MEDICAL EXPENDITURE PANEL SURVEY MEDICAL PROVIDER COMPONENT

EVENT FORM

FOR HOSPITAL PROVIDERS

FOR

REFERENCE YEAR 2020

OMB STATEMENT

DCS: READ THIS ALOUD ONLY IF REQUESTED BY RESPONDENT

OMB Statement:

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

PRESS 1 TO CONTINUE

SECTION 1 – MEDICAL RECORDS – LOCATION OF SERVICES

A1. The (first/next) time (PATIENT NAME) received services during calendar year 2020, were the services received:

CODE ONLY ONE

As an Inpatient = 1
In a Hospital Outpatient Department = 2 In a Hospital Emergency Room = 3
In a Long Term Care unit such as skilled nursing facility =5 Somewhere else = 4

(IF SOMEWHERE ELSE: Where was that?)

6. **Ambulance**
9. **Hospital Free Standing Clinic/ Hospital Satellite Clinic**
5. **Independent Facility**

15. Independent Pathology Clinic. Laboratory, Clinical Lab
14. Independent Radiology Clinic, Imaging CTR, X-Ray
13. Observation, Ambulatory Surgery Center
2. SurgiCenter
16. Telehealth
17. Drive-through
91. Other

IF SOMEWHERE ELSE: Specify other location [FREE TEXT BOX OF 30 CHARACTERS]

[IF A1=1 or 5 GO TO A2a,
IF A1 =2 or 3 or 4 GO TO A2c]

SECTION 2 – MEDICAL RECORDS – EVENT DATE – INPATIENT/LTC (ADMIT/DISCHARGE DATES)

A2a. What were the admit and discharge dates of the inpatient stay?

REFERENCE PERIOD – CALENDAR YEAR 2020

ADMIT:

Month:_____
Day: _____
Year: _____

DISCHARGE:

Month:_____
Day: _____
Year: _____

IF A2a = NOT YET DISCHARGED, CODE DISCHARGE AS 99/99/9999

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

YES = 1
NO = 2

IF A2b = 2 go to A3,

SECTION 3 – MEDICAL RECORDS – EVENT DATE – OUTPATIENT/ER/OTHER (VISIT DATE)

A2c. What was the date of this visit?

REFERENCE PERIOD – CALENDAR YEAR 2020

Month:_____
Day: _____
Year: _____

DK/REF – CONTINUE TO A3

SECTION 4 – MEDICAL RECORDS – SBD

A3. I need to record the name and specialty of each physician who provided services during the (TYPE OF EVENT) (DATE(S)) and whose charges might not be included in the hospital bill. We want to include such doctors as surgeons, attending physicians, radiologists, anesthesiologists, pathologists, and consulting specialists, but not residents, interns, or other doctors-in-training whose charges are included in the hospital bill.

THERE MAY BE MORE THAN ONE TYPE OF EACH DOCTOR, SO PROBE FOR MULTIPLE SURGEONS, RADIOLOGISTS, ANESTHESIOLOGISTS, AND OTHER SEPARATELY BILLING MEDICAL PROFESSIONALS.

IF RESPONDENT IS NOT SURE WHETHER A PARTICULAR DOCTOR 'S CHARGES ARE INCLUDED IN THE HOSPITAL BILL, ANSWER YES HERE.

IF THIS IS A VA PROVIDER, DO NOT COLLECT THE SBD AND ALERT YOUR SUPERVISOR. THE VA FLAG WILL NEED TO BE SET.

YES, SEPARATELY BILLING DOCTORS FOR THIS EVENT = 1
NO SEPARATELY BILLING DOCTORS FOR THIS EVENT = 2

IF A3 ANYSBDS=NO, DK/REF – SKIP TO A4a
IF A3 ANYSBDS=YES, ASK SBD_SOURCE

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.

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

[IF A3=NO, DK/REF – SKIP TO A4a IF A3=YES,
ASK SBD_SOURCE]

SECTION 5 – MEDICAL RECORDS – 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.

Group Name: _____
Prefix: _____
First Name: _____
Middle Name: _____
Last Name: _____
National Provider ID: _____

EF3. What is this physician '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?

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

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 DESCRIBE)
Please describe the other role.

EF6. ENTER ANY COMMENTS ABOUT THIS SBD INCLUDING ADDITIONAL SERVICE(S) TO THE ONE PREVIOUSLY SELECTED [FILL SPECIALTY].

SECTION 6 – MEDICAL RECORDS – DIAGNOSES

A4a. I need the diagnoses for (this stay/this visit). I would prefer the ICD-10 codes, or the DSM-5 codes, if they are available.

IF CODES ARE NOT USED, RECORD DESCRIPTIONS. RECORD UP TO FIVE ICD-10 CODES OR DESCRIPTIONS.

ICD 10 CODE:_____DESCRIPTION:_____

A4a. DESCRIPTION

I need the diagnoses for this (stay/visit).

