MEDICAL EXPENDITURE PANEL SURVEY

MEDICAL PROVIDER COMPONENT

EVENT FORM

FOR

INSTITUTIONAL PROVIDERS
(NON-HOSPITAL FACILITIES)

FOR

REFERENCE YEAR 2022

PROGRAMMERS: This document details the specifications for the **Institutional 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.

    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 1:
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 2:
Items requiring integration with the call center case management system (see items in PINK FONT) are still pending.

NOTE 3:
WESTAT EDIT SPECS:

Westat did not have Institutional edit specs, so the appropriate Hospital edit specs are provided. Same for the decision logs.

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 4:
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

EVENT DATE - admit/discharge dates
At least month and year must be recorded.

SERVICES/CHARGES –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, OTPAYMOSTXT, OTHOTOS, OTHOTOSTXT, Q13OTPAYMOS, Q13OTPAYMOSTXT, WHATANC, WHATANCTXT, ANCWHAT, ANCWHATTXT.

SECTION 1 – OMB

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

READ THIS ALOUD ONLY IF REQUESTED BY RESPONDENT.

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

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

1. CONTINUE

SECTION 2 – MEDICAL RECORDS – EVENT DATE

[PAGE 1 – MEDICAL RECORDS – EVENT DATE (1 of 1)]

A1. What was the (admit/discharge) dats of the (first/next) stay? ENTER A DATE IN FORMAT MM/DD/YYYY. INCLUDE LEADING 0's FOR SINGLE DIGIT MONTHS AND DAYS.	ADMIT: **EVTBEG_DATE** MM/DD/YYYY DISCHARGE: **EVTEND_DATE** MM/DD/YYYY

PROGRAMMER NOTES

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

EVTBEG_DATE – value for month (MM) should be between 1 and 12
EVTBEG_DATE – 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)
EVTBEG_DATE – value for year (YYYY) should be 2021 or 2022 (Add soft check for 2021 "WARNING - YOU HAVE ENTERED A YEAR OTHER THAN STUDY YEAR. PLEASE REVIEW AND CORRECT IF NEEDED, OR SUPPRESS AND CONTINUE.") (Add hard check for years other than 2021 or 2022 "YEAR MUST BE 2022, PLEASE CORRECT")
EVTEND_DATE – value for month (MM) should be between 1 and 12
EVTEND_DATE – 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)
EVTEND_DATE – value for year (YYYY) should be 2022 or 2023 (Add soft check for 2023 "WARNING - YOU HAVE ENTERED A YEAR OTHER THAN STUDY YEAR. PLEASE REVIEW AND CORRECT IF NEEDED, OR SUPPRESS AND CONTINUE.") (Add hard check for years other than 2022 or 2023 "YEAR MUST BE 2022, PLEASE CORRECT")

Onscreen for A1 EVTEND_DATE, display: CODE AS "9/9/9999" IF NOT YET DISCHARGED.

if EVTBEG_DATE year (YYYY) is 2021 and EVTEND_DATE year (YYYY) is 2023 (or 9999), then display soft check, otherwise go to A3; or if EVTBEG_DATE year (YYYY) and EVTEND_DATE year (YYYY) are not 2022, then display soft check otherwise goto A3. Soft check reads: YOU ENTERED DATES FOR A SINGLE STAY THAT INCLUDED ALL OF

2021. IF THIS WAS AN ERROR, PRESS "Goto" TO CORRECT YOUR DATE ENTRIES. IF THIS IS CORRECT, PRESS "Suppress."

If YYYY from EVTBEG_DATE = 2021 or if YYYY form EVTEND_DATE = 2023, display soft check: WARNING – YOU HAVE ENTERED A YEAR OTHER THAN STUDY YEAR. PLEASE REVIEW AND CORRECT IF NEEDED, OR SUPPRESS AND CONTINUE.

DK/REF: go to A2.

EDIT SPECS FROM WESTAT

QA2a INPATIENT (OR IC OR LTC) DOS

Follow Skip Pattern

DATA ITEM	SPECIFICATIONS	ACTION, if specification not met
QA2a - Dates of Inpatient, or IC, or LTC stay **CRITICAL ITEM (Month and Year)**	Admit date and Discharge date must both be present.	**Blue Sheet.**
	Month, day and year are needed.	**Blue Sheet** if all are blank. **Blue Sheet** if month or day is blank. **Blue Sheet** if year is blank and can't be determined. Fix year, if book is part of a sequence of books in 2009.
	Admit date may be in 2021 if Discharge date is in 2022. Discharge date may be in 2022 if Admit date is in 2022.	**Blue Sheet** if year is wrong, unless it is obvious that it is 2021. If it is in the middle of a sequence of books in chronological order, add 2021 if missing, or change to 2022 if wrong.
	Month, and Day are acceptable as DK or RF. Year is acceptable as DK or RF only after TRC verifies on Blue Sheet. If month or year is DK or RF, RC code for Pair is 60 – critical item is missing.	Change DK to – 8. Change RF to – 7. If year is DK or RF, write a **Blue Sheet,** asking if at least the year can be determined. Note: Day is not a critical item.
	Duplicate dates need managerial review. Book dates are same DOS (Date of Service). Inpatient date range overlaps an OP or ER DOS in another book. Inpatient date range overlaps a Global Fee date or Repeat Visit date in another book.	**Yellow Sheet.**

1. QA2b ADMITTED FROM ER?

Follow Skip Pattern

DATA ITEM	SPECIFICATIONS	ACTION, if specification not met
QA2b – For HS Event (inpatient stay) – Was the patient admitted from ER?	1 or 2 must be circled.	If missing, answer can be transferred from Box 4. **Blue Sheet,** if Box 4 answer is also missing.
	For HS: If 1 = Admitted from ER, there should be an ER event book. If 2 = Not Admitted from ER, there should not be an ER event book with a DOS that immediately precedes the HS event DOS.	If answer is 1, Admitted from ER, review other books in the case. **Blue Sheet,** if there is not an ER event book prior to the inpatient stay.

For IC Event - Is the discharge date given, or is the patient still in the institution? IC events are transferred from IC to HOSP event books.	Answer to QA2b must agree with the answer to Box 4.	Review Box 4. **Yellow Sheet** if answers to QA2b and Box 4 are not the same.
	FOR IC: 1 = Not yet discharged (Needs managerial review) 2 = Has discharge date	**Blue Sheet,** if missing and can't be determined from IC book.
		Yellow Sheet, if 1 (Not yet discharged).

Decision Log for QA2b

Question - Form Type	Problem	Decision / Categorization
QA2b, BOX 4, QC2b	**LINKED BOOKS - ONE BOOK IS NOT IN REFERENCE YEAR**	PER P. WARD AND C. VINCENT 3/3/05
Linked Books	TRC NOTES THAT CHARGES CANNOT BE BROKEN OUT	DELETE ER OR OP LINKED BOOK
	BOOK IS NOT IN REFERENCE YEAR, BUT IS LINKED TO BOOK IN REFERENCE YEAR.	WRITE "DELETED - YEAR _____ LINKED EVENT" ON THE FRONT COVER AND INITIAL COVER
		RENUMBER REMAINING BOOKS
		CROSS OUT ALL NODES THAT CAME FROM DELETED BOOK
		CROSS OUT ANY SBD FORMS THAT ONLY HAD NODES FROM DELETED BOOK
		IN LINKED INPATIENT BOOK, QA2B SHOULD SAY "1" YES, ADMITTED FROM ER
		IN LINKED INPATIENT BOOK, BOX 4 SHOULD SAY "1" ADMITTED FROM ER
		IN LINKED INPATIENT BOOK, QC2b SHOULD SAY "1" EMERGENCY ROOM CHARGE INCLUDED.

SECTION 3 – MEDICAL RECORDS – DIAGNOSES
[PAGE 2 – MEDICAL RECORDS - DIAGNOSES (1 of 1)]

A3. I need the diagnoses for this stay. I would prefer the ICD-10 codes (or DSM-5 codes), if they are available. IF CODES ARE NOT USED, RECORD DESCRIPTIONS. RECORD UP TO FIVE ICD-10 CODES OR DESCRIPTIONS.	CODE	DESCRIPTION
	ICDCND#	**ICDPDS#**
	ICDCND#	**ICDPDS#**
	ICDCND#	**ICDPDS#**
	ICDCND#	**ICDPDS#**
	ICDCND#	**ICDPDS#**

a letter number Letter or number

PROGRAMMER NOTES
[SYSTEM WILL ALLOW FOR A MAXIMUM OF 5 ICD-10 CODES TO BE COLLECTED]

This is a question loop that will require:

(1) A HISTORY BOX to display responses already collected.

(2) A question to appear after each iteration of the questions that reads: Any more diagnoses? YES=1 NO=2

Description field (ICDPDS) = up to 100 characters.

For ICDCND, display “ENTER CODE” on screen. For ICDPDS, display “ENTER DESCRIPTION” on screen.

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

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

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

EDIT SPECS FROM WESTAT

QA4a DIAGNOSIS
Diagnosis is a Critical Item
Follow Skip Pattern

DATA ITEM	SPECIFICATIONS	ACTION, if specification not met
QA4a – Diagnosis	Must have at least one Diagnosis, in text or code.	Blue Sheet.
	DK and RF are acceptable answers.	Change DK to –8. Change RF to –7. Code PL-IV as 60, critical item is DK or RF.

<table>
<tr><td rowspan="5">CRITICAL ITEM

USED FOR DETERMINING SBDs</td><td></td><td>If one Diagnosis is given and another is DK, cross out the DK and keep the Diagnosis given.</td></tr>
<tr><td>Diagnosis descriptions must be valid, clear, and legible.</td><td>Blue Sheet</td></tr>
<tr><td rowspan="2">Diagnosis descriptions may be the identification of a disease or illness.
Symptoms are acceptable for Diagnosis.
Procedures are acceptable for Diagnosis.</td><td>Accept the name of a disease.
Accept symptoms such as cough or nausea.
Accept procedures such as lab work, screening mammogram, flu shot, employment physical, or school physical.</td></tr>
<tr><td>Do not accept “Follow-up” without any other information. Blue Sheet, asking Follow-up for what.</td></tr>
<tr><td>Abbreviations in the Description field should be standard medical abbreviations.</td><td>Review abbreviations.
Check reference list in manual.
Check medical dictionary.
Ask team leader to check website.
Yellow Sheet, if not found, and team leader is not available.</td></tr>
<tr><td>There should be only 1 diagnosis per line.
If there are 5 or more codes, the order of the codes must be maintained.
<table>
<tr><th>Change</th><th>To</th><th></th><th>Change</th><th>To</th></tr>
<tr><td>650 652
V27.1
V25.2
V25.09</td><td>650
652
V27.1
V25.2
V25.09</td><td></td><td>650
652
V27.1
V25.2</td><td>650
V27.1
V25.2
652</td></tr>
</table></td><td>If two codes are listed on the same line, rewrite one of the codes.
If there are 4 or less Diagnoses, write the code on the last line.
If there are 5 or more Diagnoses, write the code on the next line and rewrite all other codes, keeping them in order.</td></tr>
<tr><td>The code field and the description field cannot be used on the same line.
CODE DESCRIPTION
650 <s>Normal Delivery</s>

A mixture of codes and descriptions are acceptable if they are on different lines.
CODE DESCRIPTION
650 _____
____ Normal Delivery</td><td>Look up the diagnosis code in the ICD-10 reference book.

If they are on the same line, and the code’s definition exactly matches the text description, cross out the text and keep the code. Do not look up codes if they are on different lines.

If there are 5 or more Diagnoses, write the code on the next line and rewrite all other codes, keeping them in order</td></tr>
<tr><td>QA4a–Diagnosis, cont.

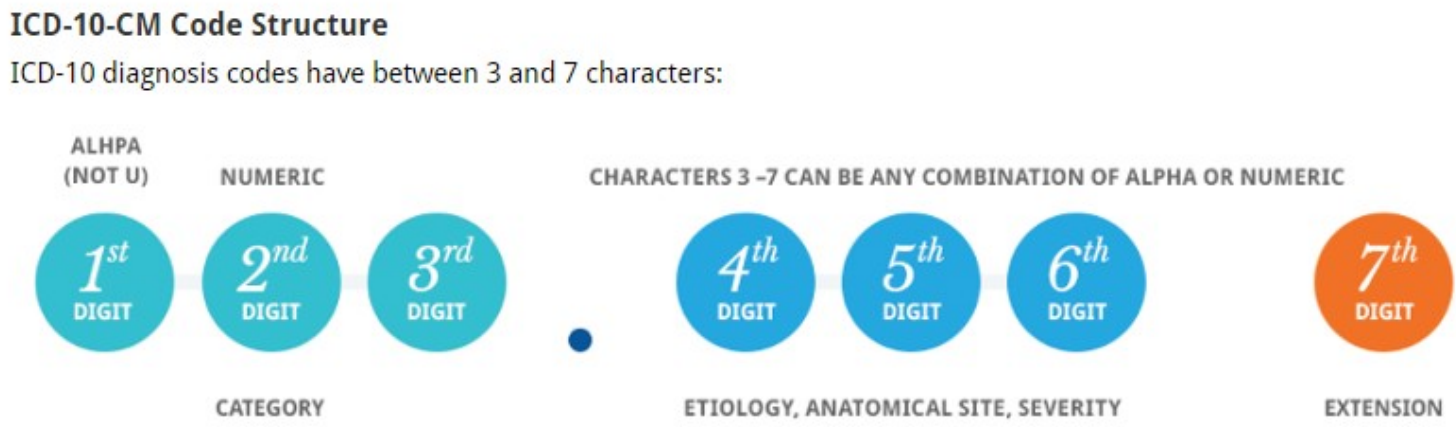
CRITICAL ITEM

USED FOR DETERMINING SBDs</td><td>A diagnosis may only appear in the book once.
Note: different numbers after the decimal mean that a diagnosis is not a duplicate. Keep both.
547.11 and 547.1 are not duplicates.
698 and 698.0 are not duplicates.</td><td>Cross out a duplicate diagnosis.</td></tr>
<tr><td rowspan="2">If the number of diagnoses is greater than 4, a continuation sheet may be used.</td><td>Staple the continuation sheet to the top of Page 2.</td></tr>
<tr><td>If extra diagnoses were written without a continuation sheet, make sure that they are legible for Cading, or rewrite them on a continuation sheet.</td></tr>
<tr><td>Descriptions cannot go over 100 characters.</td><td>Take to a team leader to shorten, or write a Yellow Sheet.</td></tr>
</table>

	Some sequential events will have ongoing treatments for a condition. Pre-natal care Dialysis Physical or Occupational Therapy If diagnosis is given in some books, but DK or RF in other books, managerial review is needed	**Yellow Sheet**, if diagnosis is given in some books, but is DK or RF in other books.
Diagnosis Counter	Office Use Only box must be filled in. The Office Use Only box is only used on the booklet page, not on the Continuation Sheet.	Count the number of diagnoses and enter as a 2-digit, zero-filled number.
		Diagnosis of DK or RF = Diagnosis count of 01.

CHEAT SHEET RANGES FOR DIAGNOSES (ICD-10)

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



A2. I need to record the name and specialty of each physician who provided services during the stay starting on (ADMIT DATE) and whose charges might not be included in the facility bill. We are interested in physicians with whom your facility has contractual arrangements, not the patient's private physician.

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

IF RESPONDENT IS UNSURE WHETHER A PARTICULAR DOCTOR'S CHARGES ARE INCLUDED IN THE INSTITUTION BILL, RECORD YES HERE.

YES, SEPARATELY BILLING DOCTORS FOR THIS EVENT……1

NO SEPARATELY BILLING DOCTORS FOR THIS STAY……..2

DO NOT HAVE THIS INFORMATION……..3

ANYSBDS

I need to record the name and specialty of each physician who provided services during the stay starting on (ADMIT DATE) and whose charges might not be included in the facility bill. We are interested in physicians with whom your facility has contractual arrangements, not the patient's private physician.

ENTER NEW SBD INFO.....1
SELECT EXISTING SBD.....2
UPDATE DATA FOR THIS SBD.....3
DELETE THIS SBD ROW.....4
DONE ENTERING SBDS / NO MORE.....7

SBD_SOURCE

SELECT SBBD ACTION

PROGRAMMER NOTES

If ANYSBDS = 1, the system will automatically generate an SBD form at that time to be filled out with MR (see specifications for programmers in *MPC-DC09 SBD Form 2009v1_forRCD(v1.0).doc*)
If ANYSBDS = 2 or 3, continue to Step 1 of SBD Real Time Prompting.
IF A3 ANYSBDS=YES, ASK EF1

(ADMIT DATE) should fill from EVTBEG_DATE from A1.

DK/REF – CONTINUE TO Step 1 of SBD Real Time Prompting.

2019 UPDATE: When no SBDs have yet been added to any events within a contact group, the options available for the SBD_SOURCE item are:

1. ENTER NEW SBD INFO
7. DONE ENTERING SBDs / NO MORE

After SBDs have been entered for any event(s) within a contact group, additional options are displayed at item SBD_SOURCE. In addition to options 1 and 7 (from list above), other options include:

2. SELECT EXISTING SBD
3. UPDATE DATA FOR THIS SBD
4. DELETE THIS SBD ROW

Option 1 allows the entering of information about an SBD new to a contact group.

Option 2 allows an SBD already entered in another event to be selected from an existing list of SBDs entered in other events within the contact group.When an existing SBD is selected, the name and specialty fill, but Service and role do not fill, and must be completed for each new event.The Comments field can also be added for the new event (but is not required to be completed).

Option 3 allows a selected SBD's GROUP, PREFIX, FIRST, MIDDLE, LAST, NTL_PROVIDER, and SPECIALTY fields to be edited. Edits to these fields will affect all occurrences of a particular SBD within the contact group.

Option 4 deletes a selected SBD and associated information from the current event, but not from the entire contact group.

Option 7 exits the SBD subroutine.

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

Physician Name: **NODE.SBDDOC**

GROUP/PREFIX/FIRST /MIDDLE /LAST NTL_PROVIDER

EF3 What is this physician's specialty?

DCS: START TYPING IN SPECIALTY TO MAKE A SELECTION.

Specialty: **NODE.SBDSPEC**

(IF OTHER SPECIFY:) Please specify the other specialty. **R_NODE.OSSBDSPEC**

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

SELECT ONE

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

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

SELECT ONE

SCREEN LABEL	DISPLAY ORDER	NODE	STORED VALUE
Active Physician/Providing Direct Care	1	**NODE.ACTIVE**	6
Referring Physician	2	**NODE.REFERRAL**	1
Copied Physician	3	**NODE.COPIED**	2
Follow-up Physician	4	**NODE.FOLLOWUP**	3
Department Head	5	**NODE.DEPTHEAD**	4
Primary Care Physician	6	**NODE.PRIMARY**	5
Some Other Physician	7	**NODE.OTHDOC**	7
None of the above	8	**NODE.NONE**	8
DON'T KNOW	9	**R_NODE.DOCDK**	9

Please describe the other role. (IF OTHER DESCRIBE) **NODE.ODOCTYOS**

EF6 ENTER ANY COMMENTS ABOUT THIS SBD, INCLUDING ADDITIONAL SERVICES TO THE ONE PREVIOUSLY SELECTED [FILL SPECIALTY].

