

PATIENT LABEL

FORM \_\_\_\_\_ OF \_\_\_\_\_

**MEDICAL EXPENDITURE PANEL SURVEY**

**MEDICAL PROVIDER COMPONENT**

**INSTITUTIONAL EVENT FORM  
(NON-HOSPITAL FACILITIES)**

**FOR**

**REFERENCE YEAR 2006**



**INSTITUTIONAL EVENT FORM**  
[COMPLETE ONE FORM FOR EACH STAY]

**QUESTIONS 1 THROUGH 3: TO BE COMPLETED WITH MEDICAL RECORDS.**

READ ONLY FOR FIRST STAY FOR THIS PATIENT: Someone in (PATIENT)'s family reported that (he/she) was a patient in this facility during 2006.

**MEDICAL RECORDS**

<p>1. What were the admit and discharge dates of the (first/next) stay?</p>	<p style="text-align: center;">MO      DAY      YR</p> <p>ADMIT:      _____ / _____ / _____</p> <p>DISCHARGE: _____ / _____ / _____</p> <p>NOT YET DISCHARGED.....1</p>															
<p>2a. I need the diagnoses for this stay. I would prefer the ICD-9 codes (or DSM-IV codes), if they are available.</p> <p>[IF CODES ARE NOT USED, RECORD DESCRIPTIONS.]</p>	<table border="0" style="width: 100%;"> <tr> <td style="width: 15%; text-align: center;">CODE</td> <td style="width: 10%; text-align: center;">DESCRIPTION</td> <td></td> </tr> <tr> <td> _  </td> <td>_____</td> <td>_____</td> </tr> </table>	CODE	DESCRIPTION		_	_____	_____	_	_____	_____	_	_____	_____	_	_____	_____
CODE	DESCRIPTION															
_	_____	_____														
_	_____	_____														
_	_____	_____														
_	_____	_____														
<p>2b. OMITTED</p>																
<p>3. Please give me the name, specialty, and telephone number of each physician who provided services during the stay starting on (ADMIT DATE) <u>and</u> 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.</p>	<p>[RECORD NAMES ON SEPARATELY BILLING DOCTOR FORM. IF RESPONDENT IS NOT SURE WHETHER A PARTICULAR DOCTOR'S CHARGES ARE INCLUDED IN THE FACILITY BILL, RECORD INFORMATION FOR THAT DOCTOR ON SEPARATELY BILLING DOCTOR FORM.]</p> <p>DOES NOT HAVE THIS INFORMATION .....0</p> <p>SEPARATELY BILLING DOCTORS FOR THIS EVENT ..... 1</p> <p><b>NO SEPARATELY BILLING DOCTORS FOR THIS STAY .....2</b></p>															
<p>4a. Have we covered all of this patient's stays during the calendar year 2006?</p>	<p>YES, ALL STAYS COVERED ..... 1 (Q4b)</p> <p>NO, NEED TO COVER ADDITIONAL STAYS..... 2 (Q1-NEXT EVENT FORM)</p>															
<p>4b. [IF ALL STAYS ARE RECORDED FOR THIS PATIENT, REVIEW NUMBER OF STAYS REPORTED BY HOUSEHOLD.]</p>	<p>NO DIFFERENCE OR FACILITY REPORTED MORE STAYS THAN HOUSEHOLD..... 1 (ENDING FOR MEDICAL RECORDS)</p> <p>FACILITY RECORDED FEWER STAYS..... 2</p> <p>PROBE: (PATIENT NAME) reported (NUMBER) stays at (FACILITY) during 2006, but I have only recorded (NUMBER) stays. Do you have any information in your records that would explain this?</p> <p>_____</p> <p>_____</p>															

**GO TO ENDING FOR MEDICAL RECORDS**

**ENDING FOR MEDICAL RECORDS:**  
GO TO NEXT PATIENT. IF NO MORE PATIENTS, THANK RESPONDENT AND END. THEN ATTEMPT CONTACT WITH PATIENT ACCOUNTS OR ADMINISTRATIVE OFFICE.

