Form Approved
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MEDICAL EXPENDITURE PANEL SURVEY

MEDICAL PROVIDER COMPONENT

MEDICAL EVENT FORM

FOR

INSTITUTIONAL PROVIDERS
(NON-HOSPITAL FACILITIES)

FOR

REFERENCE YEAR 2010

VERSION 1.0

Revision History

Version	Author/Title	Date	Comments
1.0	Multiple RTI and SSS authors	04/01/10	Changes from final 2009 version made via track changes

INSTITUTIONAL EVENT FORM

1. VERIFY ALL PATIENT(S)

First, I'd like to review the patient(s) in our study who reported receiving care from your practice or facility during 2010. I'm going to read their names to you, and for each one please confirm whether the patient received health care services from you during the calendar year 2010.

For each of the patient(s) you confirm as receiving care during the calendar year 2010, I'll need to ask about services you provided and charges for those services. I will ask about each confirmed patient individually.

READ EACH PATIENT NAME FROM THE LIST. IF THE PERSON ON THE PHONE SAYS "NO", ASK: Did the patient receive services in some year other than 2010, or do you have no records at all?

FOR EACH LISTED PATIENT, CHOOSE A RESPONSE FROM THE DROP-DOWN LIST IN THE PATIENT CONFIRMATION COLUMN BELOW.

ONCE YOU CONFIRM A PATIENT FOR 2010, CLICK ON THE NAME OF THAT PATIENT AND COMPLETE THE EVENT FORM(S) FOR THAT PATIENT.

2. PATIENT DISAVOWAL

Finally, I need to review with you the patient(s) in the list who you indicated did not receive care during the calendar year 2010.

3. CLOSE OUT THE CALL

Thank you for your time.

Do you have any (more) medical events for (PATIENT NAME) for 2010?

SECTION 1 – OMB

DCS: READ THIS ALOUD ONLY IF REQUESTED BY RESPONDENT.

PRESS NEXT TO CONTINUE IN THIS EVENT FORM

PRESS BREAKOFF TO DISCONTINUE

(Public reporting burden for this collection of information is estimated to average 5 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, 540 Gaither Road, Room # 5036, Rockville, MD 20850.) OMB No. 0935-0118; Exp. Date 1/31/2013

SECTION 2 – MEDICAL RECORDS – EVENT DATE

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

	MEDICAL RECORDS
QA1. What were the admit and discharge dates of the (first/next) stay?	MO DAY YR ADMIT: _____/_____/_____ DISCHARGE: _____/_____/_____ IF NOT YET DISCHARGED ENTER DATE AS 99/99/9999

If neither EVNTBEGY and EVNTENDY are 2010, send user to Not2010. Otherwise go to A3.

DK/REF/RETRIEVABLE: go to A2.

SECTION 2 – INVALID EVENT DATE

Not2010

YOU ENTERED DATES FOR A SINGLE STAY THAT INCLUDED ALL OF 2010.

IF THIS WAS AN ERROR PRESS "PREVIOUS" TO CORRECT YOUR DATE ENTRIES.

IF THIS IS CORRECT PRESS "NEXT."

SECTION 3 – MEDICAL RECORDS – DIAGNOSES

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

QA3. I need the diagnoses for this stay. I would prefer the ICD-9 codes or DSM-IV codes, if they are available.

IF CODES ARE NOT USED, RECORD DESCRIPTIONS.

[SYSTEM WILL ALLOW FOR A MAXIMUM OF 5 ICD-9 CODES TO BE COLLECTED]

DK/REF/RETRIEVABLE – CONTINUE TO 4a

CODE	DESCRIPTION
_____	_____
_____	_____
_____	_____
_____	_____

CLICK HERE IF THIS IS AN ICD-10 CODE

SECTION 4 – MEDICAL RECORDS – SBD

[PAGE 3 – MEDICAL RECORDS - SBD (1 of 1)]

QA4. 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.

SEPARATELY BILLING DOCTORS FOR THIS EVENT……..1

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

DOES NOT HAVE THIS INFORMATION……3

If ANYSBDS = 2 or 3, continue to A4c.

IF A3=YES, ASK EF1

DK/REF/RETREIVABLE – CONTINUE TO A3

EF1 What is the name of the doctor providing services for this event, whose charges might not be included in the hospital bill?

Prefix
First
Middle
Last
Group Name

EF3 What is this doctor's specialty?

Specialty: _____
If other, please specify:_____

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

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?