R_NODE.EVENNOTE

PROGRAMMER NOTES: SBD SUBROUTINE

2019 UPDATE: When the first SBDs within a contact group are being added to an event, the options available for the SBD_SOURCE item are:

- 1. ENTER NEW SBD INFO
- 7. DONE ENTERING SBDs / NO MORE

After SBDs have been entered for any event(s) within a contact group, additional options are displayed at item SBD_SOURCE. In addition to options 1 and 7 (from list above), other options include:

- 2. SELECT EXISTING SBD
- 3. UPDATE DATA FOR THIS SBD
- 4. DELETE THIS SBD ROW

Option 1 allows the entering of information about an SBD new to a contact group.

Option 2 allows an SBD already entered in another event to be selected from an existing list of SBDs entered in other events within the contact group.When an existing SBD is selected, the name and specialty fill, but Service and role do not fill, and must be completed for each new event.The Comments field can also be added for the new event (but is not required to be completed).

Option 3 allows a selected SBD's GROUP, PREFIX, FIRST, MIDDLE, LAST, NTL_PROVIDER, and SPECIALTY fields to be edited. Edits to these fields will affect all occurrences of a particular SBD within the contact group.

Option 4 deletes a selected SBD and associated information from the current event, but not from the entire contact group.

Option 7 exits the SBD subroutine.

2018 UPDATE: Create the ability to add notes in the system when keying SBD or any "additional information" (Example: Internal Medicine Dr serving as the Cardiologist). This information would be seen on the SBD node listing screen and master node list. This will assist the SBD DCS to probe more effectively to locate the correct SBD/data.

2018 UPDATE: On the list for SBD specialties, add "Respiratory Therapy".

2017 UPDATE: Move "Previous SBD" list to the middle of the page for better visibility.

2017 UPDATE: On the dropdown for SBD specialties, add the following options.

- Occupational Therapy
- Physical Therapy
- Speech Therapy

2016 UPDATE: SBD information collected to appear in alphabetical order in the SBD list.
2016 UPDATE: SBD groups to appear in the SBD list.
2016 UPDATE: The following items will be edited so that the Event Form matches the Abstraction Notes Forms:

In the list for item EF2, place #s in front of each option:

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

In the list for item EF5, place #s in front of each option:

1. Active Physicians/Providing Direct Care
2. Referring Physician
3. Copied Physician
4. Followup Physician
5. Department Head
6. Primary Care Physician

7. Some Other Physician
8. None of the above
9. DON'T KNOW

This SBD subroutine in hospital event form is a loop of six (6) questions, EF1 to EF6, and a "stop command" in EF7. The subroutine collects SBD name, specialty, billing practices, and role in this particular institution event (e.g., sometimes SBDs are just offering advice).

After the collection of the SBD name in EF1, display the name under the main header in the upper left, but above the next questions within the SBD subroutine. After the collection of specialty in EF3, display the specialty with the name in the header for remaining SBD subroutine questions about that SBD.

Launch the SBD subroutine when question A3 ANYSBDS=YES (1).
If user enters A3=NO (2) or DK or REF, A3 should remain accessible via navigation back to item A3 to allow revision of A3 to YES.

EF1: We want users to enter name of doctor or group and populate a dynamic database *at the provider-level, no higher.* Display three text fields for user to record the SBD's first name, middle name or initial, and last name. Label those text fields as FIRST, MIDDLE, LAST. In later event forms, the user should be able to "Select Existing SBD" and see names already entered from previous event forms. Move Group Name before Prefix and Name fields.
Allow DK/REF

Fields include:
- GROUP = EF1GROUP
- PREFIX = EF1PREFIX
- FIRST = EF1FIRST
- MIDDLE = EF1MIDDLE
- LAST = EF1LAST
- NTL_PROVIDER = EF1NPID

EF3:
As one types characters in this field, EF3 should display corresponding list of specialties. For example if user starts entering "pedi…" they should see "pediatric allergy," "pediatric cardiology," pediatric critical care medicine," and so on. Note the other-specify text box, R_NODE.OSSBDSPEC, to hold 50 characters. Do not require response in box. There is an enumerated option for "Unknown."

Fields include:
- SPECIALTY = EF3SPECIALTYDESC
- EF3SPECIALTY (automatically fills specialty ID based on description entered in SPECIALTY)
- OTH_SPECIALTY = EF3SPEC_OTHER

EF2: Do not allow DK/REF. Note that Don't Know is an enumerated response.

Field: SERVICE = EF2SERVICE

EF5: Allow REF. Note that Don't Know is an enumerated response.

Fields include:
- ROLE_ASK = EF5ROLE_ASK
- EF5ROLE (automatically filles based on value entered in EF5ROLE_ASK)
- OTHER_ROLE = EF5ROLE_OTHER

Note the other-specify text box, NODE.ODOCTYOS, to hold 50 characters. Do not require response in box.

EF6: Text box to allow 100 characters. Do not require response in box.
DK/REF CONTINUE TO SBD_SOURCE

Field: OTHER_ROLE = EF5ROLE_OTHER

At the form level, the required fields are EF1 (Items EF1FIRST and EF1LAST), EF3 (EF3SPECIALTYDESC), EF2 (EF2SERVICE), EF5 (EF5ROLE_ASK). Other fields within EF1 are optional. EF6 is optional. User is not allowed to move beyond item EF5 for an SBD before completing the required fields FOR EF1, EF3, EF2, AND EF5. Attempting to move past past EF5 without completing all the required elements results in the following hard check: “FIRST AND LAST NAME, SPECIALTY, SERVICE, AND ROLE ARE REQUIRED WHEN ENTERING OR UPDATING AN SBD.”

Table of Physician Specialties

General Classification from EF2	code	New label for user in OY2
1, Radiology	1000	Radiology - General
1, Radiology	1001	Radiology - Abdominal
1, Radiology	1002	Radiology - Diagnostic
1, Radiology	1003	Radiology - Neuroradiology
1, Radiology	1004	Radiology - Nuclear
1, Radiology	1005	Radiology - Pediatric
1, Radiology	1006	Radiology - Radiation Oncology
1, Radiology	1007	Radiology - Radiological Physics
1, Radiology	1008	Radiology - Radiology/Neuroradiology
1, Radiology	1009	Radiology - Vascular & Interventional Radiology
1, Radiology	1999	Radiology - Radiology Other Specify
2, Anesthesiology	2000	Anesthesiology - General
2, Anesthesiology	2001	Anesthesiology - Certified Registered Nurse Anesthesiologist (CRNA)
2, Anesthesiology	2002	Anesthesiology - Critical Care Medicine
2, Anesthesiology	2003	Anesthesiology - Medical Toxicology Preventive Medicine
2, Anesthesiology	2004	Anesthesiology - Pain Management
2, Anesthesiology	2005	Anesthesiology - Pediatric
2, Anesthesiology	2999	Anesthesiology - Anesthesiology Other specify
3, Pathology	3000	Pathology - General
3, Pathology	3001	Pathology - Allergy & Immunology / Clinical & Lab Immunology
3, Pathology	3002	Pathology - Anatomic & Clinical Pathology
3, Pathology	3003	Pathology - Anatomic
3, Pathology	3004	Pathology - Chemical
3, Pathology	3005	Pathology - Clinical & Lab Dermatological Immunology
3, Pathology	3006	Pathology - Clinical & Lab Immunology Internal Medicine
3, Pathology	3007	Pathology - Clinical & Lab Immunology Pediatrics
3, Pathology	3008	Pathology - Clinical
3, Pathology	3009	Pathology - Cytopathology
3, Pathology	3010	Pathology - Dermatopathology
3, Pathology	3011	Pathology - Forensic
3, Pathology	3012	Pathology - Hematology
3, Pathology	3013	Pathology - Molecular Genetic Pathology
3, Pathology	3014	Pathology - Neuropathology
3, Pathology	3015	Pathology - Pediatric
3, Pathology	3016	Pathology - Selective
3, Pathology	3999	Pathology - Pathology Other specify
4, Surgery	4000	Surgery - General
4, Surgery	4001	Surgery - Abdominal
4, Surgery	4002	Surgery - Adult Reconstructive Orthopedics
4, Surgery	4003	Surgery - Cardiothoracic
4, Surgery	4004	Surgery - Certified Peri Surgery Nurse (CNOR)
4, Surgery	4005	Surgery - Colon & Rectal
4, Surgery	4006	Surgery - Craniofacial
4, Surgery	4007	Surgery - Dermatologic

4, Surgery	4008	Surgery - Facial Plastic
4, Surgery	4010	Surgery - Hand
4, Surgery	4011	Surgery - Head & Neck
4, Surgery	4012	Surgery - Neurological
4, Surgery	4013	Surgery - Orthopedic
4, Surgery	4014	Surgery - Orthopedic Surgery of the Spine
4, Surgery	4015	Surgery - Pediatric Cardiothoracic
4, Surgery	4016	Surgery - Pediatric
4, Surgery	4017	Surgery - Pediatric Surgery Neurology
4, Surgery	4018	Surgery - Plastic
4, Surgery	4019	Surgery - Plastic Surgery within Head & Neck
4, Surgery	4020	Surgery - Sports Medicine Orthopedic
4, Surgery	4021	Surgery - Surgeon/Thoracic
4, Surgery	4022	Surgery - Critical Care
4, Surgery	4023	Surgery - Surgical Oncology
4, Surgery	4024	Surgery - Transplantation
4, Surgery	4025	Surgery - Traumatic
4, Surgery	4026	Surgery - Vascular
4, Surgery	4999	Surgery - Surgery Other specify
5, Other specialty	5000	Addiction Medicine
5, Other specialty	5001	Addiction Psychiatry
5, Other specialty	5002	Adolescent Medicine Internal Medicine
5, Other specialty	5003	Allergy & Immunology
5, Other specialty	5004	Audiology
5, Other specialty	5005	Blood Banking/Transfusion
5, Other specialty	5006	Cardiac Electrophysiology
5, Other specialty	5130	Cardiology
5, Other specialty	5007	Cardiovascular Diseases
5, Other specialty	5008	Certified Nurse Midwife
5, Other specialty	5009	Certified Registered Nurse First Assistant (CRNFA)
5, Other specialty	5010	Child & Adolescent Psychiatry
5, Other specialty	5011	Child Neurology
5, Other specialty	5012	Chiropractic
5, Other specialty	5013	Clinical Biochemical Genetics
5, Other specialty	5014	Clinical Cytogenetics
5, Other specialty	5015	Clinical Genetics
5, Other specialty	5016	Clinical Molecular Genetics
5, Other specialty	5017	Clinical Neurophysiology
5, Other specialty	5018	Clinical Pharmacology
5, Other specialty	5019	Critical Care Medicine Internal Medicine
5, Other specialty	5020	Critical Care Medicine Obstetrics & Gynecology
5, Other specialty	5021	Dermatology
5, Other specialty	5022	Developmental Behavioral Pediatrics
5, Other specialty	5023	Diabetes
5, Other specialty	5024	Emergency Medicine
5, Other specialty	5025	Endocrinology, Diabetes & Metabolism
5, Other specialty	5026	Epidemiology
5, Other specialty	5027	Family Nurse Practitioner (FNP)

5, Other specialty	5028	Family Practice
5, Other specialty	5029	Forensic Psychiatry
5, Other specialty	5030	Gastroenterology
5, Other specialty	5031	General Practice
5, Other specialty	5032	General Preventive Medicine
5, Other specialty	5033	Geriatric Medicine Family Practice
5, Other specialty	5034	Geriatric Medicine Internal
5, Other specialty	5035	Geriatric Psychiatry
5, Other specialty	5036	Gynecological Oncology
5, Other specialty	5037	Gynecology
5, Other specialty	5038	Hematology Internal Medicine
5, Other specialty	5039	Hematology/Oncology
5, Other specialty	5040	Hepatology
5, Other specialty	5041	Hospital Rounders/Hospitalist
5, Other specialty	5042	Immunology
5, Other specialty	5043	Infectious Diseases
5, Other specialty	5044	Infertility
5, Other specialty	5045	Internal Medicine
5, Other specialty	5046	Internal Medicine/Pediatrics
5, Other specialty	5047	Interventional Cardiology
5, Other specialty	5048	Legal Medicine
5, Other specialty	5049	Licensed Alcohol and Drug Counselor (LADC)
5, Other specialty	5050	Licensed Professional Counselor (LPC)
5, Other specialty	5051	Maternal & Fetal Medicine
5, Other specialty	5052	Medical Genetics
5, Other specialty	5053	Medical Management
5, Other specialty	5054	Medical Microbiology
5, Other specialty	5055	Medical Oncology
5, Other specialty	5056	Medical Toxicology Emergency Medicine
5, Other specialty	5057	Medical Toxicology Pediatrics
5, Other specialty	5058	Medicine Emergency Medicine
5, Other specialty	5059	Medicine Pediatrics
5, Other specialty	5060	Mental Health
5, Other specialty	5061	Molecular Genetic Pathology (Medical Genetics)
5, Other specialty	5062	Musculoskeletal Oncology
5, Other specialty	5063	Adolescent Medicine Pediatrics
5, Other specialty	5064	Aerospace Medicine
5, Other specialty	5065	Allergy
5, Other specialty	5066	Neonatal Perinatal Medicine
5, Other specialty	5067	Nephrology
5, Other specialty	5068	Neurodevelopmental Disabilities (Pediatrics)
5, Other specialty	5069	Neurodevelopmental Disabilities (Psychiatry)
5, Other specialty	5070	Neurology
5, Other specialty	5071	Neurology/Diagnostic
5, Other specialty	5072	Nuclear Medicine
5, Other specialty	5073	Nurse Practitioner (NP)
5, Other specialty	5074	Nutrition
5, Other specialty	5075	OB Advanced RN Practitioner (ARNP)

5, Other specialty	5076	Obstetrics
5, Other specialty	5077	Obstetrics & Gynecology
5, Other specialty	5078	Occupational Medicine
5, Other specialty	5132	Occupational Therapy
5, Other specialty	5079	Oncology
5, Other specialty	5080	Ophthalmology
5, Other specialty	5081	Orthopedic Trauma
5, Other specialty	5082	Orthopedics
5, Other specialty	5083	Osteopathic Manipulative Medicine Foot & Ankle
5, Other specialty	5131	Osteopathy
5, Other specialty	5084	Otolaryngology
5, Other specialty	5085	Otology
5, Other specialty	5086	Pain Management (Physical Medicine & Rehabilitation)
5, Other specialty	5087	Pain Medicine
5, Other specialty	5088	Palliative Medicine
5, Other specialty	5089	Pediatric Allergy
5, Other specialty	5090	Pediatric Cardiology
5, Other specialty	5091	Pediatric Critical Care Medicine
5, Other specialty	5092	Pediatric Emergency
5, Other specialty	5093	Pediatric Endocrinology
5, Other specialty	5094	Pediatric Gastroenterology
5, Other specialty	5095	Pediatric Hematology Oncology
5, Other specialty	5096	Pediatric Infectious Diseases
5, Other specialty	5097	Pediatric Nephrology
5, Other specialty	5098	Pediatric Ophthalmology
5, Other specialty	5099	Pediatric Orthopedics
5, Other specialty	5100	Pediatric Otolaryngology
5, Other specialty	5101	Pediatric Pulmonology
5, Other specialty	5102	Pediatric Rehabilitation Medicine
5, Other specialty	5103	Pediatric Rheumatology
5, Other specialty	5104	Pediatric Urology
5, Other specialty	5105	Pediatrics
5, Other specialty	5106	Pharmaceutical Medicine
5, Other specialty	5107	Physiatrist
5, Other specialty	5108	Physical Medicine & Rehabilitation
5, Other specialty	5133	Physical Therapy
5, Other specialty	5109	Physicians Assistant (PA, PAC)
5, Other specialty	5110	Podiatry
5, Other specialty	5111	Preventive Medicine Public Health & Gen Prev Med
5, Other specialty	5112	Proctology
5, Other specialty	5113	Psychiatry
5, Other specialty	5114	Psychoanalysis
5, Other specialty	5115	Pulmonary Critical Care Medicine
5, Other specialty	5116	Pulmonary Diseases
5, Other specialty	5117	Reproductive Endocrinology
5, Other specialty	5135	Respiratory Therapy
5, Other specialty	5118	Rheumatology
5, Other specialty	5119	Sleep Medicine

5, Other specialty	5134	Sleep Therapy
5, Other specialty	5120	Spinal Cord Injury
5, Other specialty	5121	Sports Medicine (Physical Medicine & Rehabilitation)
5, Other specialty	5122	Sports Medicine Emergency Medicine
5, Other specialty	5123	Sports Medicine Family Practice
5, Other specialty	5124	Sports Medicine Internal Medicine
5, Other specialty	5125	Sports Medicine Pediatrics
5, Other specialty	5126	Undersea Medicine & Hyperbaric Medicine
5, Other specialty	5127	Urgent Care
5, Other specialty	5128	Urology
5, Other specialty	5129	Vascular Medicine
5, Other specialty	5999	Other Unclassified Specialty
5, Other specialty	6999	Unknown

SBD REAL-TIME PROMPTING

OVERVIEW: If A3 collects a code in ICDCND# or text in ICDPDS# that is associated with certain expected SBDs (see list below STEP 3), but no such SBD was described in EF2, the system will prompt the respondent in real time with questions SBDPR1-SBDPR3. Those ask whether respondent overlooked SBDs in the medical record.

STEP 1: Upon collecting ICD code (ICDCND#) or description (ICDPDS#) then the system should set “expectation flags” for surgery, anesthesiology, pathology, radiology. Flag names are R_SPECTYPE_R (radiology), R_SPECTYPE_A (anesthesiology), R_SPECTYPE_P (pathology), and R_SPECTYPE_S (surgery). Flag values are by default 0, or set to 1 based on reported ICD code or description.

EXAMPLE 1: ICDCND# records a code of 91.6, which means microscopic examination of skin sample. That would set the flag to R_SPECTYPE_P = 1 because such a procedure implies an SBD trained in pathology was involved.

EXAMPLE 2: ICDPDS# records ”fluoroscopy” and R_SPECTYPE_R = 1 because such a procedure implies an SBD trained in radiology was involved.

EXAMPLE 3: ICDPDS# records “high fever and delirium” and no flag is set because those text phrases are not among those we are tracking in the list below STEP 3.

STEP 2: If R_SPECTYPE_S is set to “1” based on A3 responses, then system will check EF2 to see if it recorded specialties of Surgery (4), Anesthesiology (2), and Pathology (3) because those three specialties of SBDs often associated with surgery.

If R_SPECTYPE_A is set to “1” based on responses to A3, system will check EF2 to see if we have recorded an SBD specialty = Anesthesiology (2).

If R_SPECTYPE_P is set to “1” based on responses to A3, system will check EF2 to see if we have collected an SBD specialty = Pathology (3).

If R_SPECTYPE_R is set to “1” based on responses to A3, system will check EF2 to see if we have collected an SBD specialty = Radiology (1).

STEP 3: If STEP 2 determines we are not missing any expected specialty of SBDs, then go to A4c.

STEP 4: If STEP 2 determines we are missing one or more specialty, then SBDPR1 to SBDPR3 below administer as needed for each missing specialty to prompt respondents to re-check medical records.

SBDPR1: A diagnosis that you mentioned often involves a (FILL SPECIALTY) and we did not record such persons in the earlier questions about separately billing doctors. Do your records indicate that a [FILL_SPECIALTY] was associated with this patient event?

