFY line.	**Blue Sheet** if missing.

	Answer on the SPECIFY line needs review.	Accept if found on Decision Log there.If the answer is not there, **Yellow Sheet.**
	HMO is not acceptable as a SPECIFY answer. The name of an insurance company is not acceptable as a SPECIFY answer. Note: The same insurance company may provide Private Insurance, and also administer Medicare or Medicaid plans.	**Blue Sheet**, asking which type of insurance is the HMO or the insurance company.
	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 ADJUSMENT in QC6. Exceptions: Provider write-off in QC6 will not have a comparable answer in QC4.	**Yellow Sheet, unless…** …Accept if payment in line h is $0.00 and Total Payments is $0.00. There will not be an answer in OTHER/SPECIFY to match to QC6.
	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 there is another insurance type indicated.
	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 go beyond 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 instructions.

DATA ITEM	**SPECIFICATIONS**	**ACTION, if specification not met**
QC5- Total Payments **CRITICAL ITEM** is source of payments plus Total Payments.	Total Payments cannot be blank.	**Blue Sheet**, if it can't be determined.
		If blank and all Individual Payments are filled in with a value or with $0.00, fill in the Total Payments.
	Calculator tape should be run to verify Total if there are multiple payments. Do not use the TRC's tape.	Run calculator tape. Do not accept the TRC tape. Initial the tape.
	Total Payments should equal sum of Individual Payments. Review calculator tape. Initial tape, compare to Total.	If there is only one payment and it doesn't agree with Total, **Blue Sheet**.
	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. Compare the amount of the difference and the Total Payment as written by the TRC.	If the difference is 10% or less than the Total, correct the Total Payment.
		Blue Sheet, if the difference is greater than 10%.
		Change Box 1 to the appropriate answer.

	Note that changes can affect the answers to Box 1 and QC6.	**Blue Sheet,** if QC6 was skipped, but now must be answered.
	If the Total Payments written by the TRC is greater than the sum of the Individual Payments, the TRC must make any corrections.	**Blue Sheet**, asking if we are missing a payment or service.
	DK or RF is an acceptable answer. Code PL-IV as 60, critical item is missing.	Change DK to – 8. Change RF to – 7.
	Booklets with DK or RF for Procedures and Charges and Payments need special review.	**Yellow Sheet** if all three fields are DK or RF.
	If Total Payments is given but Individual Payments are all DK or RF AND Total Payments = Total Charge, managerial review may be needed.	**Yellow Sheet** in this situation if there is a comment saying "Paid in Full," or "Zero Balance" or another comment that indicates that the account is clear. If no such comment, accept as is.

Decision Log for QC4
[PROGRAMMER NOTE: Decision log is taken from OBD as there is no Decision Log for SBD]

[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.

DATA ITEM	SPECIFICATIONS	ACTION, if specification not met
QC4 – QC5 LUMP SUM INFORMATION	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. 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	**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.	**Blue Sheet,** if answers are given but are not consistent. If all books are blank, **Blue Sheet**. 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.
	Box 1 should be the same in all books of the lump.	Answer if blank.

	If total lump charges = total lump payments, then Box 1 should be answered 1 in all books of the lump. If total lump charges don't equal total lump payments, then Box 1 should be answered 2 (NO) in all books of the lump.	Correct Box 1 if wrong. This may change the skip pattern. Review QC6, if necessary.
	If lump payments = lump charges, and there is only one source of payments, the lump won't have to go for computer calculation.	Enter the payment amount equal to the charges on the line for the payment source, and on the line for Total Payments. If there is more than one payer, the lump will have to be processed in the usual way.

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 - 4 (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 NE 0 IS 'a' (patient or patient's family - PATPAYM), GO TO **LSPCHECK**.
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 **ADJEXTRA**.
IF C2 > C5 GO TO PLC1

EDIT SPECS FROM WESTAT

	1 (YES), 2 (YES) or 3 (NO) must be circled.	Compare Total Charge to Total Payments.