**QUESTIONS 5 THROUGH END: TO BE COMPLETED WITH PATIENT ACCOUNTS.**

5. According to Medical Records, (PATIENT NAME) was a patient in your facility during the period from [ADMIT DATE] to [DISCHARGE DATE/END OF 2006]. Was the facility reimbursed for this stay on a fee-for-service basis or a capitated basis?

**FEE-FOR-SERVICE BASIS ..... 1**  
**CAPITATED BASIS..... 2 (Q21a)**

[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.

[INTERVIEWER: IF IN DOUBT, CODE FEE-FOR-SERVICE.]

**BASIC CHARGES**

6. 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 2006]?

**FULL ESTABLISHED CHARGE OR CHARGE EQUIVALENT:**

\$ \_\_\_\_\_ . \_\_\_\_\_ (Q7)

[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.*]

**CAN'T GIVE TOTAL CHARGE ..... 991 (Q10)**  
**NO CHARGE ..... 992 (Q6A)**

[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?*]

6a. Why is there no charge for room, board, and basic care for this stay?

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

GO TO Q14

7. From what sources has the facility received payment for these charges and how much was paid by each source?
- IF NAME OF INSURER, PROBE: And is that Medicare, Medicaid, or private insurance?
- a. Patient or patient's family \$\_\_\_\_\_.
  - b. Medicare \$\_\_\_\_\_.
  - c. Medicaid \$\_\_\_\_\_.
  - d. Private Insurance \$\_\_\_\_\_.
  - e. VA \$\_\_\_\_\_.
  - f. TRICARE/CHAMPVA/CHAMPUS \$\_\_\_\_\_.
  - g. WORKER'S COMP \$\_\_\_\_\_.
  - h. OTHER (SPECIFY): \_\_\_\_\_ \$\_\_\_\_\_.
8. IF NOT VOLUNTEERED, ASK: And what was the total? [IF NOT AVAILABLE, COMPUTE.]
- TOTAL PAYMENTS** \$\_\_\_\_\_.

BOX 1	
DO TOTAL PAYMENTS (Q8) EQUAL TOTAL CHARGES (Q6)?	
YES.....	1 (Q14)
NO.....	2 (Q9)

9. It appears that the total payments were (less than/more than) the total charges. What is the reason for this difference? [CODE 1 (YES) FOR ALL REASONS MENTIONED.]
- |  | <u>YES</u> | <u>NO</u> |
|--|------------|-----------|
| <b>PAYMENTS LESS THAN CHARGES:</b>   |            |           |
| <b>Adjustment or discount</b>  |            |           |
| a. Medicare limit or adjustment .....                                      | 1          | 2         |
| b. Medicaid limit or adjustment .....                                      | 1          | 2         |
| c. Contractual arrangement with insurer or managed care organization ..... | 1          | 2         |
| d. Courtesy discount .....   | 1          | 2         |
| e. Insurance write-off .....   | 1          | 2         |
| f. Worker's Comp limit or adjustment .....                                 | 1          | 2         |
| g. Eligible veteran .....  | 1          | 2         |
| h. Other (Specify:) _____  | 1          | 2         |
| <b>Expecting additional payment</b>  |            |           |
| i. Patient or Patient's Family .....                                       | 1          | 2         |
| j. Medicare .....  | 1          | 2         |
| k. Medicaid.....   | 1          | 2         |
| l. Private Insurance .....   | 1          | 2         |
| m. VA .....  | 1          | 2         |
| n. TRICARE/CHAMPVA/CHAMPUS .....   | 1          | 2         |
| o. WORKER'S COMP .....   | 1          | 2         |
| p. Other (Specify:) _____  | 1          | 2         |
| q. <b>Charity care or sliding scale</b> .....                              | 1          | 2         |
| r. <b>Bad debt</b> .....   | 1          | 2         |
| <b>PAYMENTS MORE THAN CHARGES:</b>   |            |           |
| s. Medicare adjustment.....  | 1          | 2         |
| t. Medicaid adjustment.....  | 1          | 2         |
| u. Private insurance adjustment .....                                      | 1          | 2         |
| v. Other (Specify:) _____  | 1          | 2         |

GO TO Q14

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

\$\_\_\_\_\_ (Q11)

**RATE CHANGED DURING STAY ..... 991 (Q12)**  
**NO CHARGE ..... 992 (Q10A)**

10a. Why was there no charge for room, board, and basic care for this stay?