YES=1
NO=2

SBDPR1 PROGRAMMING NOTES

FILL SPECIALTY = “surgeon,” “anesthesiologist,” and “pathologist” when R_SPECTYPE_S=1
FILL SPECIALTY = “anesthesiologist” when R_SPECTYPE_A=1
FILL SPECIALTY = “pathologist” when R_SPECTYPE_P=1
FILL SPECIALTY = “radiologist” when R_SPECTYPE_R=1

If SBDPR1=YES, RETURN USER TO A2 via hard check: IF YES, GO BACK TO A2 AND THE SBD SELECTION SCREENS IN ORDER TO ACCOUNT FOR THE MISSING SBD FOR (FILL SPECIALTY). HIGHLIGHT ‘SBD.ANYSBDS’ BELOW, THEN CLICK ON THE ‘Goto’ BUTTON TO MOVE TO A2.
If SBDPR1=NO, ASK SBDPR3

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

Create a text box that allows 100 characters.

ICD-10 CODES ASSOCIATED WITH SBDS (VARIABLE NAME ICDCND#)

***NOTE ALL SURGERY RELATED CODES WILL ALSO PROMPT FOR ANESTHESIOLOGY AND PATHOLOGY**

ICD10	Text	Surg	Anest	Path	Rad	Other	ICD9
NA	procedure codes						01.0-86.99
I46.9	Cardiac arrest				Y	Cardiologist, ER physician	427.5
I51.1	Rupture of chordae tendineae	Y	Y	Y	Y	Cardiologist	429.5
I51.2	Rupture of papillary muscle	Y	Y	Y	Y	Cardiologist	429.6
J95.00	Tracheostomy complications					ER physician, pulmonologist	519
K11.3	Abscess of salivary gland	Y	Y	Y	Y		527.3
P00.6/ P00.7	Surgical operation on mother and fetus	Y	Y	Y		Neonatologist, OB-GYN	760.6
S11	Open wound of neck	Y	Y	Y		ER physician, pulmonologist	874
NA	Open wound of genital organs (external) including traumatic amputation	Y	Y	Y	Y	Gynecologist/urologist (depending on sex), neurologist	878
T30.0	Burn unspecified site	Y	Y	Y	Y	ER physician, neurologist, plastic surgeon	949
T41.44	Poisoning by other central nervous system depressants and anesthetics		Y	Y		Neurologist	968
S40 - S69	Traumatic amputation of thumb (complete) (partial), Traumatic amputation of other finger(s) (complete) (partial),Traumatic amputation of arm and hand (complete) (partial)	Y	Y	Y	Y	ER physician, neurologist	885-7

S88, S98	Traumatic amputation of toe(s) (complete) (partial), Traumatic amputation of foot (complete) (partial), Traumatic amputation of leg(s) (complete) (partial)	Y	Y	Y	Y	ER physician, neurologist	895-7
T80-T88	Complications Of Surgical And Medical Care, Not Elsewhere Classified	Y	Y	Y	Y		996-9
Z41.1	Elective hair transplant for purposes other than remedying health states, Other plastic surgery for unacceptable cosmetic appearance	Y	Y	Y		Plastic surgeon	V50-1
O74.9	Complications of the administration of anesthetic or other sedation in labor and delivery		Y			Cardiologist, neurologist, OB-GYN, pulmonologist	668
P02.9	Fetus or newborn affected by complications of placenta cord and membranes	Y	Y	Y		Neonatologist, OB-GYN, pediatrician	762
P03.9	Fetus or newborn affected by other complications of labor and delivery	Y	Y	Y		Neonatologist, neurologist, OB-GYN, pediatrician	763
Z37.9	Outcome of delivery	Y	Y	Y		Neonatologist, OB-GYN, pediatrician	V27
NA	procedure codes						90.0-91.9
D58.9	Hereditary hemolytic anemias			Y		Hematologist	282
D64.89, D64.9	Other and unspecified anemias			Y		Hematologist	285
D72.9	Diseases of white blood cells			Y		Hematologist	288
O99.119	Coagulation defects complicating pregnancy, childbirth, or the puerperium			Y		Hematologist, neonatologist, OB-GYN, pediatrician	649.3
O99.350	Epilepsy complicating pregnancy, childbirth, or the puerperium				Y	Neonatologist, neurologist, OB-GYN, pediatrician	649.4

<u>ICD-10 TEXT ASSOCIATED WITH SBDS</u> (VARIABLE NAME ICDPDS#)

***NOTE ALL SURGERY RELATED TEXT WILL ALSO PROMPT FOR ANESTHESIOLOGY AND PATHOLOGY**

Surgery: surg*, excision, removal, incision, introduction, repair, operat*, biopsy, recovery, delivery, graft, transplant, *oscopy, EGD, ERCP, dilation, courettage, *ectomy, *ostomy, *oplasty, *rrhaphy,

Anesthesiology: anesth*, block, local

Pathology: pathol*, test, lab*, finding, biopsy, result, -puncture, draw, culture, chemistry, micro*, cytology, panel, profile, hemoglobin, hematology, cholesterol, lipid, lipoproteins, assay, antibody, screen, blood gases, smear, stain, occult blood, count, hematocrit, re-agent, transfusion, blood bank, blood sugar, A1C, ABD, AFB, thrombo*, APTT, BMP, bleeding time, BT, blood urea, BUN, C & S, CBC, sensitivity, creatine, CK, CMP, dilation, courettage, D & C, ERA, FBS, Hb, lipoprotein, HDL, LDL, volume, MCV, MPV, OB, PAP, PKU, phenyl*, TB, PPD, PSA, antigen, prothrombin, PT, PTT, RBC, RDW, red cell, T & S, type, TSH, thyroid, UA, WBC, *alysis

Radiology: Radiolog*, ultra*, MRI, *scan, *gram, x-ray, imaging, diagnostic, nuclear, compute*, tomography, magnetic, resonance, fluoroscopy, *raphy, abdomen, wrist, upper GI, angio*, barium, techni*, roentgen, anterior*, posterior, AP, Ba, BaE, enema, CAT, C-spine, CT, axial, film, DSA, ERCP, endoscop-, radiation, ERT, Fx, fracture, GB, IRT, IVC, IVP, intravenous, KUB, kV, kW, kilo*, lateral, Lat, LGI, LL, NMR, PA, PET, emission, Ra, Rad, RL, UGI, UL, US, *graph

2019 Update: The following terms from the lists above will result in a prompt for SBDs only when the terms are stand-alone terms, and not part of a larger word or term.

PA, RA, US, CT, UL, LL, BA, ERA, CK, ERT, OB, LAT, CAT, RL, AP, ABD

These short terms are excluded from resulting in a prompt for SBDs based on the following process:

1. Process first searches for the existence of the small string within a larger string. If exists:
    a. Searches beginning of larger string for existence of smaller string plus space or other special character placed after it. Examples: "ct ", "ct-"
    b. Searches end of larger string for existence of smaller string plus space or other special character placed before it. Examples: " ct", ":ct"
    c. Searches larger string for existence of smaller string with combinations of special characters surrounding it. Examples: " ct ", "(ct ", " ct/", "(ct)", "[ct ", "+ct;", "_ct."
2. If one of the short terms is found through these searches to be a stand-alone term, it is allowed to result in the prompt for an SBD, as appropriate. If it is found to be part of a larger word/term, it is excluded from resulting in a prompt for an SBD.
3. Special characters involved in steps 1a-1c are:
    - (hyphen)
    (
)
    _ (underscore)
    +
    ‘
    “
    <
    >
    :
    ;
    /
    \
    [
    ]
    {
    }
    , (comma)
    . (period)

EDIT SPECS FROM WESTAT

QA3 ANY SBDs?

Follow Skip Pattern

DATA ITEM	SPECIFICATIONS	ACTION, if specification not met
QA3 – Any Separately Billing Doctors for this event?	Must be answered. 1 – YES, there are Separately Billing Doctors for this event 2 – NO, there are no SBDs for this event Live SBDs must have the Billing Status box BILLS SEPARATELY checked on the SBD form. ➢ If CHARGES ARE INCLUDED IN HOSPITAL BILL is checked on the SBD form, do not count this form as a live SBD. ➢ If no Billing Status box is checked on the SBD form – if the SBD form is completed, check the BILLS SEPARATELY box and count this form as a live SBD. ONLY THE TRC CAN CIRCLE 2 (NO SBDs).	If blank, review SBD forms. Do any dates on an SBD form match this event?
		If blank If the event date appears on a live SBD form for this event, write answer YES (1), THERE ARE SBDs.
		If QA3 is blank And no SBD for this event, **Blue Sheet,** saying "QA3 is not answered."
	I4 CASES HAVE NO SBDs. IF ALL PAIRS IN THE CASE ARE CODED I4, FOLLOW THE INSTRUCTIONS ON THE "I4 = NO SBDs REFERENCE SHEET. **In I4 cases, QA3 should be 2 (NO SBDs).**	
	If the answer is 1 – SEPARATELY BILLING DOCTORS FOR THIS EVENT There must be a live SBD for this event. This is true for all cases, even I4 cases which usually don't have SBDs.	**Blue Sheet**, if answered "1" but no live SBD for this event. Every event book with the answer "1" must have a live SBD. **Blue Sheet,** even if the case is an I4.
	If the answer from the TRC is 2 –NO SEPARATELY BILLING DOCTORS FOR THIS EVENT There should be no live SBD for this event. **Editors can change NO to YES, but ONLY THE TRC CAN CIRCLE 2 (NO SBDs).**	Change 2 (NO) to 1 (YES) if there is a live SBD form.
		SBD forms that are crossed out because "Charges are included in Hosp bill" cannot be counted as Separately Billing Doctors for the QA3 answer.
	DK or RF needs managerial review.	**Yellow Sheet.**
Notes on inside cover account for expected SBDs. **If the case is NOT an I4 –**	All cases except I4 cases must be reviewed to identify what SBDs would be expected. Look for S, A, P, R, ER **The TRC writes notes across from QA3 to indicate why an expected SBD is missing.**	As you edit the rest of the booklet, determine what specialties would be expected to provide service.
		Record the initials of the expected specialty on the front cover.
		Account for the specialty by reviewing SBD forms and TRC documentation.
	I4 cases do not need notes to account for expected specialties. Follow the instructions on the I4 reference sheet to make sure that the case follows the I4 criteria.	Write "I4 on the cover of the book, in place of the abbreviations for needed SBDs. Do not determine which SBDs are needed.

SECTION 7 – PATIENT ACCOUNTS – REIMBURSEMENT TYPE

[PAGE 6 – PATIENT ACCOUNTS - REIMBURSEMENT TYPE (1 of 1)]

SCREEN LAYOUT

Q5. Was the facility reimbursed for this stay on a fee-for-service basis or a capitated basis?

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

Capitated basis means that the patient was enrolled in a prepaid managed care plan, such as an HMO, and reimbursement to the facility was not based on the services provided. This is also called Per Member Per Month.

IF IN DOUBT, CODE FEE-FOR-SERVICE.

FEE-FOR-SERVICE BASIS ..... 1 **FEEORCAP**
CAPITATED BASIS..... 2

PROGRAMMER NOTES

IF FEEORCAP=1 GO TO Q6_1.

IF FEEORCAP=2 GO TO Q21a

DK/REF – CONTINUE TO Q6_1

EDIT SPECS FROM WESTAT

QC3 REIMBURSEMENT TYPE

Follow Skip Pattern

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 consistent 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 8 – PATIENT ACCOUNTS – SERVICES/CHARGES

[PAGE 7 – PATIENT ACCOUNTS - SERVICES/CHARGES (1 of 2)]

SCREEN LAYOUT

Q6_1. Did [Patient] have any health-related ancillary charges for this stay? That is, were there charges for additional services not included in the basic rate?

O 1 YES
O 2 NO

ADDANCSVCS

PROGRAMMER NOTES

IF Q6_1 = 2 (NO); GO TO Q6
IF Q6_1 = 1 (YES), DK, OR RF; GO TO Q6_2

SCREEN LAYOUT

Q6_2. Can you separate payments for ancillary services from payments for room/board/basic care?

O 1 YES
O 2 NO
O 3 NO, ANCILLARY CHARGES WERE ADJUSTED 100%

SEPANCSVCS

PROGRAMMER NOTES

IF Q6_2 = 1 (YES), DK, RF; GO TO Q6
IF Q6_2 = 2 OR 3, GO TO Q6 (WITH ADDITION OF “ANCILLARY CHARGES” TO QUESTION WORDING)

[PAGE 8 – PATIENT ACCOUNTS - SERVICES/CHARGES (1 of 2)]

SCREEN LAYOUT

Q6. What was the **full established charge** for room, board, and basic care for this stay, before any adjustments or discounts, between (ADMIT DATE) and (DISCHARGE DATE/END OF 2022?

EXPLAIN IF NECESSARY: The **full established charge** is the charge maintained in the facility's master fee schedule for billing private pay patients. It is the “list price” for the service, before consideration of any discounts or adjustments resulting from contractual arrangements or agreements with insurance plans.

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

FULL ESTABLISHED CHARGE OR CHARGE EQUIVALENT:

$ **TOTLCHRG**

CHECKPOINT: HAVE YOU BEEN ABLE TO DETERMINE THE FULL ESTABLISHED CHARGE?

YES, DID PROVIDE TOTAL CHARGE……..1
NO, CANNOT PROVIDE TOTAL CHARGE …2

UNESTCHRG

PROGRAMMER NOTES

2016 UPDATE: IF Q6_2 = 2 OR 3, ADD “ANCILLARY CHARGES” TO QUESTION WORDING. Question would read: What was the **full established charge** for room, board, basic care, and ancillary charges for this stay, before any adjustments or discounts, between (ADMIT DATE) and (DISCHARGE DATE/END OF 2022)?

Validation: If TOTLCHRG = 0 or > 250,000 administer soft check “YOU HAVE ENTERED ZERO OR AN AMOUNT OVER $250,000. PLEASE REVIEW AND CORRECT IF NEEDED, OR SUPPRESS AND CONTINUE.”

(ADMIT DATE) should fill from EVTBEG_DATE from A1.

(DISCHARGE DATE/END OF 2022) should fill from EVTEND_DATE from A1 unless A1=1. If A1 EVTEND_DATE=9/9/9999 fill with “end of 2022”.

Make the UNESTCHRG CHECKPOINT a required response. Interviewers must answer 1 or 2 before moving forward.

If UNESTCHRG=1 go to Q7. If UNESTCHRG=2 go to Q10.

Q6 - DOLLAR AMOUNTS SHOULD BE FORMATTED TO INCLUDE COMMAS and DECIMAL POINTS.

DK/REF ALLOWABLE FOR TOTLCHRG: IF DK OR REF, ASK UNESTCHRG, THEN GO TO Q10

Checkpoint response option 2 to be allowable only if a reserve code is used.

EDIT SPECS FROM WESTAT

QC2 TOTAL CHARGE

Follow Skip Pattern

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.	If there is only one charge, compare to Total. **Blue Sheet** if not the same.
	Calculator tape should be run to verify Total if there are multiple charges. Do not use the TRC's tape.	Run calculator tape. If tape doesn't match book, write NOT OK. If tape matches book, write OK. Initial the tape.
	If the Total Charge written by the TRC is less than sum of the Individual Charges, a correction can be made if the difference is 10% or less. Compare the amount of the difference and the Total Charge as written by the TRC. Note that changes can affect the answers to Box 2 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 2 to the appropriate answer.
		Blue Sheet, if QC6 was skipped, but now must be answered.
	If the Total Charge written by the TRC is greater than the sum of the Individual Charges, the TRC must make any corrections.	**Blue Sheet**.
	DK or RF is acceptable.	If Total Charge, and Total Pay, and Procedures are all DK or RF, **Yellow Sheet.**
	If one charge is DK or RF, Total Charge should be DK or RF.	**Yellow Sheet.**
	$0.00 is not acceptable. Nothing is Free.	**Yellow Sheet.**

[PAGE 8 – PATIENT ACCOUNTS - SERVICES/CHARGES (2 of 2)]

SCREEN LAYOUT

Q6a. Why is there no charge for room, board, and basic care for this stay?

FACILITY ASSUMES COST.....	1	NOCHARG
PREPAID TO CONTINUING CARE.....	2	
STATE-FUNDED INDIGENT CARE (NOT MEDICAID).....	3	
RELIGIOUS ORGANIZATION ASSUMES COST.....	4	
VA FACILITY.....	5	
OTHER (SPECIFY)_____	6	
OTHNOCHARG		

PROGRAMMER NOTES

After Q6a go to Q14.

"OTHER (SPECIFY)" option 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 REASONS? YES=1 NO=2

EDIT SPECS FROM WESTAT

There are no edits specs that reference Q6a in the Institutional event form & no comparable Hospital event form specs.

SECTION 9 – PATIENT ACCOUNTS – SOURCES OF PAYMENT

[PAGE 9 – PATIENT ACCOUNTS - SOURCES OF PAYMENT (1 of 1)]

SCREEN LAYOUT

Q7. From which of the following sources has the facility received payment for this charge and how much was paid by each source? Please include all payments that have taken place between (ADMIT DATE) and now for this stay.

IF NONE, ENTER ZERO (0).

[DCS ONLY] 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 Q5 AND CODE AS CAPITATED BASIS.

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

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**

Q8. [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?
IF NO, CORRECT ENTRIES ABOVE AS NEEDED.

TOTAL PAYMENTS **$ TOTLPAYM**

TOTALPAYMOK
YES=1
NO=2

PROGRAMMER NOTES

(ADMIT DATE) should fill from EVTBEG_DATE from A1.
Q7 - [SYSTEM WILL SET UP "SOMETHING ELSE" AS A LOOP, SO NO LIMIT REQUIRED]
Q7 - The OTPAYMOSTXT variable was added to record free-form text for the "Other, Specify" option. Interviewers will be able to record responses in the text box that do not occur in the listed items. Allows up to 50 characters.
Require an entry in each source of payment (SOP) field PATPAYM to WORKPAYM. Require an entry in OTHRPAYM if MoreSources = 1. The following are allowed entries: 0, integer, integer with 2 decimal places, F6/DK, F7/REF.
In the summary of charges that displays, "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 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?
If all the entries in the SOP fields are reserve codes, then display:
"I show the total payment as undetermined."
TOTLPAYM counts entries of DK or REF in the individual SOPs as "0".
This variable that is recorded on screen Q8 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., hotkeys F6, F7 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 are missing.

Even if all the individual payments recorded in Q7 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.”

2019 UPDATE: Each Q7 item a-h (PATPAYM to OTHERPAYM) appears on its own screen, along with the entire Q7 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.

When a user answers MoreSources_1 (“Any more payments”) as “No”, and one or more entries among PATPAYM, CAREPAYM, AIDPAYM, PINSPAYM, VAPAYM, CHAMPAYM, WORKPAYM equals DK, RF administer a soft check message: “ONE OR MORE PAYMENTS WAS RECORDED AS DON’T KNOW OR REFUSED. PLEASE REVIEW AND CORRECT IF NEEDED, OR SUPPRESS AND CONTINUE.”

Design Note Q8

Q8. REVIEW THIS SUMMARY

CHARGES
Total charges for room, board, basic care = $[TOTLCHRG]

PAYMENTS

Patient or family	$[PATPAYM]
Medicare	$[CAREPAYM]
Medicaid	$[AIDPAYM]
Private insurance	$[PINSPAYM]
VA/ChampVA	$[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?