BOX 1 – Total Payments = Total Charges or not	DK or RF is not acceptable.	Circle 3 (NO). Blue Sheet for answer to QC6, if skipped.
	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.	If Total Charges and Total Payments are $0.00, Yellow Sheet for Total Charges = $0.00. Change DK or RF to 3 (NO). Answer QC6 as – 8 (DK).
	Cannot be blank.	If blank, circle the correct answer. • Compare Total Payments to Total Charges. • Look at the Source of Payments.
	Should be consistent with Total Charges, Total Payments, and Source of Payments.	If answered 1 and it should be 2 or 3, change to the correct answer. If answered 3, and should be 1 or 2, change to the correct answer. An answer changed to 2 will follow the skip pattern to QC5a. If that is blank, write a **Blue Sheet**.
	The skip pattern to QC5a cannot be lost. QC5a is flagged to record the number of times it is answered. QC5a sends the DCS back to QC4 to look at the payments again. Changes to QC4 will NOT generate a change in Box 1.	Do NOT change the answer 2 (YES) to another answer, even if it is now no longer consistent with QC4 or QC5.
	Comments may need special review.	**Yellow Sheet.**
	FOLLOW THE SKIP PATTERN	

SECTION 7 – VERIFICATION OF PAYMENT

[Page 7 – VERIFICATION OF PAYMENT (1 of 1)]

SCREEN LAYOUT

	C5a. I recorded that the payment(s) you received equal the charge(s). I would like to make sure that I have this recorded correctly. I recorded that the total payment is [SYSTEM WILL DISPLAY TOTAL PAYMENT FROM C5]. Does this total payment include any other amounts such as adjustments or discounts, or is this the final payment? IF NECESSARY, READ BACK AMOUNT(S) RECORDED IN C4.	YES, FINAL PAYMENTS RECORDED IN C4 AND C5 =1 NO, TOTAL PAYMENT INCLUDES AMOUNTS SUCH AS ADJUSTMENTS OR DISCOUNTS =2
EQPAYOK		

.

PROGRAMMER NOTES

[IF EQPAYOK=1 GO TO **LSPCHECK**, IF EQPAYOK=2 DISPLAY HARD CHECK: "PLEASE GO BACK AND MAKE CORRECTIONS"]

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 **LSPCHECK**.

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.

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 BADEB2 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 8 – DIFFERENCE BETWEEN PAYMENTS AND CHARGES

[Page 8–DIFFERENCE BETWEEN PAYMENTS AND CHARGES (1 of 1)]

SCREEN LAYOUT

C6_Additional, Question Q6_additional

Are you expecting additional payment from:

Expecting additional payment

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 75 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 75 characters.

C6p – Include the following 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
QC6 A – R REASON FOR PAYMENTS LESS THAN CHARGES	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 on page 3-9.
SEE QC4-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 the YES answer is circled, and the 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. Answer on the SPECIFY line (QC6 line h or line p) needs review.	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.**
		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.
	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.**
		“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.**

	Books should be compared for consistency.	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.

DATA ITEM	SPECIFICATIONS	ACTION, if specification not met
QC6 S – V REASON FOR PAYMENTS MORE THAN CHARGES SEE QC4-QC6 CONSISTENCY NOTES	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, and answers in the PAYMENTS MORE section are all blank, and there is a YES (1) answer in the PAYMENTS LESS section,. Circle NO (2) for all answers in the PAYMENTS MORE section.
QC6 S – V REASON FOR PAYMENTS MORE THAN CHARGES SEE QC4-QC6 CONSISTENCY NOTES	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. Answer on the SPECIFY line (QC6 line v) needs review.	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.**
		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**.