Active Physician/Providing Direct Care 1
Referring Physician 2
Copied Physician 3
Follow-up Physician 4
Department Head 5
Primary Care Physician 6
Some Other Physician 7
None of the above 8
DON'T KNOW 9

If other, please describe: _____

EF6 ENTER ANY COMMENTS ABOUT THIS SBD, INCLUDING ADDITIONAL SERVICES TO THE ONE SELECTED IN EF2

Q4a. Do you have any medical events for [PATIENT] in 2010??

YES, ALL STAYS COVERED ..... 1 (GO TO Q4b)
NO, NEED TO COVER ADDITIONAL STAYS..... 2 (GO TO Q1-NEXT EVENT FORM)

Q4b. IF ALL STAYS ARE RECORDED FOR THIS PATIENT, REVIEW NUMBER OF STAYS REPORTED BY HOUSEHOLD.

RECONCILIATION SCREEN
NO DIFFERENCE OR FACILITY REPORTED MORE STAYS THAN HOUSEHOLD..... 1 (GO TO ENDING FOR MEDICAL RECORDS)

FACILITY RECORDED FEWER STAYS..... 2

[DCS ONLY] PROBE: (PATIENT NAME) reported (NUMBER) stays at (FACILITY) during 2010, but I have only recorded (NUMBER) stays. Do you have any information in your records that would explain this discrepancy?

DON'T KNOW……1
UNACCESSIBLE ARCHIVED RECORDS….2
ACCESSIBLE ARCHIVED RECORDS…….. 3 COLLECT CONTACT INFORMATION FOR PERSON WITH RECORDS
OTHER (SPECIFY):……4

_____
_____

Q4a
PRESS "BREAKOFF" TO CLOSE THIS MEDICAL RECORDS SECTION. CMS WILL ASK WHETHER YOUR MEDICAL RECORDS RESPONDENT HAS ADDITIONAL EVENTS FOR THIS PATIENT.

PRESS "NEXT" WHEN YOU ARE READY TO BEGIN PATIENT ACCOUNTS SECTION.

PA_Intro

I have information from Medical Records that (PATIENT NAME) received health care services between [DATE] and [DATE].

NOTE: IF THE ONLY EVENT KNOWN BY PATIENT ACCOUNTS IS WITHIN A DAY OR TWO OF WHAT WAS REPORTED BY MEDICAL RECORDS, ANSWER YES BELOW.

YES, RECORDS FOUND FOR THIS EVENT.	= 1
NO, RECORDS NOT FOUND FOR THIS EVENT.	= 2
NO, OTHER RECORDS PROBLEM	= 3

SECTION 7 – PATIENT ACCOUNTS – REIMBURSEMENT TYPE

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

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 where reimbursement is not tied to specific visits.

IF IN DOUBT, CODE FEE-FOR-SERVICE.

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

IF FEEORCAP=1 GO TO Q6.

IF FEEORCAP=2 GO TO Q21a

DK/REF/RETRIEVABLE – CONTINUE TO Q6

SECTION 8 – PATIENT ACCOUNTS – SERVICES/CHARGES

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

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 2010)?

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:

$_____ . _____ (GO TO Q7)

If UNESTCHRG=1 go to Q7.

If UNESTCHRG=2 go to Q10.

If UNESTCHRG=3 go to Q6a.

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

1 YES, DID PROVIDE TOTAL CHARGE
2 NO, CANNOT PROVIDE TOTAL CHARGE
3 NO, THERE WAS NO CHARGE

Q6a. 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.

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.

SELECT ALL THAT APPLY

[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

RECORD PAYMENTS FROM ALL APPLICABLE PAYERS

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?) _____	$_____.____
TOTAL PAYMENTS	**$_____.__**

Q8. I show the total payment as [SYSTEM WILL COMPUTE AND DISPLAY TOTAL]. Is that correct?
IF NO, CORRECT ENTRIES ABOVE AS NEEDED.

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…….. …….. 3 (GO TO Q9)

IF, AFTER VERIFICATION, PAYMENTS DO NOT EQUAL CHARGE COMPLETE Q9 AND GO TO Q14

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/RETRIEVABLE, GO TO Q14

SECTION 10 – PATIENT ACCOUNTS – VERIFICATION OF PAYMENT

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

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 (GO TO Q14)

NO……..……2 (GO BACK TO Q7)

DK/REF/RETRIEVABLE – CODE AS 2 (NO) FIRST TIME THROUGH (GOES BACK TO Q7), IF NOTHING CHANGES AND END UP BACK AT Q8a, GO TO Q14.