IF INCORRECT, CORRECT ENTRIES SHOWN ABOVE AS NEEDED

Programmer:
Q8=NO THEN RETURN USER TO Q7, OTHERWISE CONTINUE.

Q7h is a question loop that will require:

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

Q7h – Include the following options for the “Other Specify”;
Auto or Accident Insurance

Indian Health Service
State Public Mental Plan
State/County/Local program
Other

Q7 - DK/REF – CONTINUE TO Q8

Q8 TOTLPAYM - DK/REF – CONTINUE TO BOX 1

DOLLAR AMOUNTS SHOULD BE FORMATTED TO INCLUDE COMMAS and DECIMAL POINTS

EDIT SPECS FROM WESTAT

QC4 PAYMENT SOURCES AND AMOUNTS

Follow Skip Pattern

DATA ITEM	SPECIFICATIONS	ACTION, if specification not met
C4 - Payment sources/ amounts **CRITICAL ITEM** is source of payment plus Total Payments The amount of Individual Payments is not a critical item See QC4 – QC6 Consistency notes on page 34.	Must be completed if Reimbursement Type = Fee For-Service	**Blue Sheet** if blank
	Every source of payment must have an amount 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 missing, or if sum of other sources does not equal Total.
	DK or RF are acceptable	Change DK to – 8. Change RF to – 7.
	If OTHER is answered, there must be an answer on the SPECIFY line	**Blue Sheet** if missing.
		If the answer is written outside of the answer line, circle the answer.
	Answer on the SPECIFY line needs review. Sometimes the answer is written outside the line, as a comment.	If the answer is written outside of the Specify line, and it is on the Decision Log, circle the answer to indicate that it should be Coded. **Yellow Sheet** if it is not on the Decision Log.
	"HMO" is not acceptable as a SPECIFY answer. "Public" is not acceptable as a SPECIFY answer. The name of an insurance co. is not acceptable as a SPECIFY answer. Note the same insurance company may provide private insurance and also administer Medicare and/ or Medicaid payments.	**Blue sheet,** asking which type of insurance Note the same insurance company can provide private insurance and also administer Medicare and/ or Medicaid payments
	Expect that an answer on line h OTHER/ SPECIFY will have a comparable answer in QC6 line h. For example, STATE PROGRAM in QC4 will have STATE PROGRAM ADJUSTMENT in QC6. Exceptions: Hospital w/o and Small bal adj in QC6 will not have a comparable answer in QC4. If there is no payment in QC4 line h, there may still be an adjustment in QC6.	**Yellow Sheet** if there is not a comparable answer in both questions.
	Adjustments and write offs should not be included in payments.	**Blue Sheet** if comments or answer to line (h) indicate that adjustments or write offs have been included.
	If payment by patient is $1.00 or less, expect that the insurance type will be a public type – Medicare, Medicaid, state program, etc.	**Yellow Sheet** if the insurance is not government insurance
	If a payment is made by VA, expect that the answer to QC6 will be Eligible Veteran or an OTHER/ SPECIFY answer that will reflect military service	**Yellow Sheet**
	Comments may need review. Payments by three or more insurance types need managerial review.	Compare comments about sources to the answers given in C4. **Yellow Sheet** if comments don't agree with the answer to QC4. **Yellow Sheet** all comments that are not included in the answer to QC4.
		Look at the payment sources in all books for a patient. **Yellow Sheet** if three or more insurance types.
	Lump payments need special handling.	See Lump payment instruction sheet, on page 5-29.

QC5 TOTAL PAYMENTS

Follow Skip Pattern

DATA ITEM	SPECIFICATIONS	ACTION, if specification not met
C5- Total Payments **CRITICAL ITEM**	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 If tape doesn't match book, write NOT OK. If tape matches book, write OK. Initial 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 Payments as written by the TRC. Note that changes can affect the answers to Box 2 and QC6.	If the difference is 10% or less than the Total, correct the Total Payments.
		Blue Sheet, if the difference is greater than 10%.
		Change Box 2 to the appropriate answer.
		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.	Change DK to – 8. Change RF to – 7. Code PL-IV as 60, critical item is missing.
	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. Comments: "Paid in Full," or "Zero Balance" or any other comment indicating that account is clear.	**Yellow Sheet** Total Pay = Total Charge, and we don't know Individual Payments, if there are comments as at left. If no such comment, accept as is.
	Total Payments greater than Total Charge need managerial review.	**Yellow Sheet all overpayments.**

Decision Log for QC4

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

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

LUMP SUM - PENDING FURTHER RTI DISCUSSION

QC4 – QC5 LUMP SUM PAYMENTS

DATA ITEM	SPECIFICATIONS	ACTION, if specification not met
QC4 – QC5 LUMP SUM INFORMATION	TRC supplies information needed to process the lump. This is usually in the form of a label on page 4 of the first book of a lump. Information supplied by TRC 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 QA 6b 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.
	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 2 should be the same in all books of the lump. If total lump charges = total lump payments, then Box 2 should be answered 1 (YES) in all books of the lump. If total lump charges don't equal total lump payments, then Box 2 should be answered 2 (NO) in all books of the lump.	Answer if blank.
		Correct Box 2 if wrong. This may change the skip pattern. Review QC6, if necessary.
	If lump payments = lump charges, and there is only one source of payment, 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.

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

BOX 1

DO TOTAL PAYMENTS EQUAL TOTAL CHARGE?

YES, AND ALL PAID BY PATIENT OR PATIENT'S FAMILY…… 1 (GO TO Q14)

YES, OTHER PAYERS…… 2 (GO TO Q8a)

NO, PAYMENTS < CHARGES - 3 (GO TO PLC1)
NO, PAYMENTS > CHARGES - 4 (GO TO ADJEXTRA**)**

IF, AFTER VERIFICATION, PAYMENTS DO NOT EQUAL CHARGE COMPLETE Q9 AND GO TO Q14
[PROGRAM BEHIND THE SCENES – SHOULD NOT APPEAR ON SCREEN. VARIABLE NAME=CPAYBOX]

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)***

PROGRAMMER NOTES

DESCRIPTION OF PROGRAMMING REQUIRED FOR BOX 1

IF Q6=Q8 AND ONLY Q7 OPTION WITH A RESPONSE IS 'a' (patient or patient's family – PATPAYM, GO TO Q14.
IF Q6=Q8 AND Q7 OPTIONS b, c, d, e, f, g, or h HAVE A RESPONSE, GO TO Q8a.
IF Q6≠Q8, GO TO Q9.

IF Q6 OR Q8 = DK/REF, GO TO Q14

EDIT SPECS FROM WESTAT

BOX 2 DO PAYMENTS = CHARGES? **Follow Skip Pattern**

DATA ITEM	SPECIFICATIONS	ACTION, if specification not met
BOX 2 – Total Payments = Total Charges or not	1 (YES), 2 (YES) or 3 (NO) must be circled.	Compare Total Charge to Total Payments.
	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 2.	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 10 – PATIENT ACCOUNTS – VERIFICATION OF PAYMENT

[PAGE 10 – PATIENT ACCOUNTS - VERIFICATION OF PAYMENT (1 of 1)]

SCREEN LAYOUT

Q8a. I recorded that the payment(s) you received equal the charge. 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 Q8]. 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 Q7.

YES, FINAL PAYMENTS RECORDED IN Q7 AND Q8 =1 **EQPAYOK**

NO =2

PROGRAMMER NOTES

[IF EQPAYOK=1 GO TO Q14.
IF EQPAYOK=2 DISPLAY HARD CHECK: "IF INCORRECT, RETURN TO Q7 AND CORRECT PAYMENT ENTRIES AS NEEDED."]

payment(s) - If Q7 has one response fill: " " ELSE fill: "s".

AMOUNT(S) – If Q7 has one response fill: " " ELSE fill: "s".

IF EQPAYOK = DK OR REF, DISPLAY SOFT CHECK: "DON'T KNOW OR REFUSED WAS RECORDED. PLEASE REIVEW AND CORRECT IF NEEDED, OR SUPPRESS AND CONTINUE."

EDIT SPECS FROM WESTAT

BOX 2 and QC5a DO PAYMENTS = CHARGES?

Follow Skip Pattern

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 2 jumps over this question, unless Box 2 is answered 2.	If QC5a is blank, and Box 2 is 2 (YES, other payer), **Blue Sheet** for an answer to QC5a. If QC5a is answered, and Box 2 is answered 1 or 3, cross out the answer.

SECTION 11 – PAYMENTS LESS THAN CHARGES *(new section, Q9_UNDERPAYMENT)*

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

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

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

PROGRAMMER NOTE:

2020 UPDATE: If MOREPAY = 1 and BADDEB2 = 1, display a soft check after 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 Q9_UNDERPAYMENT to contain DISADJ, MOREPAY, SLIDSCA2, BADDEB2, and ELIGVET2 spec'd above as PLC1a-d.

ELIGVET2 – allow DK/REF

If MOREPAY=1 then show Q9_additional.

If **[**DISAD=1 and MOREPAY=1 **] or [**DISAD=2 and MOREPAY=2 and SLIDSCA2=2 and BADDEB2=2**]** then show Q9_additional.

If both SLIDSCA2=1 and BADDEB2=1 with no other selection, do not show Q9_additional.

If both SLIDSCA2=1 or BADDEB2=1 with no other selection, do not show Q9_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 12 – PATIENT ACCOUNTS – DIFFERENCE BETWEEN PAYMENT AND CHARGES

[PAGE 11 – PATIENT ACCOUNTS - DIFFERENCE BETWEEN PAYMENT AND CHARGES (1 of 1)]

SCREEN LAYOUT

Are you expecting additional payment from:

C9_Additional, Question Q9_additional

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; or 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 payment was more than the total charges. Is that correct?

DCS: IF THE ANSWER IS "NO" PLEASE GO BACK TO Q8 (VERIFY TOTAL PAYMENTS) TO RECONFIRM CHARGES AND PAYMENTS AS NEEDED

YES=1, NO=2

.

PROGRAMMER NOTES

2016 UPDATE:

(less than/more than) – [If Q8 < Q6 fill: "less than", else if Q8 > Q6 fill: "more than".

At least one entry among the variables on screen C9_additonal must be a "1", DK or RF. If all entries in the series are "2" (No) then administer a hard check when the user presses "Next" at C9_Additional, "You must select at least one reason for underpayment."

