

PATIENT LABEL

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

**MEDICAL EXPENDITURE PANEL SURVEY**  
**MEDICAL PROVIDER COMPONENT**  
**HOSPITAL EVENT FORM**  
**FOR**  
**REFERENCE YEAR 2007**

**HOSPITAL EVENT FORM**

[COMPLETE ONE FORM FOR EACH EVENT]

**QUESTIONS A1 THROUGH A4: TO BE COMPLETED WITH MEDICAL RECORDS.**

READ ONLY FOR FIRST EVENT FOR THIS PATIENT: (PATIENT NAME) reported that (he/she) received health care services from this facility during 2007.

**MEDICAL RECORDS**

A1. The (first/next) time (PATIENT NAME) received services during calendar year 2007, were the services received:  
 [CODE ONLY ONE]

As an Inpatient; ..... 1 (A2a)  
 In a Hospital Outpatient Department; ..... 2 (A2c)  
 In a Hospital Emergency Room; or ..... 3 (A2c)  
 Somewhere else? (SPECIFY:) ..... 4 (A2c)  
 LONG TERM CARE UNIT (SNF, etc.) (SPECIFY:) ..... 5 (A2a)

A2a. What were the admit and discharge dates of the (event/inpatient stay)?

MO DAY YR

ADMIT: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 DISCHARGE: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

A2b. Was (PATIENT NAME) admitted from the emergency room?

YES ..... 1 (COMPLETE SEPARATE EVENT FORM FOR ER EVENT)  
 NO ..... 2

**GO TO A3**

A2c. What was the date of this visit?

MO DAY YR  
 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

A3. Please give me the name, specialty, and telephone number of each physician who provided services during the (TYPE OF EVENT) on (DATE(S)) **and** whose charges might not be included in the hospital bill. We want to include such doctors as radiologists, anesthesiologists, pathologists, and consulting specialists, but **not** residents, interns, or other doctors-in-training whose charges **are** included in the hospital bill.

[RECORD NAMES ON SEPARATELY BILLING DOCTOR FORM. IF RESPONDENT IS NOT SURE WHETHER A PARTICULAR DOCTOR'S CHARGES ARE INCLUDED IN THE HOSPITAL BILL, RECORD INFORMATION FOR THAT DOCTOR ON SEPARATELY BILLING DOCTOR FORM.]

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

A4a. I need the diagnoses for (this stay/this visit). I would prefer the ICD-9 codes (or DSM-4 codes), if they are available.  
 [IF CODES ARE NOT USED, RECORD DESCRIPTIONS.]  
 [IF THERE ARE MORE THAN FOUR DIAGNOSES, USE A CONTINUATION SHEET.]

CODE	DESCRIPTION	
_____	_____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> OFFICE USE ONLY
_____	_____	
_____	_____	
_____	_____	

A4b. OMITTED

A4c. Have we covered all of this patient's events during the calendar year 2007?

YES, ALL EVENTS COVERED ..... 1 (A4d)  
 NO, NEED TO COVER ADDITIONAL EVENTS ..... 2 (A1-NEXT EVENT FORM)

A4d. IF ALL EVENTS ARE RECORDED FOR THIS PATIENT, REVIEW NUMBER OF EVENTS REPORTED BY HOUSEHOLD.

NO DIFFERENCE OR FACILITY REPORTED MORE EVENTS THAN HOUSEHOLD ..... 1 (ENDING FOR MEDICAL RECORDS)  
 FACILITY RECORDED FEWER VISITS ..... 2  
 PROBE: (PATIENT NAME) reported (NUMBER) events at (FACILITY) during 2007, but I have only recorded (NUMBER) visits. Do you have any information in your records that would explain this discrepancy?  
 \_\_\_\_\_  
 \_\_\_\_\_

**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.



A6a. I need to know what services were provided during (this visit/these visits). I would prefer the CPT-4 codes, if they are available.

[IF CPT-4 CODES ARE NOT USED, RECORD DESCRIPTION OF SERVICES AND PROCEDURES PROVIDED.]