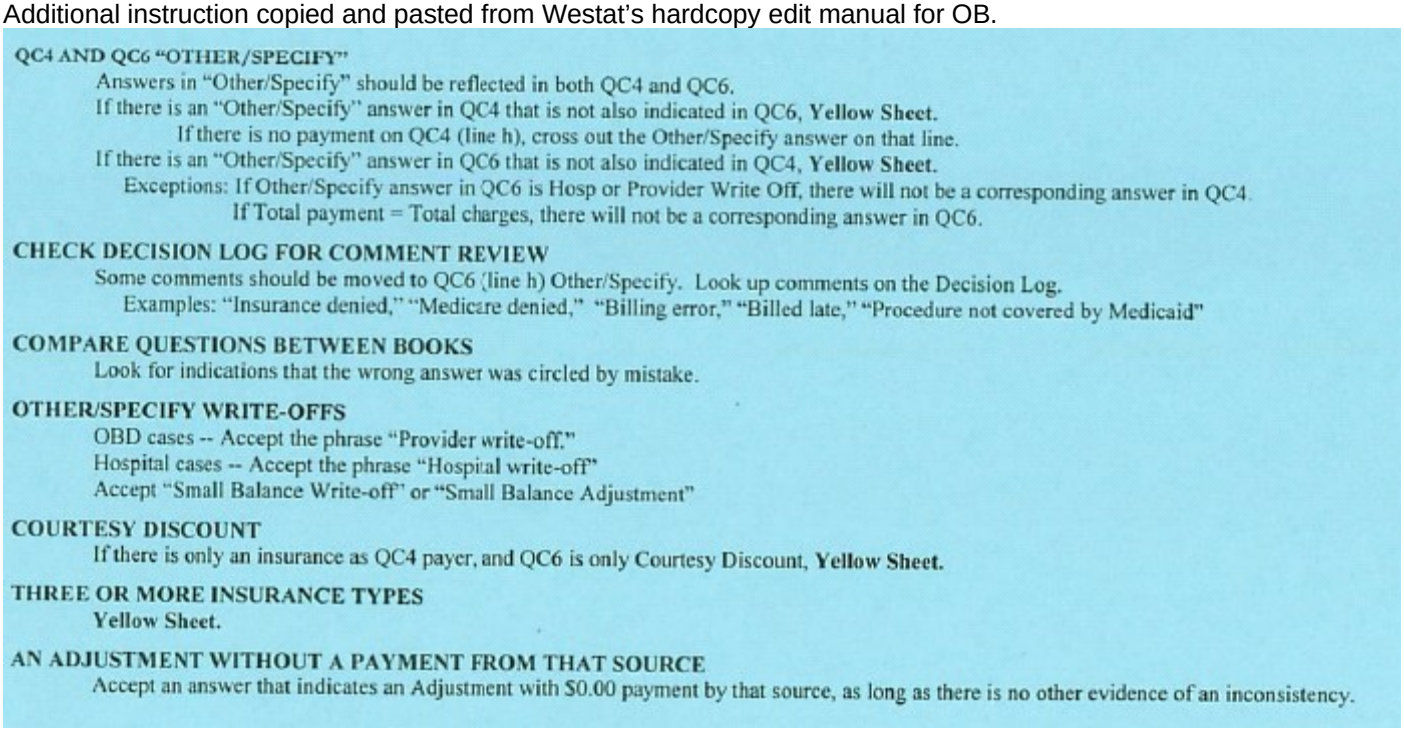
QC4 AND QC6 CONSISTENCY NOTES

PAYER IN QC4	ANSWER TO QC6
Medicare	Accept any of these alone: Medicare Adjustment, Contractual Arrangement, Expecting Payment from any source, Charity, or Bad Debt. Accept Medicare Adjustment plus any of the following: Medicaid Adjustment, Contractual Arrangement, Courtesy Discount, Expecting Payment from any source, Charity or Bad Debt. If Insurance Write-Off is answered, **Yellow Sheet.** 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**.
Medicaid	Accept any of these alone: Medicaid Adjustment; Expecting Payment from any source, Charity, or Bad Debt. Accept Medicaid Adjustment plus any of the following: Medicare Adjustment, Contractual Arrangement, Courtesy Discount, Expecting Payment from any source, Charity or Bad Debt. If Insurance Write-Off is answered, **Yellow Sheet.** 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**.
Private Insurance	Accept any of these alone: Contractual Arrangement; Expecting Payment from any source, Charity, or Bad Debt. 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. 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**.
TRICARE, Champus, ChampVA	Accept anything that is acceptable for Private Insurance, and/or accept Eligible Veteran or OTHER/SPECIFY: Tricare Adjustment or Champus Adjustment. May be the primary insurance or secondary to other kinds of insurance.
VA or Indian Health	Usually says “ELIGIBLE VETERAN” or OTHER/SPECIFY: “ELIGIBLE…” There may be no payment or payment by any source. 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. If Insurance Write-Off is answered, **Yellow Sheet.** Accept Courtesy Discount, Charity and Bad Debt in addition to “Eligible…” or other insurance adjustment.
Workers’ Comp	Should say “Workers’ Comp Adjustment.” If missing, **Blue Sheet.** Accept Courtesy Discount, Charity and Bad Debt in addition to Workers’ Comp Adjustment. If Insurance Write-Off is answered, **Yellow Sheet.** Expect that no other insurance will be involved. If Workers’ Comp is given with any other insurance, **Yellow Sheet.**