At C9_Additional

If Additional pymt expected (MOREPAY) selected as a reason at PLC1, require a selection (1,DK,RF) at C9_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_SLIDSCA2] == "No" || [SLIDSCA2] =="2") && ([SHOW_BADDEB2] == "No" || [BADDEB2] =="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.");
```

(ADMIT DATE) should fill from EVTBEG_DATE from A1.

Q9p, should 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.

Q9p - 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 instructions onscreen for EPAYOTOSTXT read “EXPECTING OTHER ADDITIONAL PAYMENT,” and ““PLEASE SPECIFY OTHER.” EPAYOTOSTXT field is 50 characters.

Q9p – Include the following options in a drop down menu 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 Q7h.

New is a multi-form validation check that for other providers appears on LSPCHECK. It should instead occur at the bottom of Q9 reasons series. IF (all source of payment fields PATPAYM to WORKPAYM and OTHRPAYM have entries of 0.00) or (TOTLPAYM is 0.00 or missing) AND (SLIDSCA2=”No” and BADDEB2=”No”) and all reasons for underpayment in the range of DISCARE to EPAYOTH, SLIDSCA, and BADDEB are answered “No”) AND (LSPCHECK=”No”) display a hard error at LSPCHECK, “PAYMENT VALIDATION FAILED: No payment source or reason(s) identified. Navigate to Sources of Payment or Payments NE Charges, or record Lum Sum Payment here.” This hard error will require user to correct one of those conditions or break off the event form.

2019 UPDATE: Each C9_additional item i-p (EPAYPAT to EPAYOTH) appears on its own screen, along with the entire C9_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 C9_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 C9_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 Q8 (VERIFY TOTAL PAYMENTS) TO RECONFIRM CHARGES AND PAYMENTS AS NEEDED."

EDIT SPECS FROM WESTAT

QC6 REASONS FOR PAYMENTS LESS THAN CHARGES — Follow Skip Pattern

DATA ITEM	SPECIFICATIONS	**ACTION, if specification not met**
QC6 a – r Reason for PAYMENTS LESS THAN CHARGES See QC4-QC6 CONSISTENCY notes	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, or page 5-34 of the spex.
	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.
		Blue Sheet if only YES answer is circled, and NO answers are blank, and the payments are less than charges. Let the TRC fill in the NO answers.
	If there is a YES answer in PAYMENTS MORE THAN CHARGES section, all choices in the PAYMENTS LESS THAN CHARGES SECTION should be NO (2).	**Blue Sheet** if there is a YES answer in both PAYMENTS LESS and PAYMENTS MORE sections.
		Circle NO (2) for all answers in the PAYMENTS LESS section, if all answers are blank and there is a YES (1) answer in the PAYMENTS MORE section.
	If OTHER is answered, there must be an answer on the SPECIFY line (QC6 line h or line p). Sometimes the answer is written outside the line, as a comment. 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, 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.
	QC6 line h answers should also be reflected in QC4 unless total pay is $0.00. State program paid; State program adj. Exceptions :Hospital 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.

QC6 Reasons for Payments More Than Charges.

Follow Skip Pattern

DATA ITEM	SPECIFICATIONS	**ACTION, if specification not met**
QC6 s – v Reason for PAYMENTS MORE THAN CHARGES See QC4-QC6 CONSISTENCY notes on page 5- 34.	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 5-34.
	YES (1) or NO (2) must be circled for each choice.	**Blue Sheet** if missing and payment is less than charge.
	Since YES (1) may be answered for more than one choice, only the TRC can answer NO (2).	**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.
	If OTHER is answered, there must be an answer on the SPECIFY line (QC6 line v). Sometimes the answer is written outside the line, as a comment.	Check Decision log for all Specify answers. If it is on the Decision log, follow directions given there. If the answer is not there, **Yellow Sheet.**
		Blue Sheet if Specify answer is missing.

	Answer on the SPECIFY line (QC6 line v) needs review.	If the answer is written outside of the Specify line, circle the answer if it is on the Decision Log. **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

Compare QC4 and QC6

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

QC4 AND QC6 “OTHER/SPECIFY”
Answers in “Other/Specify” should be reflected in both QC4 and QC6.
If there is an “Other/Specify” answer in QC4 that is not also indicated in QC6, **Yellow Sheet.**
If there is no payment on QC4 (line h), cross out the Other/Specify answer on that line.
If there is an “Other/Specify” answer in QC6 that is not also indicated in QC4, **Yellow Sheet.**
Exceptions: If Other/Specify answer in QC6 is Hosp or Provider Write Off, there will not be a corresponding answer in QC4.
If Total payment = Total charges, there will not be a corresponding answer in QC6.

CHECK DECISION LOG FOR COMMENT REVIEW
Some comments should be moved to QC6 (line h) Other/Specify. Look up comments on the Decision Log.
Examples: “Insurance denied,” “Medicare denied,” “Billing error,” “Billed late,” “Procedure not covered by Medicaid”

COMPARE QUESTIONS BETWEEN BOOKS
Look for indications that the wrong answer was circled by mistake.

OTHER/SPECIFY WRITE-OFFS
OBD cases -- Accept the phrase “Provider write-off.”
Hospital cases -- Accept the phrase “Hospital write-off”
Accept “Small Balance Write-off” or “Small Balance Adjustment”

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

THREE OR MORE INSURANCE TYPES
Yellow Sheet.

AN ADJUSTMENT WITHOUT A PAYMENT FROM THAT SOURCE
Accept an answer that indicates an Adjustment with $0.00 payment by that source, as long as there is no other evidence of an inconsistency.

DECISION LOG FOR QC6

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

Problem	Decision / Categorization
Payment Less than Charges	If instructions say to add an answer to line h or line p, change the YES/NO answer to 1 and cross out the answer 2. If instructions say to delete an answer from line h or line p, change the YES/NO answer to 2 and cross out the answer 1.
Underpayment exists in Q(C4) by a State (or Federal, or County, or City) Plan ---- Plan may be Fund, Program, Grant ------ type of plan may be given ------- REMOVE Name of State if it is present	Code in 'OTHER' as (name of source given in Q(C4h)).

Examples:	
Nevada State Disability	State Disability.
State Breast Cancer Program	State Breast Cancer Program.
Maryland Indigent Program	State Indigent Program.
Federal Grant	Federal Grant.
Cook County Indigent Fund	County Indigent Fund.
State Program	State Program.
Zero total payment in Q(C4) but comment about a State (or Federal, or County, or City) Plan ---- Plan may be Fund, Program, Grant ------ type of plan may be given ------- REMOVE Name of State if it is present	If TRC says Charity care, accept as is. otherwise Yellow Sheet
Comment says that insurance was never billed	Code in 'Other' (line h) as NEVER BILLED. Include type of insurance, if known, such as MEDICARE NEVER BILLED
Comment says Insurance denied payment.	Code in 'Other' (line h) as INSURANCE DENIED. Include type of insurance, if known, such as MEDICARE DENIED.
Comment mentions billing error.	Code in 'Other' (line h) as Billing Error. Include type of insurance if known, such as: MEDICARE DENIED: BILLING ERROR
Comment mentions untimely filing, billed late.	Code in 'Other' (line h) as Billed Late. Include type of insurance if known, such as MEDICARE DENIED: BILLED LATE.
Comment mentions Insurance denied, with an amount, such as Private Insurance denied $52.50.	Code in 'Other' (line h) as INSURANCE DENIED. Include type of insurance, if known, such as PRIV INS DENIED. Do not include the amount.
Comment mentions that the insurance doesn't cover a procedure.	Code in 'Other' (line h) as INSURANCE DENIED: PROCEDURE NOT COVERED. Include type of insurance, if known, such as MEDICAID DENIED: PROCEDURE NOT COVERED.
Comment mentions that insurance doesn't cover if no pre-authorization	Code in 'Other' (line h) as INSURANCE DENIED: NO PRE-AUTHORIZATION. Include type of insurance, if known, such as TRICARE DENIED: NO PRE-AUTHORIZATION
Comment mentions nurse visit not covered	Code in 'Other' (line h) as INSURANCE DENIED: NURSE VISIT. Include type of insurance, if known, such as MEDICAID DENIED: NURSE VISIT
Comment says patient paid the deductible.	Do not code in 'Other' (line h). If there is an adjustment or limit answered, or payment is expected from any source, accept as is. If there is no adjustment or limit, or expectation of future payment, Yellow Sheet.
Comment says insurance made an adjustment.	Do not code in 'Other' (line h). If there is an adjustment or limit answered, or payment is expected from any source, accept as is. If there is no adjustment or limit, or expectation of future payment, Yellow Sheet.
Comment mentions Collection Agency or " in Collections"	Do not code in 'Other' line h or line p. Accept answers EXPECTING PATIENT PAYMENT and/or BAD DEBT. Otherwise, Yellow Sheet.
Collection Agency or "in collections" is Other/Specify answer (line h or line p)	Cross out "in collections," etc. as the 'Specify' answer (line h or line p). Accept answers EXPECTING PATIENT PAYMENT and/or BAD DEBT. Otherwise Yellow Sheet.
Small balance w/o (Small balance write off)	Code in Other as Small Balance W/O
Small balance Adj (Small balance adjustment)	Code in Other as Small balance Adj
Military	Blue Sheet for more specific information
Dependent of active duty military / Active duty military dependent	Code in 'other' as Eligible Active Duty Fam Mem
Active duty armed forces member / Active duty military	Code in 'Other' as Eligible Active Duty
Active duty family member	Code in 'Other' as Eligible Act Duty Fam Mem
Retired veteran / Retired military	Code in 'Other' as Eligible Retiree

Retired veteran's family member	Code in 'Other' as Eligible Retiree Fam Mem
Retired Military Dependent	Code in 'Other' as Eligible Retiree Fam Mem
Veteran's family member	Code in 'Other' as Eligible Veteran Fam Mem
Indian Health	Code in 'Other' as Eligible Native American
Clerical fee; administrative fee	YELLOW SHEET
Grant - DK who is funding it	Code in 'Other' as Grant - DK who is funding it.
HMO	Blue Sheet for type of insurance: Medicare, Medicaid, or Private, other
Comment says No payments due to Federal Vaccines given	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 13 – PATIENT ACCOUNTS – RATES/CHARGES

[PAGE 12 – PATIENT ACCOUNTS – RATE/CHARGES (1 of 3)]

SCREEN LAYOUT

Q10. Can you tell me what the facility's full established daily rate for room and board and basic care was during this stay?

$_____ . _____ **DAILYRT**

CHECKPOINT: HAVE YOU BEEN ABLE TO DETERMINE THE RATE?

RATE PROVIDED……1
RATE CHANGED DURING STAY.....2
UNESTDRATE

PROGRAMMER NOTES

2016 UPDATE: IF Q6_2 = 2 OR 3, ADD "ANCILLARY CHARGES" TO QUESTION WORDING. Can you tell me what the facility's full established daily rate for room, board, basic care, and ancillary charges was during this stay?

Validation: If DAILYRT> 687 administer soft check "YOU HAVE ENTERED A DAILY RATE OVER $687.00. PLEASE REVIEW AND CORRECT IF NEEDED, OR SUPPRESS AND CONTINUE."

Prelogic for Q10: We arrive at Q10 after answering "**NO, CANNOT PROVIDE TOTAL CHARGE**" (option 2) at the Q6 checkpoint (**UNESTCHRG**).

If Q10 UNESTDRATE=1 go to Q11.

If Q10 UNESTDRATE=2 go to Q12.

Q10 - DOLLAR AMOUNTS SHOULD BE FORMATTED TO INCLUDE COMMAS and DECIMAL POINTS.

DK/REF ALLOWABLE, AND GO TO Q12
RESPONSE OPTION 2 FOR UNESTDRATE TO BE ALLOWABLE ONLY IF A RESERVE CODE IS USED. SELECTION OF OPTION 2 WITH ENTRY OF A VALUE OTHER THAN A RESERVE CODE FOR DAILYRT RESULTS IN HARD CHECK: "OPTION 2 SHOULD ONLY BE SELECTED IF THE DAILY RATE IS DON'T KNOW OR REFUSED."

RESPONSE OPTION 1 FOR UNESTDRATE TO BE ALLOWABLE ONLY IF A VALUE OTHER THAN A RESERVE CODE IS USED. (2019 UPDATE: 0 IS ALLOWABLE FOR DAILYRT). SELECTION OF OPTION 1 WITH ENTRY OF A VALUE OF A RESERVE CODE FOR DAILYRT RESULTS IN HARD CHECK: "OPTION 1 REQUIRES A DAILY RATE AMOUNT. PLEASE PROVIDE DAILY RATE."

[PAGE 14 – PATIENT ACCOUNTS – RATES/CHARGE (3 of 3)]

SCREEN LAYOUT

Q11. This stay for [PATIENT] that we are discussing lasted [STAYDAYS.] For how many days was the patient charged during this stay? Please give only the days during 2022.

_____ # DAYS **DAYSCHRG**

CHECKPOINT: HAVE YOU BEEN ABLE TO DETERMINE THE NUMBER OF DAYS?

DAYS PROVIDED.....1
DAYS NOT REPORTED.....2
UNDAYSTAY

PROGRAMMER NOTES

STAYDAYS is a variable calculated by the difference between ADMIT DATE and DISCHARGE date, plus 1. Thus the value of STAYDAYS for a stay of 1/1/2022 and 1/4/2022 would be 4, not 3. If DISCHARGE DATE IS 9/9/9999 (still institutionalized) then assume a discharge date of 12/31/2022 for calculation purposes. FOR ADMIT DATE, USE EVTBEG_DATE FROM A1. FOR DISCHARGE DATE, USE EVTEND_DATE FROM A1.

IF RESPONDENT CAN'T PROVIDE TOTAL DAYS (UNDAYSTAY=2), GO TO Q12. ELSE GO TO Q11a.

DK/REF ALLOWABLE

EDIT SPECS FROM WESTAT

none

SECTION 14 – PATIENT ACCOUNTS – SOURCES OF PAYMENT 2

[PAGE 15 – PATIENT ACCOUNTS – SOURCES OF PAYMENT 2 (1 of 1)]

SCREEN LAYOUT

Q11a. From which of the following sources has the facility received payment for these charges and how much was paid by each source? Please include all payments that have taken place between (ADMIT DATE) and now for this stay.

IF NONE, ENTER ZERO (0).

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

[DCS ONLY] IF PROVIDER VOLUNTEERS THAT PATIENT PAYS A MONTHLY PREMIUM, VERIFY: So, you receive a monthly payment rather than payment for the specific service? IF YES: GO BACK TO Q5 AND CODE AS CAPITATED BASIS.

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

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. Something else? (IF SOMETHING ELSE: What was that?) **OTHOTOS** **OTHOTOSTXT**	$**OTHOTHR**

Q11b. [I show the total payment as Q11bTOTPAYM / I show the payment as undetermined. / I show the payment as Q11bTOTPAYM, although one or more payments are missing] . Is that correct?
IF NO, CORRECT ENTRIES ABOVE AS NEEDED.

TOTAL PAYMENTS **$ Q11bTOTLPAYM**

PROGRAMMER NOTES

(ADMIT DATE) should fill from EVTBEG_DATE from A1.

Q11a - [SYSTEM WILL SET UP "SOMETHING ELSE" AS A LOOP, SO NO LIMIT REQUIRED]

2019 UPDATE: Each Q11a item a-h (OTHPAT to OTHOTHER) appears on its own screen, along with the entire Q11a 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 OTHPAT to OTHWORK. Require an entry in OTHOTHR if MoreSources = 1. The following are allowed entries: 0, integer, integer with 2 decimal places, F6/DK, F7/REF.
In the summary of charges that displays, "I show the total payment as [Q11bTOTLPAYM]" 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 total payment as Q11bTOTPAYM / I show the payment as undetermined. / I show the payment as Q11bTOTPAYM, although one or more payments are missing] Is that correct?

Q11bTOTLPAYM counts entries of DK or REF in the individual SOPs as "0".
This variable that is recorded on this screen is called Q11TOTLPAYMOK, it saves values of Yes or No. It is a critical item.

FILL INSTRUCTIONS:

4. All SOP >=0 (e.g., 0, integer dollars, dollars + cents)
    a. Text: I show the total payment as Q11bTOTLPAYM.
5. All SOP <0 (e.g., hotkeys F6, F7 whose numeric values are -1, -2)
    a. Text: I show the total payment as undetermined.
6. Mixed entries (e.g., a zero or dollar amount along with one or more DK/REF)
    a. Text: I show the payment as Q11bTOTLPAYM, although one or more payments are missing.

Design Note Q11 (specifically Q11a_OTH and Q11b)

CHARGES

Total charges for room, board, basic care = $[TOTLCHGDAILY]

PAYMENTS

Patient or family	$[**OTHPAT**]
Medicare	$[**OTHCARE**]
Medicaid	$[**OTHAID**]
Private insurance	$[**OTHPINS**]
VA/ChampVA	$[**OTHVA**]
TRICARE	$[**OTHCHAM**]
Workers comp	$[**OTHWORK**]
Other$_1$	**$[OTHOTHR$_1$]**
.	
.	
.	
Other$_N$	**$[OTHOTHR$_N$]**

Programmer:
New variable TOTLCHGDAILY=DAILYRT * DAYSCHRG

Q11B=NO, RETURN USER TO Q11A, OTHERWISE CONTINUE.
Q11a(h) - The OTHOTOSTXT variable was added to record free-form text for the "Other, Specify" option. Interviewers will be able to record responses in the text box that do not occur in the listed options. Field = up to 50 characters. OTHOTOSTXT onscreen text: "OTHER SPECIFY: PROBE FOR SOURCE OF FUNDS AND TYPE OF PLAN".

Q11a(h) is a question loop that will require:
1) A HISTORY BOX to display responses already collected.
2) A question to appear after each iteration of the question that reads: Any more sources? YES=1 NO=2
3) The "something else" option should be set up so a response can be selected from among response options, or entered in as text.

Q11a(h) – Include the following options for the "Other Specify";
Auto or Accident Insurance
Indian Health Service
State Public Mental Plan
State/County/Local program

Other

If Q11b=1 go to Q14.
If Q11b=2 display hard check: “IF INCORRECT, CORRECT ENTRIES AS NEEDED”.

Q11a - DK/REF – CONTINUE TO Q11b

DOLLAR AMOUNTS SHOULD BE FORMATTED TO INCLUDE COMMAS and DECIMAL POINTS

EDIT SPECS FROM WESTAT

QC4 PAYMENT SOURCES AND AMOUNTS

Follow Skip Pattern

DATA ITEM	SPECIFICATIONS	ACTION, if specification not met
C4 -Payment sources/ amounts **CRITICAL ITEM** is source of payment plus Total Payments The amount of Individual Payments is not a critical item See QC4 – QC6 Consistency notes on page 34.	Must be completed if Reimbursement Type = Fee For-Service	**Blue Sheet** if blank
	Every source of payment must have an amount 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 missing, or if sum of other sources does not equal Total.
	DK or RF are acceptable	Change DK to – 8. Change RF to – 7.
	If OTHER is answered, there must be an answer on the SPECIFY line	**Blue Sheet** if missing.
		If the answer is written outside of the answer line, circle the answer.
	Answer on the SPECIFY line needs review. Sometimes the answer is written outside the line, as a comment.	If the answer is written outside of the Specify line, and it is on the Decision Log, circle the answer to indicate that it should be Coded. **Yellow Sheet** if it is not on the Decision Log.
	"HMO" is not acceptable as a SPECIFY answer. "Public" is not acceptable as a SPECIFY answer. The name of an insurance co. is not acceptable as a SPECIFY answer. Note the same insurance company may provide private insurance and also administer Medicare and/ or Medicaid payments.	**Blue sheet,** asking which type of insurance Note the same insurance company can provide private insurance and also administer Medicare and/ or Medicaid payments
	Expect that an answer on line h OTHER/ SPECIFY will have a comparable answer in QC6 line h. For example, STATE PROGRAM in QC4 will have STATE PROGRAM ADJUSTMENT in QC6. Exceptions: Hospital w/o and Small bal adj in QC6 will not have a comparable answer in QC4. If there is no payment in QC4 line h, there may still be an adjustment in QC6.	**Yellow Sheet** if there is not a comparable answer in both questions.
	Adjustments and write offs should not be included in payments.	**Blue Sheet** if comments or answer to line (h) indicate that adjustments or write offs have been included.
	If payment by patient is $1.00 or less, expect that the insurance type will be a public type – Medicare, Medicaid, state program, etc.	**Yellow Sheet** if the insurance is not government insurance
	If a payment is made by VA, expect that the answer to QC6 will be Eligible Veteran or an OTHER/ SPECIFY answer that will reflect military service	**Yellow Sheet**
	Comments may need review. Payments by three or more insurance types need managerial review.	Compare comments about sources to the answers given in C4. **Yellow Sheet** if comments don't agree with the answer to QC4. **Yellow Sheet** all comments that are not included in the answer to QC4.
		Look at the payment sources in all books for a patient. **Yellow Sheet** if three or more insurance types.
	Lump payments need special handling.	See Lump payment instruction sheet, on page 5-29.

QC5 TOTAL PAYMENTS

Follow Skip Pattern

DATA ITEM	SPECIFICATIONS	ACTION, if specification not met
C5- Total Payments **CRITICAL ITEM**	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 If tape doesn't match book, write NOT OK. If tape matches book, write OK. Initial 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 Payments as written by the TRC. Note that changes can affect the answers to Box 2 and QC6.	If the difference is 10% or less than the Total, correct the Total Payments.
		Blue Sheet, if the difference is greater than 10%.
		Change Box 2 to the appropriate answer.
		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.	Change DK to – 8. Change RF to – 7. Code PL-IV as 60, critical item is missing
	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. Comments: "Paid in Full," or "Zero Balance" or any other comment indicating that account is clear.	**Yellow Sheet** Total Pay = Total Charge, and we don't know Individual Payments, if there are comments as at left. If no such comment, accept as is.
	Total Payments greater than Total Charge need managerial review.	**Yellow Sheet all overpayments.**

Decision Log for QC4

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

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

LUMP SUM - PENDING FURTHER RTI DISCUSSION

QC4 – QC5 LUMP SUM PAYMENTS

DATA ITEM	SPECIFICATIONS	ACTION, if specification not met
QC4 – QC5 LUMP SUM INFORMATION	TRC supplies information needed to process the lump. This is usually in the form of a label on page 4 of the first book of a lump. Information supplied by TRC 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 QA 6b 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.
	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 2 should be the same in all books of the lump. If total lump charges = total lump payments, then Box 2 should be answered 1 (YES) in all books of the lump. If total lump charges don't equal total lump payments, then Box 2 should be answered 2 (NO) in all books of the lump.	Answer if blank.
		Correct Box 2 if wrong. This may change the skip pattern. Review QC6, if necessary.
	If lump payments = lump charges, and there is only one source of payment, 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.

SECTION 15 – PATIENT ACCOUNTS – BILLING PERIOD INFORMATION WITH PAYMENTS

[PAGE 16 – PATIENT ACCOUNTS – BILLING PERIOD INFORMATION (1 of 7)]

SCREEN LAYOUT

Q12. Perhaps it would be easier if you gave me information about payments by billing period. What was the billing start date?

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

BPBEG_DATE

MM/DD/YYYY

Q12a. What was your billing end date?

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

BPEND_DATE
MM/DD/YYYY

[PAGE 17 – PATIENT ACCOUNTS – BILLING PERIOD INFORMATION (2 of 7)]

SCREEN LAYOUT

Q12-1. BILLING PERIOD IS BETWEEN BPBEG_DATE# and BPEND_DATE#. Thanks, that means there were (**DAYSBILLPER#**) days in your billing period. Between (BPBEG_DATE# and BPEND_DATE), how many days was the patient charged for room, board and basic care?

_____# BILLED DAYS **DAYSBILLED#**

PROGRAMMER NOTES
2016 UPDATE: IF Q6_2 = 2 OR 3, ADD "ANCILLARY CHARGES" TO QUESTION WORDING. "…how many days was the patient charged for room, board, basic care, and ancillary charges?"

DAYSBILLPER# is a calculated field representing the span of days (not the difference) accounted for in BPBEGM/BPBEGD/BPBEGY AND BPENDM/BPENDD/BPENDY. For example, the DAYSBILLPER# for dates 7/1/2022 and 7/15/2022 is 15 days (not 14).

(BPBEG_DATE# and BPEND_DATE#) is filled from Q12 and Q12a.

Q12 & Q12a: DK/REF ALLOWABLE. IF Q12 = DK/REF, GO TO Q12a. IF Q12a DK/REF, GO TO Q12-1.

Q12-1: IF **DAYSBILLED#** IS LESS THAN **DAYSBILLPER#** in Q12 go to Q12-1a else go to Q12-2.

Q12-1: IF **DAYSBILLED#** IS MORE THAN **DAYSBILLPER#** in Q12, DISPLAY HARD CHECK: "THE NUMBER OF DAYS BILLED CANNOT EXCEED THE DAYS IN THIS BILLING PERIOD. YOU MUST CORRECT THIS PROBLEM BEFORE YOU CAN CONTINUE."

Q12-1: DK/REF ALLOWABLE. IF Q12-1 DK/REF, GO TO Q12-2.

[PAGE 18 – PATIENT ACCOUNTS – BILLING PERIOD INFORMATION (2 of 7)]

SCREEN LAYOUT

Q12-1a. The number of days the patient was charged for room, board and basic care was (DAYSBILLED#) days and that is less than the number of days in the billing period, (DAYSBILLPER#). Do you know why?

_____ **EXPLAINDIFF#**

PROGRAMMER NOTES
2016 UPDATE: IF Q6_2 = 2 OR 3, ADD "ANCILLARY CHARGES" TO QUESTION WORDING. "The number of days the patient was charged for room, board, basic care, and ancillary charges was …"

EXPLAINDIFF FIELD ALLOWS UP TO 75 CHARACTERS.

(DAYSBILLED#) fills from Q12-1.
(DAYSBILLPER#) fills from Q12-1
DK/REF ALLOWABLE

[PAGE 19 – PATIENT ACCOUNTS – BILLING PERIOD INFORMATION (3 of 7)]

SCREEN LAYOUT

Q12-2. Between (BPBEG_DATE# and BPEND_DATE#), what was the private pay rate for room, board and basic care (PATIENT NAME) received? If the rate changed, please give me the initial rate.

$_____.____ **BASEPAYRATE#**

12-3. How many days was that rate applied during this billing period?

_____ # DAYS **BASERATEDAY#**

PROGRAMMER NOTES
2016 UPDATE: IF Q6_2 = 2 OR 3, ADD "ANCILLARY CHARGES" TO QUESTION WORDING. "…what was the private pay rate for room, board, basic care, and ancillary charges…"

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

(BPBEG_DATE# and BPEND_DATE#) is filled from Q12 and Q12a.

Q12-3: If **BASERATEDAY#** is less than **DAYSBILLED#** go to Q12-Intro, else record **BASEPAYRATE#** in Q12-8 and continue to Q13.

Q12-6 was absorbed into the skip logic for Q12-3.

DOLLAR AMOUNTS SHOULD BE FORMATTED TO INCLUDE COMMAS and DECIMAL POINTS.

IF DAYSBILLED = BASERATEDAY skip to Q13

Q12-2 & Q12-3: DK/REF ALLOWABLE. If Q12-2 DK/REF, GO TO Q12-3. If 12-3 (BASERATEDAY#) = DK/REF, GO TO Q13.

[PAGE 20 – PATIENT ACCOUNTS – BILLING PERIOD INFORMATION (4 of 7)]

SCREEN LAYOUT

12-Intro. I see that the rate of (BASEPAYRATE#) was applied for (BASERATEDAY#) days, although your billing period was (DAYSBILLED#) long. I need to ask some questions to help account for the entire billing period.

12-2A. Between (BPBEG_DATE# and BPEND_DATE#), what other private pay rate applied to the basic care that (PATIENT NAME) received?

$_____.____ **OTHBASERATE#**

12-3A. On what date did this rate of (OTHBASERATE#) begin? ____/____/____ **OTHRATEBEG_DATE#**

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

12-4A. During this billing period, how many days was that rate of (OTHBASERATE#) applied?

DAYS: _____ **OTHRATEDAYS#**

(DAYSBILLED#) fills from Q12-1.
(PATIENT NAME) should fill with patient's first name and patient's last name from Housing Component data file.

(BASEPAYRATE#) fills from Q12-2.
(BASERATEDAY#) fills from Q12-3.

(BPBEG_DATE# and BPEND_DATE#) is filled from Q12 and Q12a.

12-5A. Why did the rate change? CODE ONLY ONE.

LEVEL OF CARE	1
PATIENT DISCHARGED TO HOSPITAL	2
PATIENT DISCHARGED TO COMMUNITY	3
PATIENT DISCHARGED TO OTHER FACILITY	4
RATE INCREASE	5
ROOM CHANGE	6
OTHER, SPECIFY	7

_____ **RTCHANG#**
RTCHOTH#

PROGRAMMER NOTES

(OTHBASERATE#) fills from Q12-2A.

Q12-5A: If **DAYSBILLED** is more than [**OTHRATEDAYS** + **BASERATEDAY**] ask Q12-2A to Q12-5A, else go to Q12-7. This means that we should administer Q12-A to Q12-5A until we "get up to" the end-of-billing period reported in Q12a.

Former Q12-6A was absorbed into the skip logic for Q12-5A.

DOLLAR AMOUNTS SHOULD BE FORMATTED TO INCLUDE COMMAS and DECIMAL POINTS.

QUESTION 12-5A OTHER SPECIFY FIELD ALLOWS UP TO 75 CHARACTERS. OTHER SPECIFY SCREEN TEXT: Specify other reason.

[PAGE 21 – PATIENT ACCOUNTS – BILLING PERIOD INFORMATION (5 of 7)]

SCREEN LAYOUT

12-7 Is (RATE IN 12-2a) the private pay rate that applied at the end of the billing period?

YES.....	1	
NO.....	2	**ENDRATE#**

PROGRAMMER NOTES

Q12-7: (RATE IN Q12-2A) should fill with the last rate reported from the looped series of Q12-2a.

If Q12-7=1 (YES) skip to Q13.
If Q12-7=2 (NO) continue to Q12-8 and record rate at end of billing period.

Q12-7: DK/REF ALLOWABLE

[PAGE 22 – PATIENT ACCOUNTS – BILLING PERIOD INFORMATION (6 of 7)]

SCREEN LAYOUT