[IF THERE ARE MORE THAN 11 SERVICES, USE A CONTINUATION SHEET.]

A6b. ASK FOR EACH CPT-4 CODE OR DESCRIPTION: What was the **full established charge** for this service, before any adjustments or discounts?

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

[IF NO CHARGE: *Some facilities that don't charge for each individual service do associate dollar amounts with services for purposes of budgeting or cost analysis. This is sometimes called a "charge equivalent." Could you give me the charge equivalents for these procedures?*]

C2. IF NOT VOLUNTEERED, ASK: And what was the total? [IF NOT AVAILABLE, COMPUTE.]

C3. Was the facility reimbursed for (this visit/these visits) on a fee-for-service basis or 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 where reimbursement is not tied to specific visits.]

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

C4. From what sources has the facility received payment for (this visit/these visits) and how much was paid by each source?

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

[INTERVIEWER: IF RESPONSE IS THE PATIENT PAYS A MONTHLY PREMIUM, GO BACK TO C3 AND CHANGE CODE TO 2 (CAPITATED BASIS).]

C5. IF NOT VOLUNTEERED, ASK: And what was the total? [IF NOT AVAILABLE, COMPUTE.]

CPT-4 (including modifier)	Full established charge at time of visit or charge equivalent
a. _____	\$ _____.
b. _____	\$ _____.
c. _____	\$ _____.
d. _____	\$ _____.
e. _____	\$ _____.
f. _____	\$ _____.
g. _____	\$ _____.
h. _____	\$ _____.
i. _____	\$ _____.
j. _____	\$ _____.
k. _____	\$ _____.

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**TOTAL CHARGES** \$ \_\_\_\_\_.

**FEE-FOR-SERVICE BASIS** ..... 1  
**CAPITATED BASIS**..... 2 (C7a)

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): _____	\$ _____.

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

<b>BOX 2</b>
<b>DO TOTAL PAYMENTS EQUAL TOTAL CHARGES?</b>
YES ..... 1 (BOX 3)
NO ..... 2 (C6)

C6. It appears that the total payments were (less than/more than) the total charges. What is the reason for that 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 BOX 3

**CAPITATED BASIS**

C7a. What kind of insurance plan covered the patient for (this visit/these visits)? Was it:		<u>YES</u>	<u>NO</u>
[IF NAME OF INSURER OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance?]	a. Medicare; .....	1	2
	b. Medicaid; .....	1	2
	c. Private Insurance; .....	1	2
	d. VA;.....	1	2
	e. TRICARE/CHAMPVA/CHAMPUS;.....	1	2
	f. Worker's Comp; or .....	1	2
	g. Something else? (SPECIFY:)	1	2
	_____		
C7b. Was there a co-payment for (this visit/these visits)?	YES .....	1	
	NO .....	2	(C7e)
C7c. How much was the co-payment?	\$ _____.		
C7d. 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
	e. Other (Specify:)	1	2
	_____		
C7e. Do your records show any other payments for (this visit/these visits)?	YES .....	1	
	NO .....	2	(BOX 3)
C7f. 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.....	\$ _____.	
[IF NAME OF INSURER OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance?]	b. Medicare .....	\$ _____.	
	c. Medicaid.....	\$ _____.	
	d. Private Insurance .....	\$ _____.	
	e. VA.....	\$ _____.	
	f. TRICARE/CHAMPVA/ CHAMPUS .....	\$ _____.	
	g. WORKER'S COMP .....	\$ _____.	
	h. OTHER (SPECIFY): _____	\$ _____.	