SECTION 11 – PAYMENTS LESS THAN CHARGES

[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
b. You are expecting additional payment YES=1 NO=2
c. This was charity care or sliding scale YES=1 NO=
d. This was bad debt YES=1 NO=2

If DISADJ=1 then show Q9_adjustments.

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 both Q9_adjustments and Q9_additional.

If both SLIDSCA2=1 and BADDEB2=1 with no other selection, show neither Q9_adjustments or Q9_additional.

If BOTH SLIDSCA2=1 OR BADDEB2=1 WITH NO OTHER SELECTION, SHOW NEITHER Q9_adjustments OR Q9_additional.

SECTION 12 – PATIENT ACCOUNTS – DIFFERENCE BETWEEN PAYMENT AND CHARGES

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

Q9_adjustments. It appears that the total payments were (less than/more than) the total charge. What is the reason for this difference? Please include all adjustment activity that has taken place between (ADMIT DATE) and now for this stay.

RECORD YES FOR ALL REASONS MENTIONED.

	YES	NO
Q9_adjustments		
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; or	1	2
h. Something else?……..	1	2
(IF SOMETHING ELSE: What was that?)		

_____

Q9_additional

Are you expecting additional payment from

i. Patient or Patient's Family;	1	2
j. Medicare;	1	2
k. Medicaid;	1	2
l. Private Insurance;	1	2
m. VA/Champva;	1	2
n. Tricare;	1	2
o. Worker's Comp; or	1	2
p. Something else? …….	1	2
(IF SOMETHING ELSE: What was that?)		

_____

Q9_Exceeded *(Note: this is displayed only if all responses to PLC1 are "No.")*
Do the charges exceed payments because of

q. Charity care or sliding scale;	1	2
r. Bad debt;	1	2

Q9_Overpayment:

s. Medicare adjustment;	1	2
t. Medicaid adjustment;	1	2
u. Private insurance adjustment; or	1	2
v. Something else? …….	1	2
(IF SOMETHING ELSE: What was that?)		

_____

(GO TO Q14)

SECTION 13 – PATIENT ACCOUNTS – RATES/CHARGES

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

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

$_____ . _____ (GO TO Q11)

RATE PROVIDED……1

RATE CHANGED DURING STAY 2
NO CHARGE 3

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

If Q10=1 go to Q11.

If Q10=2 code DAILYRT as 991 and go to Q12.

If Q10=3 code DAILYRT as 992 and go to Q10a.

Q10a. 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)

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 2010.

_____ # DAYS

DAYS PROVIDED.....1

DAYS NOT REPORTED **2**

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

SECTION 14 – PATIENT ACCOUNTS – SOURCES OF PAYMENT 2

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

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.

SELECT ALL THAT APPLY

[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

RECORD PAYMENTS FROM ALL APPLICABLE PAYERS

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?) _____	$_____.____

Q11b. I show the total payment as [SYSTEM WILL COMPUTE AND DISPLAY TOTAL]. Is that correct? IF NO, CORRECT ENTRIES ABOVE AS NEEDED.

TOTAL PAYMENTS **$_____.__**

If Q11b=1 go to Q14.
If Q11b=2 go to Q11a.

Q11a -
DK/REF/RETRIEVABLE – CONTINUE TO Q11b
Q11b -
DK/REF/RETRIEVABLE – CONTINUE TO Q14

SECTION 15 – PATIENT ACCOUNTS – BILLING PERIOD INFORMATION WITH PAYMENTS

[PATIENT ACCOUNTS – BILLING PERIOD INFORMATION]

Q12. (Perhaps it would be easier if you gave me the information billing period by billing period.)

BILLING PERIOD #1

<table>
<tr><td colspan="2">Q12. What was the billing period start date?

BILLING START DATE: _____/_____/_____
MO DY YR

Q12a. What was your billing end date?

BILLING END DATE: _____/_____/_____
MO DY YR

DAYS IN BILLING PERIOD: _____</td><td>Q12-1. Thanks. That means there were [FILL] number of days in your billing period. Between [DATE] and [DATE] how many days was the patient charged for room and board and basic care?

_____
BILLED DAYS</td><td colspan="2">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?</td></tr>
<tr><td>Q12-2. Between (BP DATES), what was the private pay rate for room, board and basic care (PATIENT) received? If the rate changed, please give me the initial rate.

$_____.____</td><td>Q 12-3. How many days was that rate applied during this billing period?

_____
DAYS
(GO TO Q12-6)</td><td></td><td></td><td>Q 12-Intro. I see that the rate of (BASEPAYRATE#) 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.</td></tr>
<tr><td>Q 12-2A.
Between (BP DATES), what other private pay rate applied to the basic care that (PATIENT) received?