12-8. What was the private pay rate that applied at the end of the billing period?
$_____._____ **ENDPAY#**

PROGRAMMER NOTES

Q12-8: DK/REF ALLOWABLE

SECTION 16 – PATIENT ACCOUNTS – SOURCES OF PAYMENT 3

[PAGE 24 – PATIENT ACCOUNTS – SOURCES OF PAYMENT (1 of 1)]

SCREEN LAYOUT

Q13. From which of the following sources did the facility receive payments for this billing period and how much was paid by each source? Please include all payments that have taken place between (ADMIT DATE) and now for this stay.

IF NONE, ENTER ZERO (0).

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

[DCS ONLY] IF PROVIDER VOLUNTEERS THAT PATIENT PAYS A MONTHLY PREMIUM, VERIFY: So, you receive a monthly payment rather than payment for the specific service? IF YES: GO BACK TO Q5 AND CODE AS CAPITATED BASIS

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

SOURCE	PAYMENT AMOUNT
a. Patient or Patient's Family;	**$Q13PATPAYM#**
b. Medicare;	**$ Q13CAREPAYM#**
c. Medicaid;	**$ Q13AIDPAYM#**
d. Private Insurance;	**$ Q13PINSPAYM#**
e. VA/ChampVA;	**$ Q13VAPAYM#**
f. Tricare;	**$ Q13CHAMPAYM#**
g. Worker's Comp; or	**$ Q13WORKPAYM#**
h. Something else? (IF SOMETHING ELSE: What was that?) **Q13OTPAYMOS#** **Q13OTPAYMOSTXT#**	**$ Q13OTHRPAYM#**

Q13a. [I show the total payment as Q13TOTPAYM / I show the payment as undetermined. / I show the payment as Q13TOTPAYM, although one or more payments are missing]
IF NO, CORRECT ENTRIES ABOVE AS NEEDED.

TOTAL PAYMENTS **$ Q13TOTLPAYM#**

PROGRAMMER NOTES

Q12, Q13, AND Q13A are question loops that will require:

(1) A HISTORY BOX to display billing periods already collected.

(2) A question to appear after each iteration of the questions that reads:

ANY MORE BILLING PERIODS? YES=1 NO=2
If answer is YES (1) cycle back to Q12.
If answer is NO (2) continue to Q14.

If no more billing periods go to Q14.

(ADMIT DATE) should fill from EVTBEG_DATE from A1.

Q13 - [SYSTEM WILL SET UP "SOMETHING ELSE" AS A LOOP, SO NO LIMIT REQUIRED]

Q13 - The Q13OTPAYMOSTXT 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 dropdown menu.

Require an entry in each source of payment (SOP) field Q13PATPAYM to Q13WORKPAYM. Require an entry in Q13OTHRPAYM if Q13MoreSources=1. The following are allowed entries: 0, integer, integer with 2 decimal places, F6/DK, F7/REF.

In the summary of charges that displays, "I show the total payment as [Q13TOTLPAYM]" 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 total payment as Q13TOTPAYM / I show the payment as undetermined. / I show the payment as Q13TOTPAYM, although one or more payments are missing] Is that correct?

Q13TOTLPAYM counts entries of DK or REF in the individual SOPs as "0".

This variable that is recorded on screen is called Q13TOTLPAYMOK, it saves values of Yes or No. It is a critical item.

FILL INSTRUCTIONS:

7. All SOP >=0 (e.g., 0, integer dollars, dollars + cents)
    a. Text: I show the total payment as Q13TOTLPAYM.
8. All SOP <0 (e.g., hotkeys F6, F7 whose numeric values are -1, -2)
    a. Text: I show the total payment as undetermined.
9. Mixed entries (e.g., a zero or dollar amount along with one or more DK/REF)
    a. Text: I show the payment as Q13TOTLPAYM, although one or more payments are missing.

Design Note Q13 (specifically Q13_OTHER and Q13a)

CHARGES

Charges for room, board, basic care:$[BASERATE_1*BASERATEDAY_1]
$[BASERATE_2*BASERATEDAY_2]
..
$[BASERATE_N*BASERATEDAY_N]

$[OTHBASERATE_1*OTHRATEDAYS_1] (OTHRATEDAYS_1 @ OTHRATEDAYS_1)
$[OTHBASERATE_2*OTHRATEDAYS_2] (OTHRATEDAYS_2 @ OTHRATEDAYS_2)
.
.
.
$[OTHBASERATE_N*OTHRATEDAYS_N] (OTHRATEDAYS_N @ OTHRATEDAYS_N)

PAYMENTS

Patient or family	$[Q13PATPAYM]
Medicare	$[Q13CAREPAYM]
Medicaid	$[Q13AIDPAYM]
Private insurance	$[Q13PINSPAYM]
VA/ChampVA	$[Q13VAPAYM]
Tricare	$[Q13CHAMPAYM]
Workers comp	$[Q13WORKPAYM]
$Other_1$	$[Q13OTHRPAYM_1]

...
Other$_N$ $[Q13OTHRPAYM$_N$]

Programmer:
There will be one or more reports of *product* BASERATE*BASERATEDAY or OTHBASERATE.
Place this above the Yes-No radio button.

Q13(h) is a question loop that will require:
1) A HISTORY BOX to display responses already collected.
2) A question to appear after each iteration of the question that reads: Any more sources? YES=1 NO=2
3) The "something else" option should be set up so a response can be selected from among response options, or entered in as text.

Q13(h) – Include the following options for the "Other Specify";
Auto or Accident Insurance
Indian Health Service
State Public Mental Plan
State/County Local program
Other

Q13(h) Other specify field (Q13OTPAYMOSTXT) allows up to 50 characters. Onscreen text: "OTHER SPECIFY: PROBE FOR SOURCE OF FUNDS AND TYPE OF PLAN".

Q13 - DK/REF – CONTINUE TO Q13a
Q13a – IF NO, SHOW HARD CHECK: "IF INCORRECT, CORRECT ENTRIES AS NEEDED"

DOLLAR AMOUNTS SHOULD BE FORMATTED TO INCLUDE COMMAS and DECIMAL POINTS

QC4 PAYMENT SOURCES AND AMOUNTS

Follow Skip Pattern

DATA ITEM	SPECIFICATIONS	ACTION, if specification not met
C4 -Payment sources/ amounts **CRITICAL ITEM** is source of payment plus Total Payments The amount of Individual Payments is not a critical item See QC4 – QC6 Consistency notes on page 34.	Must be completed if Reimbursement Type = Fee For-Service	**Blue Sheet** if blank.
	Every source of payment must have an amount 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 missing, or if sum of other sources does not equal Total.
	DK or RF are acceptable	Change DK to – 8. Change RF to – 7.
	If OTHER is answered, there must be an answer on the SPECIFY line	**Blue Sheet** if missing.
		If the answer is written outside of the answer line, circle the answer.
	Answer on the SPECIFY line needs review. Sometimes the answer is written outside the line, as a comment.	If the answer is written outside of the Specify line, and it is on the Decision Log, circle the answer to indicate that it should be Coded. **Yellow Sheet** if it is not on the Decision Log.
	"HMO" is not acceptable as a SPECIFY answer. "Public" is not acceptable as a SPECIFY answer. The name of an insurance co. is not acceptable as a SPECIFY answer. Note the same insurance company may provide private insurance and also administer Medicare and/ or Medicaid payments.	**Blue sheet,** asking which type of insurance Note the same insurance company can provide private insurance and also administer Medicare and/ or Medicaid payments.
	Expect that an answer on line h OTHER/ SPECIFY will have a comparable answer in QC6 line h. For example, STATE PROGRAM in QC4 will have STATE PROGRAM ADJUSTMENT in QC6. Exceptions: Hospital w/o and Small bal adj in QC6 will not have a comparable answer in QC4. If there is no payment in QC4 line h, there may still be an adjustment in QC6.	**Yellow Sheet** if there is not a comparable answer in both questions.
	Adjustments and write offs should not be included in payments.	**Blue Sheet** if comments or answer to line (h) indicate that adjustments or write offs have been included.
	If payment by patient is $1.00 or less, expect that the insurance type will be a public type – Medicare, Medicaid, state program, etc.	**Yellow Sheet** if the insurance is not government insurance.
	If a payment is made by VA, expect that the answer to QC6 will be Eligible Veteran or an OTHER/ SPECIFY answer that will reflect military service.	**Yellow Sheet.**
	Comments may need review. Payments by three or more insurance types need managerial review.	Compare comments about sources to the answers given in C4. **Yellow Sheet** if comments don't agree with the answer to QC4. **Yellow Sheet** all comments that are not included in the answer to QC4.
		Look at the payment sources in all books for a patient. **Yellow Sheet** if three or more insurance types.
	Lump payments need special handling.	See Lump payment instruction sheet, on page 5-29.

QC5 TOTAL PAYMENTS

Follow Skip Pattern

DATA ITEM	SPECIFICATIONS	ACTION, if specification not met
C5- Total Payments **CRITICAL ITEM**	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 If tape doesn't match book, write NOT OK. If tape matches book, write OK. Initial 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 Payments as written by the TRC. Note that changes can affect the answers to Box 2 and QC6.	If the difference is 10% or less than the Total, correct the Total Payments.
		Blue Sheet, if the difference is greater than 10%.
		Change Box 2 to the appropriate answer.
		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.	Change DK to – 8. Change RF to – 7. Code PL-IV as 60, critical item is missing
	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. Comments: "Paid in Full," or "Zero Balance" or any other comment indicating that account is clear.	**Yellow Sheet** Total Pay = Total Charge, and we don't know Individual Payments, if there are comments as at left. If no such comment, accept as is.
	Total Payments greater than Total Charge need managerial review.	**Yellow Sheet all overpayments.**

Decision Log for QC4

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

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

LUMP SUM - PENDING FURTHER RTI DISCUSSION

QC4 – QC5 LUMP SUM PAYMENTS

DATA ITEM	SPECIFICATIONS	ACTION, if specification not met
QC4 – QC5 LUMP SUM INFORMATION	TRC supplies information needed to process the lump. This is usually in the form of a label on page 4 of the first book of a lump. Information supplied by TRC 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 QA 6b 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.
	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 2 should be the same in all books of the lump. If total lump charges = total lump payments, then Box 2 should be answered 1 (YES) in all books of the lump. If total lump charges don't equal total lump payments, then Box 2 should be answered 2 (NO) in all books of the lump.	Answer if blank.
		Correct Box 2 if wrong. This may change the skip pattern. Review QC6, if necessary.
	If lump payments = lump charges, and there is only one source of payment, 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.

PRE-LOGIC FOR Q14

2016 UPDATE: IF Q6_1 = 2 (NO); SKIP Q14, GO STRAIGHT TO VALIDATE
IF Q6_2 = 2 OR 3; SKIP Q14, GO STRAIGHT TO VALIDATE

SECTION 17 – PATIENT ACCOUNTS – ANCILLARY CHARGES

[PAGE 25 – PATIENT ACCOUNTS – ANCILLARY CHARGES (1 of 1)]

SCREEN LAYOUT

Q14. Did (PATIENT NAME) have any health-related ancillary charges for this stay? That is, were there charges for additional services not included in the basic rate?

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

ANCCHRG

PROGRAMMER NOTES

If Q14=1 go to Q15. If Q14=2 go to FINISH SCREEN (Main_Case.review).

Q14 - DK/REF – CONTINUE TO Q15

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

SECTION 18 – PATIENT ACCOUNTS – TOTAL ANCILLARY CHARGES

[PAGE 26 – PATIENT ACCOUNTS – TOTAL ANCILLARY CHARGES (1 of 1)]

SCREEN LAYOUT

Q15. What was the total of full established charges for **health-related ancillary care** during this stay? Please exclude charges for non-health related services such as television, beautician services, etc.

EXPLAIN IF NECESSARY: Ancillaries are facility charges that are not included in the basic charge. Ancillary charges may include laboratory, radiology, drugs and therapy (physical, speech, occupational).

IF NO CHARGE Some facilities that don't charge for each individual service do associate dollar amounts with services for purposes of budgeting or cost analysis. This is sometimes called a "charge equivalent". Could you give me the total of the charge equivalents for health-related ancillary care during this stay?

TOTAL CHARGES: $_____.___

ANCTOTL

CHECKPOINT: HAVE YOU BEEN ABLE TO DETERMINE THE FULL ESTABLISHED CHARGES?

YES, PROVIDED ……1

CAN'T SEPARATE HEALTH AND NON-HEALTH ANCILLARY CHARGES……2
CAN'T GIVE TOTAL HEALTH-RELATED ANCILLARY CHARGES……3
UNESTANC

PROGRAMMER NOTES

If ANCTOT> 250,000 administer soft check "You have entered a total ancillary charge over $250,000. Please review and correct if needed, or suppress and continue".

IF UNESTANC=3 then go to Q19. If UNESTANC=1 go to Q16. If UNESTANC =2 go to Q16.

IF UNESTANC=1 OR 2, allow entry in ANCTOTL. IF an entry of ANCTOTL occurs in conjunction with UNESTANC = 3, then administer error message: "If total charge provided, Option 1 OR 2 should be selected." If a non-reserve amount is entered into ANCTOTL, and option 3 is selected for UNESTANC, display hard check: "RESPONSE OPTION 3 ONLY ALLOWED IF TOTAL CHARGE (ANCTOTL) = DK OR RF."

DOLLAR AMOUNTS SHOULD BE FORMATTED TO INCLUDE COMMAS and DECIMAL POINTS.

Q15 (ANCTOTL) - DK/REF ALLOWABLE
UNESTANC - WE WANT OPTION 3 TO ONLY BE ALLOWABLE IF A RESERVE CODE IS USED IN ANCTOTL.

SECTION 19 – PATIENT ACCOUNTS – SOURCES OF PAYMENT 4

[PAGE 27 – PATIENT ACCOUNTS – SOURCES OF PAYMENT (1 of 1)]

SCREEN LAYOUT

Q16. From which of the following sources has the facility received payment for these charges and how much was paid by each source? Please include all payments that have taken place between (ADMIT DATE) and now for this stay. IF NONE, ENTER ZERO (0). [DCS ONLY] IF NAME OF INSURER, PUBLIC, OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance? **OTHER SPECIFY:** PROBE FOR SOURCE OF FUNDS AND TYPE OF PLAN.	a. Patient or Patient's Family; b. Medicare; c. Medicaid; d. Private Insurance; e. VA/ChampVA; f. Tricare; g. Worker's Comp; or h. Something else? (IF SOMETHING ELSE: What was that?) _____ **WHATANC** **WHATANCTXT**	$ **PATANC** $ **CAREANC** $ **AIDANC** $ **PINSANC** $ **VAANC** $ **TRIANC** $ **CMPANC** $ **OTHANC**
Q17. [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? IF NO, CORRECT ENTRIES ABOVE AS NEEDED.	**TOTAL PAYMENTS**	**$ TOTLANC**

PROGRAMMER NOTES

2019 UPDATE: Each Q16 item a-h (PATANC to OTHANC) appears on its own screen, along with the entire Q16 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.

(ADMIT DATE) should fill from EVTBEG_DATE from A1.

Q16 - [SYSTEM WILL SET UP "SOMETHING ELSE" AS A LOOP, SO NO LIMIT REQUIRED]

Q16 - The WHATANCTXT 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. WHATANCTXT field allows up to 50 characters.

Require an entry in each source of payment (SOP) field PATANC to CMPANC and OTHANC. The following are allowed entries: 0, integer, integer with 2 decimal places, F6/DK, F7/REF.

In the summary of charges that displays, "I show the total payment as [TOTLANC]" 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 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?

TOTLPAYM counts entries of DK or REF in the individual SOPs as “0”.
This variable that is recorded on screen Q17 is called TOTLANCOK, it saves values of Yes or No. It is a critical item.

FILL INSTRUCTIONS:

10. All SOP >=0 (e.g., 0, integer dollars, dollars + cents)
    a. Text: I show the total payment as TOTLPAYM.
11. All SOP <0 (e.g., hotkeys F6, F7 whose numeric values are -1, -2)
    a. Text: I show the total payment as undetermined.
12. 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 are missing.

Even if all the individual payments recorded in Q16 are DK or REF and the value of TOTLPAYM=0, then we collect either

3. Reasons for payment < > charges (e.g., PLC2 and ADJEXTRA_2)
4. Confirmation that payment = charge (Q17a).

Design Note Q16 (specifically Q16_OTHER and Q17)

CHARGES

Total ancillary charges: $[ANCTOT]

PAYMENTS

Patient or family	$[PATPAYM]
Medicare	$[CAREANC]
Medicaid	$[AIDANC]
Private insurance	$[PINSANC]
VA/ChampVA	$[VAANC]
TRICARE	$[TRIANC]
Workers comp	$[CMPANC]
$Other_1$	$[$OTHANC_1$]
.	
.	
.	
$Other_N$	$[$OTHANC_N$]

Programmer:

IF Q17=NO, RETURN USER TO Q16.
Q16(h) is a question loop that will require:
1) A HISTORY BOX to display responses already collected.
2) A question to appear after each iteration of the question that reads: Any more sources? YES=1 NO=2
3) The “something else” option should be set up so a response can be selected from among response options, or entered in as text.

Q16(h) – Include the following options for the “Other Specify”;
- Auto or Accident Insurance
- Indian Health Service
- State Public Mental Plan
- State/County Local program
- Other

Q16 - DK/REF – CONTINUE TO Q17
Q17 - DK/REF – CONTINUE TO BOX 2

DOLLAR AMOUNTS SHOULD BE FORMATTED TO INCLUDE COMMAS and DECIMAL POINTS

EDIT SPECS FROM WESTAT

QC4 PAYMENT SOURCES AND AMOUNTS

Follow Skip Pattern

DATA ITEM	SPECIFICATIONS	ACTION, if specification not met
C4 -Payment sources/ amounts **CRITICAL ITEM** is source of payment plus Total Payments The amount of Individual Payments is not a critical item See QC4 – QC6 Consistency notes on page 34.	Must be completed if Reimbursement Type = Fee For-Service	**Blue Sheet** if blank.
	Every source of payment must have an amount 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 missing, or if sum of other sources does not equal Total.
	DK or RF are acceptable	Change DK to – 8. Change RF to – 7.
	If OTHER is answered, there must be an answer on the SPECIFY line	**Blue Sheet** if missing.
		If the answer is written outside of the answer line, circle the answer.
	Answer on the SPECIFY line needs review. Sometimes the answer is written outside the line, as a comment.	If the answer is written outside of the Specify line, and it is on the Decision Log, circle the answer to indicate that it should be Coded. **Yellow Sheet** if it is not on the Decision Log.
	"HMO" is not acceptable as a SPECIFY answer. "Public" is not acceptable as a SPECIFY answer. The name of an insurance co. is not acceptable as a SPECIFY answer. Note the same insurance company may provide private insurance and also administer Medicare and/ or Medicaid payments.	**Blue sheet,** asking which type of insurance Note the same insurance company can provide private insurance and also administer Medicare and/ or Medicaid payments.
	Expect that an answer on line h OTHER/ SPECIFY will have a comparable answer in QC6 line h. For example, STATE PROGRAM in QC4 will have STATE PROGRAM ADJUSTMENT in QC6. Exceptions: Hospital w/o and Small bal adj in QC6 will not have a comparable answer in QC4. If there is no payment in QC4 line h, there may still be an adjustment in QC6.	**Yellow Sheet** if there is not a comparable answer in both questions.
	Adjustments and write offs should not be included in payments.	**Blue Sheet** if comments or answer to line (h) indicate that adjustments or write offs have been included.
	If payment by patient is $1.00 or less, expect that the insurance type will be a public type – Medicare, Medicaid, state program, etc.	**Yellow Sheet** if the insurance is not government insurance.
	If a payment is made by VA, expect that the answer to QC6 will be Eligible Veteran or an OTHER/ SPECIFY answer that will reflect military service.	**Yellow Sheet.**
	Comments may need review. Payments by three or more insurance types need managerial review.	Compare comments about sources to the answers given in C4. **Yellow Sheet** if comments don't agree with the answer to QC4. **Yellow Sheet** all comments that are not included in the answer to QC4.
		Look at the payment sources in all books for a patient. **Yellow Sheet** if three or more insurance types.
	Lump payments need special handling.	See Lump payment instruction sheet, on page 5-29.

QC5 TOTAL PAYMENTS

Follow Skip Pattern

DATA ITEM	SPECIFICATIONS	ACTION, if specification not met
C5- Total Payments **CRITICAL ITEM**	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 If tape doesn't match book, write NOT OK. If tape matches book, write OK. Initial 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 Payments as written by the TRC. Note that changes can affect the answers to Box 2 and QC6.	If the difference is 10% or less than the Total, correct the Total Payments.
		Blue Sheet, if the difference is greater than 10%.
		Change Box 2 to the appropriate answer.
		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.	Change DK to – 8. Change RF to – 7. Code PL-IV as 60, critical item is missing.
	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. Comments: "Paid in Full," or "Zero Balance" or any other comment indicating that account is clear.	**Yellow Sheet** Total Pay = Total Charge, and we don't know Individual Payments, if there are comments as at left. If no such comment, accept as is.
	Total Payments greater than Total Charge need managerial review.	**Yellow Sheet all overpayments.**

Decision Log for QC4

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

Problem	Decision / Categorization
Source of Payments	
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 Fund	Blue Sheet to determine source of funding: Federal, State, County, Other gov't, Private etc
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.

QC4 – QC5 LUMP SUM PAYMENTS

DATA ITEM	SPECIFICATIONS	ACTION, if specification not met
QC4 – QC5 LUMP SUM INFORMATION	TRC supplies information needed to process the lump. This is usually in the form of a label on page 4 of the first book of a lump. Information supplied by TRC 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 QA 6b 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.
	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 2 should be the same in all books of the lump. If total lump charges = total lump payments, then Box 2 should be answered 1 (YES) in all books of the lump. If total lump charges don't equal total lump payments, then Box 2 should be answered 2 (NO) in all books of the lump.	Answer if blank.
		Correct Box 2 if wrong. This may change the skip pattern. Review QC6, if necessary.
	If lump payments = lump charges, and there is only one source of payment, 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 2

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 Exit
YES, OTHER PAYERS…… 2 (GO TO Q17a)
NO, PAYMENTS < CHARGES - 3 (GO TO PLC2)
NO, PAYMENTS > CHARGES - 4 (GO TO ADJEXTRA_2**)**

[PROGRAM BEHIND THE SCENES – SHOULD NOT APPEAR ON SCREEN. VARIABLE NAME=CPAYBOX2]

PROGRAMMER NOTES

DESCRIPTION OF PROGRAMMING REQUIRED FOR BOX 2

IF totChrgFlag =2 AND totPayFlag =2 ***(This means only reserve codes were used for charge and payment variables – no values recorded)*** –
-GO TO PLC2 (***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 PLC2 ***(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 PLC2 ***(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 PLC2 ***(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 PLC2 ***(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_2 ***(payments more than charges discrepancy questions)***

EDIT SPECS FROM WESTAT

BOX 2 DO PAYMENTS = CHARGES? Follow Skip Pattern

DATA ITEM	SPECIFICATIONS	ACTION, if specification not met
BOX 2 – Total Payments = Total Charges or not	1 (YES), 2 (YES) or 3 (NO) must be circled.	Compare Total Charge to Total Payments.
	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 2.	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 20 – PATIENT ACCOUNTS – VERIFICATION OF PAYMENT 2

[PAGE 28 – PATIENT ACCOUNTS - VERIFICATION OF PAYMENT (1 of 1)]

SCREEN LAYOUT

Q17a. I recorded that the payment(s) you received equal the charges. 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 Q17]. 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 Q16.

YES, FINAL PAYMENTS RECORDED IN Q16 AND Q17……..1 **Q17aEQPAYOK**

NO…… 2

PROGRAMMER NOTES

[IF Q17aEQPAYOK=1 GO TO FINISH SCREEN (Main_Case.review).
IF Q17aEQPAYOK=2 DISPLAY HARD CHECK: "IF INCORRECT, RETURN TO Q16 AND CORRECT PAYMENT ENTRIES AS NEEDED.".]

payment(s) - If Q16 has one response fill: " " ELSE fill: "s".

AMOUNT(S) – If Q16 has one response fill: " " ELSE fill: "s".

DK/REF – Display soft check: "DON'T KNOW OR REFUSED WAS RECORDED. PLEASE REVIEW AND CORRECT IF NEEDED, OR SUPPRESS AND CONTINUE." IF SUPPRESSED, GO TO FINISH SCREEN (Main_Case.review).

EDIT SPECS FROM WESTAT

BOX 2 and QC5a DO PAYMENTS = CHARGES?

Follow Skip Pattern

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 2 jumps over this question, unless Box 2 is answered 2.	If QC5a is blank, and Box 2 is 2 (YES, other payer), **Blue Sheet** for an answer to QC5a. If QC5a is answered, and Box 2 is answered 1 or 3, cross out the answer.

SECTION 21 – PAYMENTS LESS THAN CHARGES *(NEW SECTION, Q18_UNDERPAYMENT)*

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

PLC2. 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	Q18_DISADJ
b. You are expecting additional payment	YES=1 NO=2	Q18_MOREPAY
c. This was charity care or sliding scale	YES=1 NO=2	DIANSLID2
d. This was bad debt	YES=1 NO=2	DIANBAD2
e. Person is an eligible veteran	YES=1 NO=2	ELIGVET2_2

PROGRAMMER NOTE:

2020 UPDATE: If Q18_MOREPAY = 1 and DIANBAD2 = 1, display a soft check after DIANBAD2 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 Q18_UNDERPAYMENT to contain Q18_DISADJ, Q18_MOREPAY, DIANSLID2, DIANBAD2, ELIGVET2_2 spec'd above as PLC1a-e.

ELIGVET2_2 – allow DK/REF

If Q18_MOREPAY=1 then show Q18_additional.

If **[**Q18_DISAD=1 and Q18_MOREPAY=1 **] or [**Q18_DISAD=2 and Q18_MOREPAY=2 and DIANSLID2=2 and DIANBAD2=2**]** then show Q18_additional.

If both DIANSLID2=1 and DIANBAD2=1 with no other selection, do not show Q18_additional.

If both DIANSLID2=1 or DIANBAD2=1 with no other selection, do not show Q18_additional.

2019 UPDATE: Each PLC2 item a-e (Q18_DISADJ to ELIGVET2_2) appears on its own screen, along with the entire PLC2 question text. The differences among screens is only the reason payments are less than charges being asked about.

ELIGVET2_2: Display onscreen instruction: "DCS: IF THE POC IS CONFUSED BY THE QUESTION, ANSWER THE QUESTION 'NO'."

SECTION 22 – PATIENT ACCOUNTS – DIFFERENCE BETWEEN PAYMENT AND CHARGES 2

[PAGE 29 – PATIENT ACCOUNTS - DIFFERENCE BETWEEN PAYMENT AND CHARGES (1 of 1)]

SCREEN LAYOUT

C18_Additional, Question Q18_additional

Are you expecting additional payment from:

Expecting additional payment

i.	Patient or Patient's Family;	YES=1, NO=2	**DIANPAT**
j.	Medicare;	YES=1, NO=2	**DIANCAR**
k.	Medicaid;	YES=1, NO=2	**DIANCAID**
l.	Private Insurance;	YES=1, NO=2	**DIANPINS**
m.	VA/ChampVA;	YES=1, NO=2	**DIANVA**
n.	Tricare;	YES=1, NO=2	**DIANCHAM**
o.	Worker's Comp; or	YES=1, NO=2	**DIANWORK**
p.	Something else?	YES=1, NO=2	**DIANOTH**

(IF SOMETHING ELSE: What was that?) **DIANOTOS**

DIANOTOSTXT

ADJEXTRA_2
It appears that the total payments were more than the total charges. Is that correct?

DCS: IF THE ANSWER IS "NO" PLEASE GO BACK TO Q17 (VERIFY TOTAL PAYMENTS) TO RECONFIRM CHARGES AND PAYMENTS AS NEEDED

YES=1, NO=2

PROGRAMMER NOTES

2016 UPDATE:

At least one entry among the variables on screen C18_additonal must be a "1", DK or RF. If all entries in the series are "2" (No) then administer a hard check when the user presses "Next" at C18_Additional, "You must select at least one reason for underpayment."

At C18_Additional

If Additional pymt expected (Q18_MOREPAY) selected as a reason at PLC2, require a selection (1,DK,RF) at C18_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 ( [Q18_MOREPAY] =="1" &&  [DIANPAT] =="2"  && [DIANCAR]  =="2"  && [DIANCAID] =="2"  && [DIANPINS]  =="2"  && [DIANVA]  =="2"  &&  [DIANCHAM] =="2"
 && [DIANWORK] =="2" && [DIANOTH] =="2" && ([SHOW_DIANSLID2] == "No" || [DIANSLID2] =="2") && ([SHOW_DIANBAD2] == "No" || [DIANBAD2] =="2" ) )
HardCheck("ADDITIONAL PAYMENT UNSPECIFIED: You must select at least one reason for underpayment.");
```

```
if ( [Q18_MOREPAY] =="1" &&  [DIANPAT] =="2"  && [DIANCAR]  =="2"  &&
[DIANCAID]  =="2"  && [DIANPINS]  =="2"   && [DIANVA]  =="2"   &&
[DIANCHAM] =="2"   &&
[DIANWORK]  =="2"  &&  [DIANOTH]  =="2"   ) )
HardCheck("ADDITIONAL PAYMENT UNSPECIFIED: You must select at
least one reason for underpayment.");
```

```
if ( [Q18_MOREPAY] =="1" &&  [DIANPAT] =="2"  && [DIANCAR]  =="2"  &&
[DIANCAID]  =="2"  && [DIANPINS]  =="2"   && [DIANVA]  =="2"   &&
[DIANCHAM] =="2"   &&
[DIANWORK]  =="2"  &&  [DIANOTH]  =="2"   ) )
HardCheck("ADDITIONAL PAYMENT UNSPECIFIED: You must select at
least one reason for underpayment.");
```

```
if (  [ELIGVET2_2] =="2"  &&   [DIANPAT] =="2"  && [DIANCAR]  =="2"  &&
[DIANCAID]  =="2"  && [DIANPINS]  =="2"   && [DIANVA]  =="2"   &&
[DIANCHAM] =="2"   &&
[DIANWORK]  =="2"  &&  [DIANOTH]  =="2"   ) )
HardCheck("PAYMENT UNSPECIFIED: You must select at least one reason
for underpayment.");
```