**BOX 3**  
**GLOBAL FEE SITUATION**  
**(A5a=YES) .....1 (A11)**  
**RECORDED 5 OR**  
**FEWER EVENTS .....2 (A11)**  
**RECORDED 6 OR**  
**MORE EVENTS .....3 (A7a)**



**PATIENT ACCOUNTS QUESTIONS FOR INPATIENT.**

A8. According to Medical Records, (PATIENT NAME) was an inpatient during the period from [DATE] to [DATE]. What was the DRG for this stay? DRG: \_\_\_\_\_ (BOX 4)  
 DRG NOT RECORDED ..... 1 (A9)

A9. Did the patient have any surgical procedures during this stay? YES ..... 1  
 NO ..... 2 (BOX 4)

A10a. What surgical procedures were performed during this visit? Please give me the procedure codes, that is the CPT-4 codes, if they are available.  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 [IF CPT-4 CODES ARE NOT USED, RECORD DESCRIPTION OF SERVICES AND PROCEDURES PROVIDED.]

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A10b. OMITTED

<b>BOX 4</b>
<b>ADMITTED FROM</b>
<b>EMERGENCY ROOM</b>
<b>(A2b=YES)..... 1 (C2a)</b>
<b>OTHERWISE ..... 2 (C2b)</b>

C2a. What was the **full established charge** for this inpatient stay, before any adjustments or discounts? Please do not include any emergency room charges.

C2b. What was the **full established charge** for this inpatient stay, before any adjustments or discounts?

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

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

C3. Was the facility reimbursed for this inpatient stay on a fee-for-service basis or 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 where reimbursement is not tied to specific visits.]*

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

C4. From what sources has the facility received payment for this stay and how much was paid by each source?

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

[INTERVIEWER: IF RESPONSE IS THE PATIENT PAYS A MONTHLY PREMIUM, GO BACK TO C3 AND CHANGE CODE TO 2 (CAPITATED BASIS).]

C5. IF NOT VOLUNTEERED, ASK: And what was the total? [IF NOT AVAILABLE, COMPUTE.]

**FULL ESTABLISHED CHARGE OR CHARGE EQUIVALENT:**

\$ \_\_\_\_\_

**IF HS EVENT:**

EMERGENCY ROOM CHARGE INCLUDED..... 1  
EMERGENCY ROOM CHARGE NOT INCLUDED OR NOT APPLICABLE..... 2

**IF IC EVENT:**

ANCILLARY CHARGES INCLUDED..... 1  
ANCILLARY CHARGES NOT INCLUDED OR NOT APPLICABLE..... 2

FEE-FOR-SERVICE BASIS ..... 1  
CAPITATED BASIS..... 2 (C7a)

- 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):  
\_\_\_\_\_ \$ \_\_\_\_\_

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

**BOX 5**  
**DO TOTAL PAYMENTS EQUAL**  
**TOTAL CHARGES?**  
YES .....1 (A11)  
NO .....2 (C6)

C6. It appears that the total payments were (less than/more than) the total charges. What is the reason for that 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 A11

**CAPITATED BASIS**

		<u>YES</u>	<u>NO</u>
C7a. What kind of insurance plan covered the patient for (this visit/these visits)? 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
	f. Worker's Comp; or.....	1	2
	g. Something else? (SPECIFY: ).....	1	2
C7b. Was there a co-payment for (this visit/these visits)?	YES.....	1	
	NO.....	2 (C7e)	
C7c. How much was the co-payment?	\$.....		
C7d. Who paid the co-payment?		<u>YES</u>	<u>NO</u>
	a. PATIENT OR PATIENT'S FAMILY....	1	2
[IF NAME OF INSURER OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance?]	b. MEDICARE .....	1	2
	c. MEDICAID.....	1	2
	d. PRIVATE INSURANCE .....	1	2
	e. OTHER (SPECIFY: ).....	1	2
C7e. Do your records show any other payments for (this visit/these visits)?	YES.....	1	
	NO.....	2 (A11)	
C7f. 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: ).....	\$.....	

A11. ARE THERE ANY ADDITIONAL EVENTS FOR THIS PATIENT TO BE ACCOUNTED FOR? YES..... 1 (GO TO PATIENT ACCOUNTS SECTION (A5a) OF NEXT EVENT FORM.)

NO..... 2 (GO TO NEXT PATIENT. IF NO MORE PATIENTS, THANK RESPONDENT AND END.)