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

GO TO Q14

11. For how many days was the patient charged during this stay? (Please give only the days during 2006.)

\_\_\_\_\_ # DAYS

IF RESPONDENT CAN'T PROVIDE TOTAL DAYS, GO TO Q12. OTHERWISE, CONTINUE.

11a. From what sources has the facility received payment for these charges and how much was paid by each source?

- a. Patient or patient's family \$\_\_\_\_\_.
- b. Medicare \$\_\_\_\_\_.
- c. Medicaid \$\_\_\_\_\_.
- d. Private Insurance \$\_\_\_\_\_.
- e. VA \$\_\_\_\_\_.
- f. TRICARE/CHAMPVA/CHAMPUS \$\_\_\_\_\_.
- g. WORKER'S COMP \$\_\_\_\_\_.
- h. OTHER (SPECIFY): \_\_\_\_\_ \$\_\_\_\_\_.

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

11b. IF NOT VOLUNTEERED, ASK: And what was the total? [IF NOT AVAILABLE, COMPUTE.]

**TOTAL PAYMENTS \$\_\_\_\_\_.**

GO TO Q14





**ANCILLARY CHARGES**

14. 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?)

YES ..... 1  
 NO ..... 2 (Q22)

15. 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.

**TOTAL CHARGES:** \$..... (Q16)

*[Ancillaries are facility charges that are not included in the basic charge. Ancillary charges may include laboratory, radiology, drugs and therapy (physical, speech, occupational).]*

CHECK HERE IF RESPONDENT CAN'T SEPARATE HEALTH AND NON-HEALTH RELATED ANCILLARY CHARGES (Q16).  
 CHECK HERE IF RESPONDENT CAN'T GIVE TOTAL ANCILLARY CHARGES (Q19).

16. From what sources has the facility received payment for these charges and how much was paid by each source?

a. Patient or patient's family \$.....  
 b. Medicare \$.....  
 c. Medicaid \$.....  
 d. Private Insurance \$.....  
 e. VA \$.....  
 f. TRICARE/CHAMPVA/CHAMPUS \$.....  
 g. WORKER'S COMP \$.....  
 h. OTHER (SPECIFY):  
 \_\_\_\_\_ \$.....

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

17. IF NOT VOLUNTEERED, ASK: And what was the total? [IF NOT AVAILABLE, COMPUTE.]

**TOTAL PAYMENTS** \$.....

BOX 2	
DO TOTAL PAYMENTS (Q17) EQUAL TOTAL CHARGES (Q15)?	
YES.....	1 (Q22)
NO.....	2 (Q18)

18. It appears that the total payments were (less than/more than) the total charges. What is the reason for this difference? [CODE 1 (YES) FOR ALL REASONS MENTIONED.]

<b>PAYMENTS LESS THAN CHARGES:</b>	<u>YES</u>	<u>NO</u>
<b>Adjustment or discount</b>		
a. Medicare limit or adjustment.....	1	2
b. Medicaid limit or adjustment .....	1	2
c. Contractual arrangement with insurer or managed care organization .....	1	2
d. Courtesy discount .....	1	2
e. Insurance write-off .....	1	2
f. Worker's Comp limit or adjustment.....	1	2
g. Eligible veteran .....	1	2
h. Other (Specify:)	1	2
<b>Expecting additional payment</b>		
i. Patient or Patient's Family .....	1	2
j. Medicare .....	1	2
k. Medicaid.....	1	2
l. Private Insurance .....	1	2
m. VA .....	1	2
n. TRICARE/CHAMPVA/CHAMPUS .....	1	2
o. WORKER'S COMP .....	1	2
p. Other (Specify:)	1	2
q. <b>Charity care or sliding scale</b> .....	1	2
r. <b>Bad debt</b> .....	1	2
<b>PAYMENTS MORE THAN CHARGES:</b>		
s. Medicare adjustment.....	1	2
t. Medicaid adjustment.....	1	2
u. Private insurance adjustment .....	1	2
v. Other (Specify:)	1	2