After Q18 go to FINISH SCREEN (Main_Case.review).

(less than/more than) – [If Q17 < Q15 fill: "less than", else if Q17 > Q15 fill: "more than".

(ADMIT DATE) should fill from EVTBEG_DATE from A1.

Q18p - The DIANOTOSTXT 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.

Q18p, should be set up as a question loop that will require:

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

Q18p – Include the following options in listed options for the “Other Specify”;

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

ALSO ALLOW SYSTEM TO PULL UP NAME OF SOURCE SPECIFIED IN Q16h.

New is a multi-form validation check that for other providers appears on LSPCHECK. It should instead occur at the bottom of Q18 reasons series. IF (all source of payment fields PATPAYM to WORKPAYM and OTHRPAYM have entries of 0.00) or (TOTLPAYM is 0.00 or missing) AND (SLIDSCA2=”No” and BADDEB2=”No”) and all reasons for underpayment in the range of DISCARE to EPAYOTH, SLIDSCA, and BADDEB are answered “No”) AND (LSPCHECK=”No”) display a hard error at LSPCHECK, “PAYMENT VALIDATION FAILED: No payment source or reason(s) identified. Navigate to Sources of Payment or Payments NE Charges, or record Lum Sum Payment here.” This hard error will require user to correct one of those conditions or break off the event form.

2019 UPDATE: Each C18_additional item i-p (DIANPAT to DIANOTH) appears on its own screen, along with the entire C18_additional question text. The differences among screens is only the source of additional expected payment being asked about.

2019 UPDATE: IF PLC2 ITEMS Q18_DISADJ, Q18_MOREPAY, DIANSLID2, DIANBAD2, AND ELIGVET2_2 ALL = 2, AND C18_ADDITIONAL ITEMS DIANPAT, DIANCAR, DIANCAID, DIANPINS, DIANVA, DIANCHAM, DIANWORK, AND DIANOTH ALL =2, DISPLAY HARDCHECK: "YOU MUST SELECT AT LEAST ONE REASON PAYMENTS ARE LESS THAN CHARGES. RETURN TO PLC2 ITEMS AND/OR C18_ADDITIONAL ITEMS AND SELECT THE REASON(S)."

2019 UPDATE: IF ADJEXTRA_2 = 2, DISPLAY A HARD CHECK: "IF THE ANSWER IS 'NO,' PLEASE GO BACK TO Q17 (VERIFY TOTAL PAYMENTS) TO RECONFIRM CHARGES AND PAYMENTS AS NEEDED."

EDIT SPECS FROM WESTAT

QC6 REASONS FOR PAYMENTS LESS THAN CHARGES

Follow Skip Pattern

DATA ITEM	SPECIFICATIONS	**ACTION, if specification not met**
QC6 a – r Reason for PAYMENTS LESS THAN CHARGES See QC4-QC6 CONSISTENCY notes	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, or page 5-34 of the spex.
	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.
		Blue Sheet if only YES answer is circled, and NO answers are blank, and the payments are less than charges. Let the TRC fill in the NO answers.
	If there is a YES answer in PAYMENTS MORE THAN CHARGES section, all choices in the PAYMENTS LESS THAN CHARGES SECTION should be NO (2).	**Blue Sheet** if there is a YES answer in both PAYMENTS LESS and PAYMENTS MORE sections.
		Circle NO (2) for all answers in the PAYMENTS LESS section, if all answers are blank and there is a YES (1) answer in the PAYMENTS MORE section.
	If OTHER is answered, there must be an answer on the SPECIFY line (QC6 line h or line p). Sometimes the answer is written outside the line, as a comment. 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, 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.
	QC6 line h answers should also be reflected in QC4 unless total pay is $0.00. State program paid; State program adj. Exceptions :Hospital 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.

QC6 Reasons for Payments More Than Charges.

Follow Skip Pattern

DATA ITEM	SPECIFICATIONS	**ACTION, if specification not met**
QC6 s – v Reason for PAYMENTS MORE THAN CHARGES See QC4-QC6 CONSISTENCY notes on page 5- 34.	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 5-34.
	YES (1) or NO (2) must be circled for each choice.	**Blue Sheet** if missing and payment is less than charge.
	Since YES (1) may be answered for more than one choice, only the TRC can answer NO (2).	**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.
	If OTHER is answered, there must be an answer on the SPECIFY line (QC6 line v). Sometimes the answer is written outside the line, as a comment.	Check Decision log for all Specify answers. If it is on the Decision log, follow directions given there. If the answer is not there, **Yellow Sheet.**
		Blue Sheet if Specify answer is missing.

	Answer on the SPECIFY line (QC6 line v) needs review.	If the answer is written outside of the Specify line, circle the answer if it is on the Decision Log. **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

Compare QC4 and QC6

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

QC4 AND QC6 “OTHER/SPECIFY”
Answers in “Other/Specify” should be reflected in both QC4 and QC6.
If there is an “Other/Specify” answer in QC4 that is not also indicated in QC6, **Yellow Sheet.**
If there is no payment on QC4 (line h), cross out the Other/Specify answer on that line.
If there is an “Other/Specify” answer in QC6 that is not also indicated in QC4, **Yellow Sheet.**
Exceptions: If Other/Specify answer in QC6 is Hosp or Provider Write Off, there will not be a corresponding answer in QC4.
If Total payment = Total charges, there will not be a corresponding answer in QC6.

CHECK DECISION LOG FOR COMMENT REVIEW
Some comments should be moved to QC6 (line h) Other/Specify. Look up comments on the Decision Log.
Examples: “Insurance denied,” “Medicare denied,” “Billing error,” “Billed late,” “Procedure not covered by Medicaid”

COMPARE QUESTIONS BETWEEN BOOKS
Look for indications that the wrong answer was circled by mistake.

OTHER/SPECIFY WRITE-OFFS
OBD cases -- Accept the phrase “Provider write-off.”
Hospital cases -- Accept the phrase “Hospital write-off”
Accept “Small Balance Write-off” or “Small Balance Adjustment”

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

THREE OR MORE INSURANCE TYPES
Yellow Sheet.

AN ADJUSTMENT WITHOUT A PAYMENT FROM THAT SOURCE
Accept an answer that indicates an Adjustment with $0.00 payment by that source, as long as there is no other evidence of an inconsistency.