$_____.____</td><td>Q 12-3A. On what date did this rate of (OTHBASERATE#) begin?

____/____/____
MO DY YR</td><td>Q 12-4A. During this billing period, how many days was that rate applied?

DAYS: _____</td><td>Q 12-5A. Why did the rate change? CODE ONLY ONE.

LEVEL OF CARE ... 1
PATIENT DISCHARGED:
TO HOSPITAL 2
TO COMMUNITY . 3
TO OTHER FACILITY 4
RATE INCREASE .. 5
ROOM CHANGE.... 6
OTHER, SPECIFY . 7
_____</td><td></td></tr>
<tr><td colspan="5">Q 12-7 Is (RATE IN 12-2a) the private pay rate that applied at the end of the billing period?

YES 1
NO 2
If Q12-7=1 (YES) skip to 12-9 on BILLING PERIOD INFORMATION (7 of 7).
IF Q12-7=2 (NO) CONTINUE TO Q12-8 AND RECORD RATE AT END OF BILLING PERIOD.</td></tr>
<tr><td colspan="5">Q 12-8. What was the private pay rate that applied at the end of the billing period?
$_____.____</td></tr>
</table>

SECTION 16 – PATIENT ACCOUNTS – SOURCES OF PAYMENT 3

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

Q 13. 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.

SELECT ALL THAT APPLY

[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

RECORD PAYMENTS FROM ALL APPLICABLE PAYERS.

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?) _____	$_____.____
TOTAL PAYMENTS	$_____.____

Q 13a. I show the total payment for this billing period as [SYSTEM WILL COMPUTE AND DISPLAY TOTAL]. Is that correct?
IF NO, CORRECT ENTRIES ABOVE AS NEEDED.

Q12-9 Anymore billing periods?

SECTION 17 – PATIENT ACCOUNTS – ANCILLARY CHARGES

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

Q14. 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

If Q14=1 go to Q15. If Q14=2 go to Q22.

SECTION 18 – PATIENT ACCOUNTS – TOTAL ANCILLARY CHARGES

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

Q 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.

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).

TOTAL CHARGES: $_____.___ (GO TO Q16)

YES, PROVIDED ……1

CAN'T SEPARATE HEALTH AND NON-HEALTH ANCILLARY CHARGES……2

CAN'T GIVE TOTAL HEALTH-RELATED ANCILLARY CHARGES……3

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

SECTION 19 – PATIENT ACCOUNTS – SOURCES OF PAYMENT 4

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

Q 16. 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.

SELECT ALL THAT APPLY

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

.RECORD PAYMENTS FROM ALL APPLICABLE PAYERS.

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?)
_____ $_____.____

Q 17. I show the total payment as [SYSTEM WILL COMPUTE AND DISPLAY TOTAL]. Is that correct? IF NO, CORRECT ENTRIES ABOVE AS NEEDED.

TOTAL PAYMENTS **$**_____.__

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

BOX 2

DO TOTAL PAYMENTS EQUAL TOTAL CHARGES?

YES, AND ALL PAID BY PATIENT OR PATIENT'S FAMILY…… 1 (GO TO Q22)

YES, OTHER PAYERS…… 2 (GO TO Q17a)

NO…….. …… 3 (GO TO Q18)

IF, AFTER VERIFICATION, PAYMENTS DO NOT EQUAL CHARGES COMPLETE Q18 AND GO TO Q22

SECTION 20 – PATIENT ACCOUNTS – VERIFICATION OF PAYMENT 2

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

Q 17a. 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?

YES, FINAL PAYMENTS RECORDED IN Q16 AND Q17……..1 (GO TO Q22)

NO……..……2 (GO BACK TO Q16)

DK/REF/RETRIEVABLE – CODE AS 2 (NO) FIRST TIME THROUGH (GOES BACK TO Q16), IF NOTHING CHANGES AND END UP BACK AT Q17a, GO TO Q22.

SECTION 21 – PAYMENTS LESS THAN CHARGES

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
b. You are expecting additional payment YES=1 NO=2
c. This was charity care or sliding scale YES=1 NO=2
d. This was bad debt YES=1 NO=2

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

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

Q18_adjustments. It appears that the total payments were (less than/more than) the total charge. What is the reason for this difference? Please include all adjustment activity that has taken place between (ADMIT DATE) and now for this stay.

RECORD YES FOR ALL REASONS MENTIONED.

Q18_adjustments

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; or	1	2
h.	Something else?……..	1	2

(IF SOMETHING ELSE: What was that?)