ENTER DESCRIPTION

DK/REF – CONTINUE TO A5a

SBD REAL-TIME PROMPTING

SBDPR1: A diagnosis that you mentioned often involves a (FILL SPECIALTY). We did not record such persons in the earlier questions about separately billing doctors. Did you not mention them for this patient event because they were residents or interns?

IF SPECIALTY RECORDED IN COMMENTS, ANSWER "NO" HERE.

YES=1
NO=2

If SBDPR1=YES, SKIP TO A5a
If SBDPR1=NO, ASK SBDPR2

SBDPR2: Do your records indicate that a (FILL SPECIALTY) was associated with this patient event?

IF SPECIALTY RECORDED IN COMMENTS, ANSWER "NO" HERE.

YES=1
NO=2

If SBDPR2=YES, SYSTEM SKIP FOCUS BACK TO A3
If SBDPR2=NO, GO TO SBDPR3

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

IF SPECIALTY RECORDED IN COMMENTS, NOTE THAT HERE.

SECTION 9 – PATIENT ACCOUNTS – GLOBAL FEE

A5a. Was the visit on that date covered by a global fee, that is, was it included in a charge that covered services received on other dates as well?

EXPLAIN IF NECESSARY: An example would be a patient who received a series of treatments, such as chemotherapy, that was covered by a single charge.

YES = 1, (GO TO A5b)
NO = 2 (GO TO A6a)
DK/REF (GO TO A6a)

A5b. Did the global fee for this date cover any services received while the patient was an inpatient?

YES = 1, (GO TO A5c)
NO = 2 (GO TO A5d)
DK/REF (GO TO A5d)

A5c. What was the admit date of that stay?

ADMIT:

What was the discharge date of that stay?

DISCHARGE:

REFERENCE PERIOD – CALENDAR YEAR 2019

NOT YET DISCHARGED = 1, CODE DISCHARGE AS 99/99/9999

DK/REF – CONTINUE TO A5d

A5c1. Were there any other dates on which services were covered by this global fee?

YES = 1
NO = 2

A5d. What were the other dates on which services covered by this global fee were provided? Please include dates before or after 2019 if they were included in the global fee.

Did (PATIENT NAME) receive services on this date in an:

Outpatient Department YES=1, NO=2
Emergency Room YES=1, NO=2
Somewhere else YES=1, NO=2

Specify the other location where services were received.

A5e. Do you expect (PATIENT NAME) will receive any future services that will be covered by this same global fee?

YES = 1
NO = 2

A5f. [ABS ONLY] You've described different dates of service covered by a global fee. Do you know if there were additional doctors providing services whose charges weren't included in the hospital bill?

YES = 1
NO = 2

A5c1 – "NO" GO TO A5e DK/REF NOT ALLOWED

A5d - [SYSTEM WILL SET UP AS A LOOP, SO NO LIMIT ON NUMBER OF DATES REQUIRED]

A5d - DK/REF – CONTINUE TO A5e

A5e - DK/REF – IF MODE=ABS THEN CONTINUE TO A5f. IF MODE=DCS GO TO C2a.

A5f –This question should only appear when mode=abs. [IF A5f = 1, GO TO A3. IF A5f = 2, DK/RF GO TO A6A]

SECTION 10 - PATIENT ACCOUNTS – SERVICES/CHARGES – OUTPATIENT/ER/OTHER

SERVICES/CHARGES

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, DESCRIBE SERVICES AND PROCEDURES PROVIDED. ENTER UP TO 8 CHARACTERS.

IF CODE BEGINS WITH W, X, Y OR Z, ENTER A DESCRIPTION INSTEAD.

CPT-4 CODE:_____DESCRIPTION:____
CPT-4 CODE:_____DESCRIPTION:____

CPT-4 CODE:_____DESCRIPTION:____
CPT-4 CODE:_____DESCRIPTION:____

[If A6a is DK/REF/ – CONTINUE TO A6b.]

A6b. What was the full established charge for this service, before any adjustments or discounts?

NOTE: WE NEVER ENTER $0 FOR A CHARGE

IF SPECIFIC CHARGE WAS APPLIED TO ANOTHER SERVICE, ENTER -4 IF CHARGES ARE APPLIED TO ANOTHER LINKED EVENT, ENTER -5

> **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 service?

SUM OF KNOWN CHARGES = [FILL TOTAL OF ENTERED CHARGES]

$_____.____

$_____.____

$_____.____

$_____.____

$_____.____

$_____.____

$_____.____

[If A6b is DK/REF/ – CONTINUE TO C2.]

C2. I show the total charges as [SYSTEM WILL COMPUTE AND DISPLAY TOTAL] / I show the charge as undetermined. / I show the charge as [SYSTEM WILL COMPUTE AND DISPLAY TOTAL], although one or more charges are missing. Is that correct?

IF INCORRECT, CORRECT ENTRIES SHOWN ABOVE AS NEEDED

CHARGES
Service Charge: CPT4 CODE:
Charges
Charge=$____._____
Total Amount $_____._____

YES = 1 (IF A6b=-5, GO TO LC2; OTHERWISE, GO TO C3.]
NO = 2 (GO BACK TO A6b)

LC2. You reported just now that the charges are linked to another event. What was the date of that other event where the charges appear?