DECISION LOG FOR QC6

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

Problem	Decision / Categorization
Payment Less than Charges	If instructions say to add an answer to line h or line p, change the YES/NO answer to 1 and cross out the answer 2. If instructions say to delete an answer from line h or line p, change the YES/NO answer to 2 and cross out the answer 1.
Underpayment exists in Q(C4) by a State (or Federal, or County, or City) Plan ---- Plan may be Fund, Program, Grant ------ type of plan may be given ------- REMOVE Name of State if it is present	Code in 'OTHER' as (name of source given in Q(C4h)).

Examples:	
Nevada State Disability	State Disability.
State Breast Cancer Program	State Breast Cancer Program.
Maryland Indigent Program	State Indigent Program.
Federal Grant	Federal Grant.
Cook County Indigent Fund	County Indigent Fund.
State Program	State Program.
Zero total payment in Q(C4) but comment about a State (or Federal, or County, or City) Plan ---- Plan may be Fund, Program, Grant ------ type of plan may be given ------- REMOVE Name of State if it is present	If TRC says Charity care, accept as is. otherwise Yellow Sheet
Comment says that insurance was never billed	Code in 'Other' (line h) as NEVER BILLED. Include type of insurance, if known, such as MEDICARE NEVER BILLED
Comment says Insurance denied payment.	Code in 'Other' (line h) as INSURANCE DENIED. Include type of insurance, if known, such as MEDICARE DENIED.
Comment mentions billing error.	Code in 'Other' (line h) as Billing Error. Include type of insurance if known, such as: MEDICARE DENIED: BILLING ERROR
Comment mentions untimely filing, billed late.	Code in 'Other' (line h) as Billed Late. Include type of insurance if known, such as MEDICARE DENIED: BILLED LATE.
Comment mentions Insurance denied, with an amount, such as Private Insurance denied $52.50.	Code in 'Other' (line h) as INSURANCE DENIED. Include type of insurance, if known, such as PRIV INS DENIED. Do not include the amount.
Comment mentions that the insurance doesn't cover a procedure.	Code in 'Other' (line h) as INSURANCE DENIED: PROCEDURE NOT COVERED. Include type of insurance, if known, such as MEDICAID DENIED: PROCEDURE NOT COVERED.
Comment mentions that insurance doesn't cover if no pre-authorization	Code in 'Other' (line h) as INSURANCE DENIED: NO PRE-AUTHORIZATION. Include type of insurance, if known, such as TRICARE DENIED: NO PRE-AUTHORIZATION
Comment mentions nurse visit not covered	Code in 'Other' (line h) as INSURANCE DENIED: NURSE VISIT. Include type of insurance, if known, such as MEDICAID DENIED: NURSE VISIT
Comment says patient paid the deductible.	Do not code in 'Other' (line h). If there is an adjustment or limit answered, or payment is expected from any source, accept as is. If there is no adjustment or limit, or expectation of future payment, Yellow Sheet.
Comment says insurance made an adjustment.	Do not code in 'Other' (line h). If there is an adjustment or limit answered, or payment is expected from any source, accept as is. If there is no adjustment or limit, or expectation of future payment, Yellow Sheet.
Comment mentions Collection Agency or " in Collections"	Do not code in 'Other' line h or line p. Accept answers EXPECTING PATIENT PAYMENT and/or BAD DEBT. Otherwise, Yellow Sheet.
Collection Agency or "in collections" is Other/Specify answer (line h or line p)	Cross out "in collections," etc. as the 'Specify' answer (line h or line p). Accept answers EXPECTING PATIENT PAYMENT and/or BAD DEBT. Otherwise Yellow Sheet.
Small balance w/o (Small balance write off)	Code in Other as Small Balance W/O
Small balance Adj (Small balance adjustment)	Code in Other as Small balance Adj
Military	Blue Sheet for more specific information
Dependent of active duty military / Active duty military dependent	Code in 'other' as Eligible Active Duty Fam Mem
Active duty armed forces member / Active duty military	Code in 'Other' as Eligible Active Duty
Active duty family member	Code in 'Other' as Eligible Act Duty Fam Mem
Retired veteran / Retired military	Code in 'Other' as Eligible Retiree

Retired veteran's family member	Code in 'Other' as Eligible Retiree Fam Mem
Retired Military Dependent	Code in 'Other' as Eligible Retiree Fam Mem
Veteran's family member	Code in 'Other' as Eligible Veteran Fam Mem
Indian Health	Code in 'Other' as Eligible Native American
Clerical fee; administrative fee	YELLOW SHEET
Grant - DK who is funding it	Code in 'Other' as Grant - DK who is funding it.
HMO	Blue Sheet for type of insurance: Medicare, Medicaid, or Private, other
Comment says No payments due to Federal Vaccines given	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 23 – PATIENT ACCOUNTS – BILLING PERIOD INFORMATION 2

[PAGE 30 – PATIENT ACCOUNTS – BILLING PERIOD INFORMATION (1 of 1)]

SCREEN LAYOUT

Q19. Perhaps it would be easier if you gave me the information about **ancillary charges** by billing period.

a. First, what was the start date of the first billing period in which (PATIENT NAME) was a patient? [ENTER MONTH ONLY IF BILLING PERIOD IS MONTHLY, OTHERWISE LEAVE EMPTY.] [ENTER A DATE IN FORMAT MM/DD/YYYY. INCLUDE LEADING 0's FOR SINGLE DIGIT MONTHS AND DAYS.]	**BPMONTH#** (MONTH) or **Q19BPBEG_DATE#** (START DATE)
b. And what was the end date? ENTER A DATE IN FORMAT MM/DD/YYYY. INCLUDE LEADING 0's FOR SINGLE DIGIT MONTHS AND DAYS.	**Q19BPEND_DATE#** (END DATE)
c. What was the total of full established charges for health-related ancillary care during this billing period? Please exclude charges for non-health related services such as television, beautician services, etc.	**BPCHARG#** $_____.____

PROGRAMMER NOTES

These questions are designed to collect billing periods and charges for institutions who could not report total ancillary charges back in Q15. We need to permit Q19a-c to loop up to 10 times. Responses to questions Q19a-c should populate a table appearing at the top of the screen.

If **BPMONTH#** is answered, go to Q19c.

Q19a is divided into two screens – one for BPMONTH# and one for Q19BPBEG_DATE#.

- The screen for BPMONTH# displays this instruction: ENTER MONTH ONLY IF BILLING PERIOD IS MONTHLY, OTHERWISE LEAVE EMPTY.
- The screen for Q19BPBEG_DATE# displays this instruction: ENTER A DATE IN FORMAT MM/DD/YYYY. INCLUDE LEADING 0's FOR SINGLE DIGIT MONTHS AND DAYS.

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

DOLLAR AMOUNTS SHOULD BE FORMATTED TO INCLUDE COMMAS and DECIMAL POINTS.

Q19 - DK/REF ALLOWABLE

[PAGE 31 – PATIENT ACCOUNTS – SOURCES OF PAYMENT (1 of 2)]

SCREEN LAYOUT

Q20. From which of the following sources did the facility receive payments for ancillary charges for the billing period that began (BILLING PERIOD DATE) and how much was paid by each source? Please include all payments that have taken place between (ADMIT DATE) and now for this stay.

a. Patient or Patient's Family;	$_____._____	ANCPAT
b. Medicare;	$_____._____	ANCCAR
c. Medicaid;	$_____._____	ANCAID
d. Private Insurance;	$_____._____	ANCPIN
e. VA/ChampVA;	$_____._____	ANCVA
f. Tricare;	$_____._____	ANCTRI
g. Worker's Comp; or	$_____._____	ANCCMP
h. Something else? (IF SOMETHING ELSE: What was that?) _____ ANCWHAT ANCWHATTXT	$_____._____	ANCOTH

2019 UPDATE: Each Q20 item a-h (ANCPAT to ANOTH) appears on its own screen, along with the entire Q20 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.

Q20 onscreen instructions for each Q20 (a-h) screen:

- IF NONE, ENTER ZERO (0).
- [DCS ONLY] IF NAME OF INSURER, PUBLIC, OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance?
- [DCS ONLY] IF PROVIDER VOLUNTEERS THAT PATIENT PAYS A MONTHLY PREMIUM, VERIFY: So, you receive a monthly payment rather than a payment for the specific service? IF YES: GO BACK TO Q5 AND CODE AS CAPITATED BASIS.

Q20(h) - The ANCWHATTXT 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 items. ANCWHATTXT text field allows up to 50 characters. Onscreen text for ANCWHATTXT reads: OTHER SPECIFY: PROBE FOR SOURCE OF FUNDS AND TYPE OF PLAN".

Q20(h) Other Amount (ANCOTH) onscreen text: "Other payment amount".

Q20h is a question loop that will require:

(1) A HISTORY BOX to display responses already collected.

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

Q20(h) – Include the following options for “Something else?”;

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

(BILLING PERIOD DATE) should fill with either **BPMONTH#** or **Q19BPBEG_DATE#** from Q19.
(ADMIT DATE) should fill from EVTBEG_DATE from A1.

Q20 should administer once for each billing period reported in Q19a-c. The fill date for each administration of will come from the date reported in Q19a.

DOLLAR AMOUNTS SHOULD BE FORMATTED TO INCLUDE COMMAS and DECIMAL POINTS.

Q20 - DK/REF ALLOWABLE

[Page 32 – PATIENT ACCOUNTS – SOURCES OF PAYMENT (2 of 2)]

SCREEN LAYOUT

Q20a. [SYSTEM WILL GENERATE AFTER Q20 FOR EACH BILLING PERIOD IN Q19]
I show the total payment as [SYSTEM WILL COMPUTE AND DISPLAY TOTAL]. Is that correct?

PROGRAMMER NOTES

Design Note Q20 (specifically Q20_OtherAnc and Q20a)

CHARGES

Total ancillary charges: $[TOTBPCHARG]

PAYMENTS

Patient or family	$[ANCPAT]
Medicare	$[ANCCAR]
Medicaid	$[ANCAID]
Private insurance	$[ANCPIN]
VA/ChampVA	$[ANCVA]
Tricare	$[ANCTRI]
Workers comp	$[ANCCMP]
$Other_1$	$[$ANCOTH_1$]
.	
.	
.	
$Other_N$	$[$ANCOTH_N$]

Programmer:

FILL INSTRUCTIONS:

1. All SOP >=0 (e.g., 0, integer dollars, dollars + cents)
    a. Text: I show the total payment as Q20TOTLPAYM.
2. All SOP <0 (e.g., hotkeys F6, F7 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 Q20TOTLPAYM, although one or more payments are missing.

New variable: TOTBPCHARG equals sum of every reported BPCHARG reported in Q19a-c loop.

Q20a=NO, display hard error: “IF INCORRECT, CORRECT ENTRIES AS NEEDED” and return user to Q20; ELSE CONTINUE.

Validation: if TOTBPCHARG> 250,000 administer soft check “YOU HAVE VERIFIED A TOTAL ANCILLARY CHARGE OVER $250,000. IF CORRECT, SELECT SUPPRESS AND CONTINUE. IF INCORRECT, RETURN TO Q19c AND REVISE ENTRIES.”

Q20a - DK/REF NOT ALLOWABLE

After Q20a, provide a stop mechanism for user by asking “Any more periods for ancillary charges?” with YES/NO options. If YES go to Q19a#. If NO continue.

SECTION 25 – PATIENT ACCOUNTS – capitated basis

NOTE: See end of section for edit specs from Westat for questions 21a, 21b, 21c, 21d, 21e,21f, 21g, and 21h.

[PAGE 33 – PATIENT ACCOUNTS – CAPITATED BASIS (1 of 4)]

SCREEN LAYOUT

CAPITATED BASIS			
Q21a. What kind of insurance plan covered the patient for this stay? Was it: [DCS ONLY] IF NAME OF INSURER, PUBLIC, OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance? **OTHER SPECIFY:** PROBE FOR SOURCE OF FUNDS AND TYPE OF PLAN.	a. Medicare; b. Medicaid; c. Private Insurance; d. VA/ChampVA; e. Tricare; f. Worker's Comp; or g. Something else? (IF SOMETHING ELSE: What was that?)	YES=1, NO=2 YES=1, NO=2 YES=1, NO=2 YES=1, NO=2 YES=1, NO=2 YES=1, NO=2 YES=1, NO=2	**COVCARE** **COVAID** **COVPINS** **COVVA** **COVCHAM** **COVWORK** **COVOTHR** **COVOTOS** **COVOTOSTXT**
Q21b. What was the monthly payment from that plan?	$_____.__		**MONPAYM**
Q21c. Was there a co-payment for any part of this stay?	YES=1, NO=2		**ANYCOPAY**

PROGRAMMER NOTES

Q21a(g) - The COVOTOSTXT variable was added to record free-form text for the "Other, Specify" option. Interviewers will be able to record responses in the text box that do not occur in the listed options.

COVOTOSTXT field allows up to 50 characters. Screen reads: “OTHER INSURANCE PLAN…” “PLEASE SPECIFY OTHER”.

Q21a(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.

Q21a(g) – Include the following options for the “Other Specify”;

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

Q21c - [IF ANYCOPAY=2 GO TO Q21g]

Q21a - DK/REF – CONTINUE TO Q21b

Q21b - DK/REF – CONTINUE TO Q21c

Q21c - DK/REF – GO TO Q21g

DOLLAR AMOUNTS SHOULD BE FORMATTED TO INCLUDE COMMAS and DECIMAL POINTS.

2021 UPDATE: IF Q21a a-g (COVCARE, COVAID, COVPINS, COVVA, COVCHAM, COVWORK, COVOTHR) all equal 2 (NO), display soft check:

YOU HAVE INDICATED CAPITATED PAYMENT, BUT ENTERED ‘NO’ FOR ALL INSURANCE TYPES. PLEASE CHECK THE RECORDS AGAIN AND/OR PROBE WITH THE POC TO DETERMINE THE INSURANCE PLAN(S) TYPE THAT COVERED THIS EVENT, AND CHANGE THE ANSWER FOR THAT ITEM. OR CLICK ‘SUPPRESS’ TO CONTINUE.

2019 UPDATE: Each Q21a item a-g (COVCARE to COVOTHR) appears on its own screen, along with the entire Q21a question text. The differences among screens is only the payer type (Medicare, Medicaid, etc.).

[PAGE 34 – PATIENT ACCOUNTS – CAPITATED BASIS (2 of 4)]

SCREEN LAYOUT

Q21d. How much was the co-payment?		$_____.__	**COPAYAMT**
NOTE: NEXT QUESTION WILL ASK FREQUENCY (E.G., PER DAY, MONTH, ETC.)	per	DAY..... 1 WEEK..... 2 MONTH..... 3 OTHER..... 4 SPECIFY: _____	**CPAYPER** **CPAYOTH**
Q21e. For how many (days/weeks/months/other) was the co-payment paid?		_____#	**CPAYMPAY**

Q21f. 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?

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

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. Something else? (IF SOMETHING ELSE: What was that?)	YES=1, NO=2	**CPAYOTHR** **CPAYOTOS** **CPAYOTOSTXT**

PROGRAMMER NOTES

Q21d - DOLLAR AMOUNTS SHOULD BE FORMATTED TO INCLUDE COMMAS and DECIMAL POINTS

Q21d – TWO PART QUESTION. COLLECT DOLLAR AMOUNT IN COPAYAMT. COLLECT FREQUENCY OF PAYMENT IN CPAYPER. ONSCREEN TEXT FOR CPAYPER: "[DCS ONLY] PROBE TO DETERMINE IF FOR DAY, WEEK, ETC."

If Q21d CPAYPER=4 provide an "Other specify" text box.

Q21f(e) is a question loop that will require:
(1) A HISTORY BOX to display responses already collected.
(2) A question to appear after each iteration of the question that reads:
Any more payers? YES=1 NO=2
(3) The "something else" option should be set up so a response can be selected from listed options, or entered in as text.

C21f(e) - The CPAYOTOSTXT variable was added to record free-form text for the "Other, Specify" option. Interviewers will be able to record responses in the text box that do not occur in the listed options. Allows up to 50 characters.

Q21f(e) – Include the following options for the "Other Specify";
Auto or Accident Insurance
Indian Health Service
State Public Mental Plan
State/County/Local program
Other

Q21d – code DK as 8
Q21e – code DK as 98

Q21d - DK/REF– CONTINUE TO Q21e
Q21e - DK/REF – CONTINUE TO Q21f
Q21f - DK/REF – GO TO Q21g

DOLLAR AMOUNTS SHOULD BE FORMATTED TO INCLUDE COMMAS and DECIMAL POINTS.

2019 UPDATE: Each Q21f item a-e (CPAYPAT to CPAYOTHR) appears on its own screen, along with the entire Q21f question text. The differences among screens is only the payer type (Patient or Patients Family, Medicare, etc.).

[PAGE 35 – PATIENT ACCOUNTS – CAPITATED BASIS (3 of 4)]

SCREEN LAYOUT

Q21g. Do your records show any other payments for this stay? YES=1, NO=2 **OTHPAY**

PROGRAMMER NOTES

If Q21g=1 go to Q21h else go to EXIT SCREEN

Q21g - DK/REF ALLOWABLE

[PAGE 36 – PATIENT ACCOUNTS – CAPITATED BASIS (4 of 4)]

SCREEN LAYOUT

Q21h. From which of the following other sources has the facility received payment for this stay and how much was paid by each source? Please include all payments that have taken place between (ADMIT DATE) and now for this stay.

RECORD PAYMENTS FROM ALL APPLICABLE PAYERS

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

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

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. Something else? (IF SOMETHING ELSE: What was that?) **OTHOTOS** **OTHOTOSTXT**	$**OTHOTHR**

PROGRAMMER NOTES

Q21h: Each of the fields requires a non-blank entry. Entries of 0, DK, RF are allowed here.

(ADMIT DATE) should fill from EVTBEG_DATE from A1.

Q21h(h) - The OTHOTOSTXT variable was added to record free-form text for the "Other, Specify" option. Interviewers will be able to record responses in the text box that do not occur in the listed options. OTHOTOSTXT field allows up to 40 characters. Onscreen text: "OTHER PAYMENT SOURCE…" "PLEASE SPECIFY OTHER".

21h(h) is a question loop that will require:
(1) A HISTORY BOX to display responses already collected.
(2) A question to appear after each iteration of the question that reads: Any more sources? YES=1 NO=2
(3) The "something else" option should be set up so a response can be selected from listed options, or entered in as text.

21h (h) – Include the following options for the "Other Specify";
Auto or Accident Insurance
Indian Health Service
State Public Mental Plan
State/County/Local program
Other

DOLLAR AMOUNTS SHOULD BE FORMATTED TO INCLUDE COMMAS and DECIMAL POINTS.

Q21h- DK/REF ALLOWABLE

EDIT SPECS FROM WESTAT

QC7 CAPITATED BASIS.

Follow Skip Pattern

DATA ITEM	SPECIFICATIONS	**ACTION, if specification not met**
Capitated Section	Entire Capitated Section cannot be DK or RF.	**Blue Sheet,** to verify that Reimbursement type is Capitated.

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

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

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

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

Problem	Decision / Categorization
Source of Payments	
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 Fund	Blue Sheet to determine source of funding: Federal, State, County, Other gov't, Private etc
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.

FINISH SCREEN

ENTER 1 TO FINALIZE THIS CASE.

PROGRAMMER NOTES

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