*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: Decision log is taken from OBD as there is no Decision Log for SBD]

[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 (name of source given in Q(C4h)).
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 Overpayment; Patient has a balance	Yellow Sheet.

SECTION 9 – CAPITATED BASIS

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

[Page 9–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;	YES=1, NO=2 **COVCARE**
b.	Medicaid;	YES=1, NO=2 **COVAID**
c.	Private Insurance;	YES=1, NO=2 **COVPINS**
d.	VA/ChampVA;	YES=1, NO=2 **COVVA**
e.	Tricare;	YES=1, NO=2 **COVCHAM**
f.	Worker's Comp; or	YES=1, NO=2 **COVWORK**
g.	Are there any others?	YES=1, NO=2 **COVOTHR**
		COVOTHTXT

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

PROGRAMMER NOTES

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

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

C7a(g) - The COVOTHTXT 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. COVOTHTXT 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

The COVOTHTXT variable collects 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 other listed options. COVOTHTXT allows up to three entries (COVOTHTXT_1, COVOTHTXT_2, COVOTHTXT_3). Allow up to 75 characters.

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.

[Page 10–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; YES=1, NO=2 **CPAYPAT**
b. Medicare; YES=1, NO=2 **CPAYCARE**
c. Medicaid; YES=1, NO=2 **CPAYAID**
d. Private Insurance; or YES=1, NO=2 **CPAYPINS**

e. Any others pay the copayment? YES=1, NO=2 **CPAYMORE**

PROGRAMMER NOTES

C7c – If the amount of copayment is unusually high or low, administer different softchecks. Specifically, if 0 =< COPAYAMT < 5 adminster soft message: "You have entered a copayment under $5.00. Suppress if okay or make corrections." Additionally, if COPAYAMT > 100, administer soft message "You have entered a copayment over $100.00. Suppress if okay or make corrections."

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

C7d(e) - ONSCREEN TEXT FOR CPAYMORE:

Any others pay the co-payment?

IF C7d(e) CPAYMORE = 1, ask additional questions formatted like C7d a-d (CPAYPAY through CPAYPINS). The questions added are for payer types:

Auto or Accident Insurance [CPAYAUTO]
Indian Health Service [CPAYINDIAN]
State Public Mental Plan [CPAYMENTAL]
State/County/Local Program [CPAYSTATE]
Other [CPAYOTHRTXT]

C7d(e) CPAYOTHRTXT ONSCREEN TEXT:

Do your records show any other payments for these visits copayments? If so, please specify.

IF NONE PRESS ENTER TO LEAVE EMPTY

The CPAYOTHRTXT variable collects 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 other listed options. CPAYOTHRTXT allows up to three entries (CPAYOTHRTXT_1, CPAYOTHRTXT_2, CPAYOTHRTXT_3). Allow up to 75 characters.

[Page 12–CAPITATED BASIS (4 of 4)]

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 (FILL_VISITDATE) and now for this (stay/visit).

RECORD PAYMENTS FROM ALL APPLICABLE PAYERS

.