_____

Q18_additional

i.	Patient or Patient's Family;	1	2
j.	Medicare;	1	2
k.	Medicaid;.....	1	2
l.	Private Insurance;	1	2
m.	VA/Champva;.....	1	2
n.	Tricare;.....	1	2
o.	Worker's Comp; or	1	2
p.	Something else? ……	1	2

(IF SOMETHING ELSE: What was that?)

_____

Q18_Exceeded *(Note: this is displayed only if all responses to PLC1 are "No.")*
Do the charges exceed payments because of

q.	Charity care or sliding scale;.....	1	2
r.	Bad debt;.....	1	2

Q18_Overpayment:

s.	Medicare adjustment;.....	1	2
t.	Medicaid adjustment;	1	2
u.	Private insurance adjustment; or	1	2
v.	Something else? ……	1	2

(IF SOMETHING ELSE: What was that?)

(GO TO Q22)

SECTION 23 – PATIENT ACCOUNTS – BILLING PERIOD INFORMATION 2

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

Q 19. Perhaps it would be easier if you gave me the information about **ancillary charges** 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) (GO TO Q19c) or ____/____/___ (START DATE)	_____ (MONTH) (GO TO Q19c) or ____/____/___ (START DATE)	_____ (MONTH) (GO TO Q19c) or ____/____/___ (START DATE)	_____ (MONTH) (GO TO Q19c) or ____/____/___ (START DATE)	_____ (MONTH) (GO TO Q19c) or ____/____/___ (START DATE)	_____ (MONTH) (GO TO Q19c) or ____/____/___ (START DATE)
b. And what was the end date?	____/____/___ (END DATE)	____/____/___ (END DATE)	____/____/___ (END DATE)	____/____/___ (END DATE)	____/____/___ (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)	(GO TO NEXT BP)	(GO TO NEXT BP)	(GO TO NEXT BP)	(GO TO NEXT BP)	

SECTION 24 – PATIENT ACCOUNTS – SOURCES OF PAYMENT 5

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

Q 20. 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. 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? IIF YES: GO BACK TO C3 AND CODE AS CAPITATED BASIS. RECORD PAYMENTS FROM ALL APPLICABLE PAYERS.						
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?) _____	$_____.____	$_____.____	$_____.____	$_____.____	$_____.____	$_____.___
	(GO TO NEXT BP)	(GO TO NEXT BP)	(GO TO NEXT BP)	(GO TO NEXT BP)	(GO TO NEXT BP)	(GO TO Q22)

Q 20a. [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?
IF NO, CORRECT ENTRIES ABOVE AS NEEDED.
Q20a=NO RETURN USER TO Q20, ELSE CONTINUE.

SECTION 25 – PATIENT ACCOUNTS – CAPITATED BASIS

CAPITATED BASIS

Q 21a. 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?

	YES	NO
a. Medicare;	1	2
b. Medicaid;	1	2
c. Private Insurance;	1	2
d. VA/Champva;	1	2
e. Tricare;	1	2
f. Worker's Comp; or	1	2
g. Something else? (IF SOMETHING ELSE: What was that?) _____	1	2

Q 21b. What was the monthly payment from that plan?

$_____.__

Q21c. Was there a co-payment for any part of this stay?

YES 1
NO 2

Q21c - [IF ANYCOPAY=2 GO TO Q21g]

Q21a - DK/REF/RETRIEVABLE – CONTINUE TO Q21b

Q21b - DK/REF/RETRIEVABLE – CONTINUE TO Q21c

Q21c - DK/REF/RETRIEVABLE – GO TO Q21g

Q21d. How much was the co-payment?
[DCS ONLY] PROBE TO DETERMINE IF FOR DAY, WEEK, ETC.

$_____.__

per
DAY 1
WEEK 2
MONTH 3
OTHER 4
SPECIFY: _____
DON'T KNOW 8

Q21e. For how many (days/weeks/months/other) was the co-payment paid?

_____#

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.

	YES	NO
a. Patient or Patient's Family;	1	2
b. Medicare;	1	2
c. Medicaid;	1	2
d. Private Insurance; or	1	2
e. Something else? (IF SOMETHING ELSE: What was that?) _____	1	2

Q21d - DK/REF/RETRIEVABLE – CONTINUE TO Q21e

Q21e - DK/REF/RETRIEVABLE – CONTINUE TO Q21f

Q21f - DK/REF/RETRIEVABLE – GO TO Q21g

Q21g. Do your records show any other payments for this stay?

YES 1
NO ..... 2 (

If Q21g=1 go to Q21h else go to Q22.

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 FOR 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.

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?) _____	$_____.____