GO TO Q22
-----------

19. Perhaps it would be easier if you gave me the information billing period by billing period.

	BP1	BP2	BP3	BP4	BP5	LAST BP
a. First, what was the start date of the first billing period in which (PATIENT) was a patient? ENTER MONTH ONLY IF BILLING PERIOD IS MONTHLY.	_____ (MONTH) (Q19c)  or ____/____/____ (START DATE)					
b. And what was the end 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.	\$_____.	\$_____.	\$_____.	\$_____.	\$_____.	\$_____.
	GO TO NEXT BP					

20. From what sources did the facility receive payments for ancillary charges for this billing period and how much was paid by each source?						
a. Patient or patient's family	\$_____.	\$_____.	\$_____.	\$_____.	\$_____.	\$_____.
b. Medicare	\$_____.	\$_____.	\$_____.	\$_____.	\$_____.	\$_____.
c. Medicaid	\$_____.	\$_____.	\$_____.	\$_____.	\$_____.	\$_____.
d. Private Insurance	\$_____.	\$_____.	\$_____.	\$_____.	\$_____.	\$_____.
e. VA	\$_____.	\$_____.	\$_____.	\$_____.	\$_____.	\$_____.
f. TRICARE/CHAMPVA/CHAMPUS	\$_____.	\$_____.	\$_____.	\$_____.	\$_____.	\$_____.
g. OTHER (SPECIFY): _____	\$_____.	\$_____.	\$_____.	\$_____.	\$_____.	\$_____.
	GO TO NEXT BP	GO TO Q22				

**CAPITATED BASIS**

		<u>YES</u>	<u>NO</u>
21a. What kind of insurance plan covered the patient for this stay? Was it:	a. Medicare;.....	1	2
	b. Medicaid;.....	1	2
	c. Private Insurance;.....	1	2
[IF NAME OF INSURER OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance?]	d. VA;.....	1	2
	e. TRICARE/CHAMPVA/CHAMPUS;....	1	2
[CODE ALL THAT APPLY]	f. Worker's Comp; or.....	1	2
	g. Something else? (SPECIFY:.....)	1	2
21b. What was the monthly payment from that plan?	\$_____.		
21c. Was there a co-payment for any part of this stay?	YES.....	1	
	NO.....		2(Q22)
21d. How much was the co-payment? PROBE TO DETERMINE IF FOR DAY, WEEK, ETC.	\$_____.		
	per DAY.....	1	
	WEEK.....	2	
	MONTH.....	3	
	OTHER.....	4	
	SPECIFY: _____		
	DON'T KNOW.....		8
21e. For how many (days/weeks/months/other) was the co-payment paid?	_____#		
	DON'T KNOW.....		98
21f. Who paid the co-payment?		<u>YES</u>	<u>NO</u>
[IF NAME OF INSURER OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance?]	a. PATIENT OR PATIENT'S FAMILY ...	1	2
	b. MEDICARE.....	1	2
	c. MEDICAID.....	1	2
	d. PRIVATE INSURANCE.....	1	2
[CODE ALL THAT APPLY]	e. OTHER (SPECIFY: _____)	1	2
21g. Do your records show any other payments for (this visit/these visits)?	YES.....	1	
	NO.....		2 (Q22)
21h. From what other sources has the facility received payment for (this visit/these visits) and how much was paid by each source?	a. Patient or patient's family .....	\$_____.	
	b. Medicare.....	\$_____.	
	c. Medicaid.....	\$_____.	
	d. Private Insurance.....	\$_____.	
[IF NAME OF INSURER OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance?]	e. VA.....	\$_____.	
	f. TRICARE/CHAMPVA/CHAMPUS.....	\$_____.	
	g. WORKER'S COMP.....	\$_____.	
	h. OTHER (SPECIFY): _____	\$_____.	

22. ARE THERE ANY ADDITIONAL STAYS FOR THIS PATIENT TO BE ACCOUNTED FOR?	YES.....	1	(GO TO PATIENT ACCOUNTS SECTION (Q5) OF NEXT EVENT FORM.)
	NO.....	2	(GO TO NEXT PATIENT. IF NO MORE PATIENTS, THANK RESPONDENT AND END.)