SOURCE	PAYMENT AMOUNT
a. Patient or Patient's Family;	$**OTHPAT**
b. Medicare;	$**OTHCARE**
c. Medicaid;	$**OTHAID**
d. Private Insurance;	$**OTHPINS**
e. VA/ChampVA;	$**OTHVA**
f. Tricare;	$**OTHCHAM**
g. Worker's Comp; or	$**OTHWORK**
h. Were there any more payments?	$**OTHMORE**

PROGRAMMER NOTES

DOLLAR AMOUNTS SHOULD BE FORMATTED TO INCLUDE COMMAS and DECIMAL POINTS

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.

C7f - (VISITDATE) should fill based on following logic:
if MREVTYPE = 2, 3, or 4, fill with A2c_OUTPAT_DATE" (A2c of Hospital Medical Event Form).

if MREVTYPE=1, 5, or 6 then fill with date the user recorded in ENC_DATE, aka Encounter screen for the inpatient path in this event form.

C7f – (stay/visit) - If MREVTYPE (A1)=1 or 5, fill: "stay"
ELSE fill: "visit".

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

C7f – First item (OTHPAT) displays full question text. Remaining items (OTHCARE through OTHWORK) display only "(How much was paid by:)" followed by the payer type (Medicare, Medicaid, etc.).

C7f(h) OTHMORE ONSCREEN TEXT:
Were there any more payments?

IF C7f(h) OTHMORE = 1, ask additional questions formatted like C7f a-g (OTHPAT through OTHWORK). The questions added are for payer types:
Auto or Accident Insurance [OTHAUTO]
Indian Health Service [OTHINDIAN]
State Public Mental Plan [OTHMENTAL]
State/County/Local Program [OTHSTATE]
Other [othothrtxt]

C7f(h) othothrtxt ONSCREEN TEXT:
Was there payment by something else? If so, please specify.

IF NONE PRESS ENTER TO LEAVE EMPTY

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.

DATA ITEM	SPECIFICATIONS	ACTION, if specification not met
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.
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: Decision log is taken from OBD as there is no Decision Log for SBD]

[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.

DATA ITEM	SPECIFICATIONS	ACTION, if specification not met
QB10a - All events covered?	1 or 2 must be circled.	Follow directions below.
	In a booklet that is NOT the last booklet for a patient, the answer must be NO (2) – not all events are covered.	If this is not the last booklet, change blank to NO (2).
		If this is not the last booklet, change YES (1) to NO (2).
		ONLY THE TRC CAN SAY THAT ALL DATA ARE COLLECTED.
	In the last booklet for a patient, the TRC must say that all events are collected.	If missing or NO (2) in the last booklet, write a **Blue Sheet**. DO NOT CHANGE NO TO YES.

SECTION 10 – LUMP SUM PAYMENTS

[Page 13 – LUMP SUM PAYMENT (1 of 1)]

SCREEN LAYOUT new form “LSP_CHECK”

LSPCHECK WAS ANY LUMP SUM ASSOCIATED WITH THE SOURCES OF PAYMENT? **LSPCHECK**
YES
NO

PROGRAMMING NOTE:

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 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

SECTION 12 – FINISH SCREEN

[Page 15 – FINISH SCREEN (1 of 1)]

ENTER 1 TO FINISH ENTRY.

PROGRAMMER NOTES

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

For OY2, remove the Path Validate button on this screen and all others, leaving only Validate for the event form.

SECTION 11 – ENCOUNTER

[Page 14 – ENCOUNTER (1 of 1)]

Were any other services provided to (PATIENT NAME) during the inpatient stay of (DATE) that we have not recorded? **EVENT_CHECK**

1 YES
2 NO

PROGRAMMER NOTES:

Ask EVENT_CHECK when case came from hospital and MREVTYPE = 1 or 5 or event, or if it came from institution event form.
IF EVENT_CHECK=YES, then post a code to CMS that creates a new, blank event form. send user to finish screen.
IF EVENT_CHECK=NO, send user to finish/exit screen.

(DATE) should fill with “INPATBEG_DAT to INPATEND_DAT” from A2a of Hospital Event Form or “EVTBEG_DATE to EVTEND_DATE” from A1 of Institution Event Form.

FINALIZE

ENTER 1 TO FINALIZE CASE

1. CONTINUE