Month: _____

Day: _____

Year: _____

LC3. And what kind of event was that, was it...

Inpatient = 1
Hospital Outpatient Department = 2
Hospital Emergency Room = 3
Long term care unit such as skilled nursing facility = 4
Somewhere else? = 5

SECTION 11 – PATIENT ACCOUNTS – SERVICES/CHARGES – INPATIENT/LTC

A8. According to Medical Records, (PATIENT NAME) was (in long term care / an inpatient) during the period from [ADMIT DATE] to [DISCHARGE DATE]. What was the DRG for this stay?

DRG IS A CODE USED TO CLASSIFY INPATIENT STAYS AND IT IS USUALLY ONE TO THREE DIGITS LONG.

DRG: _____
DRG NOT RECORDED = 1

IF NO DRG, ENTER F6 (DON'T KNOW).

[If A8 is answered, GO TO C2a. If NODRG (A8=1) GO TO A9. DK/REF – CONTINUE TO A9.]

A9. Did the patient have any surgical procedures during this stay?

YES = 1
NO = 2

[If A9 = 2 GO TO C2a. If A9 is DK/REF/ – GO TO C2a]

A10a. What surgical procedures were performed during this stay? Please give me the procedure codes, that is the CPT-4 codes, if they are available.

IF CPT-4 CODES ARE NOT USED, DESCRIBE SERVICES AND PROCEDURES PROVIDED. ENTER UP TO 8 CHARACTERS.

IF CODE BEGINS WITH W, X, Y OR Z, ENTER A DESCRIPTION INSTEAD.

IT IS ACCEPTABLE TO ENTER ICD10 CODES FOR THIS QUESTION IF A PROCEDURE CODE OR DESCRIPTION IS NOT AVAILABLE.

CODE: _____ DESCRIPTION: _____

CODE: _____ DESCRIPTION: _____

CODE: _____ DESCRIPTION: _____

CODE: _____ DESCRIPTION: _____

C2a. What was the **full established charge** for this (long term care / inpatient) stay, before any adjustments or discounts?

Please do not include any emergency room charges.

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?

IF POSSIBLE, RECORD ONLY INPATIENT CHARGE HERE. IF YOU CANNOT SEPARATE THE INPATIENT CHARGE FROM THE EMERGENCY ROOM, YOU MAY REPORT THE COMBINED TOTAL.

NOTE: WE NEVER ENTER $0 FOR A CHARGE

FULL ESTABLISHED CHARGE OR CHARGE EQUIVALENT:

$_____.____

C2b. [IF ADMITTED FROM ER, ASK FOLLOWING QUESTION] Were the emergency room charges included with the full established charge?

YES = 1
NO = 2

C2c. [IF LONG TERM CARE, ASK FOLLOWING QUESTION] Were the ancillary charges included with the full established charge?

YES = 1
NO = 2

SECTION 12 – PATIENT ACCOUNTS – REIMBURSEMENT TYPE

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

EXPLAIN IF NECESSARY:

Fee-for-service means that the practice 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, this is also called Per Member Per Month.

IF IN DOUBT, CODE FEE-FOR-SERVICE

FEE-FOR-SERVICE BASIS = 1
CAPITATED BASIS = 2 (go to C7a)

SECTION 13 – PATIENT ACCOUNTS – SOURCES OF PAYMENT

C4. From which of the following sources has the facility received payment for (this visit/these visits/this stay) and how much was paid by each source? Please include all payments that have taken place between (DATE) and now for (this visit/these visits).

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 C3 AND CODE AS CAPITATED BASIS.

a. Patient or Patient's Family; ..... $ ..... . ____
b. Medicare; ..... $ ..... . ____
c. Medicaid; ..... $ ..... . ____
d. Private Insurance; ..... $ ..... . ____
e. VA/Champva ..... $ ..... . ____
f. Tricare ..... $ ..... . ____
g. Worker 's Comp; ..... $ ..... . ____
h. Something else ..... $ ..... . ____

(IF SOMETHING ELSE: What was that?___)

C5. [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?

/ [THE TOTAL PAYMENT IS TOTPAYM . IS THAT CORRECT?

TOTAL PAYMENTS $
YES = 1
NO = 2

IF NO, CORRECT ENTRIES ABOVE AS NEEDED.

SECTION 14 – PATIENT ACCOUNTS – VERIFICATION OF PAYMENT

C5a: I recorded that the payment(s) you received equal the charge(s). I would like to make sure that I have this recorded correctly. I recorded that the total payment is [SYSTEM WILL DISPLAY TOTAL PAYMENT FROM C5]. Does this total payment include any other amounts such as adjustments or discounts, or is this the final payment?

IF NECESSARY, READ BACK AMOUNT(S) RECORDED IN C4.

YES, FINAL PAYMENTS RECORDED IN C4 AND C5 =1
NO =2

IF NO, GO BACK AND CORRECT ENTRIES AS NEEDED.

SECTION 15 – PAYMENTS LESS THAN CHARGES *(new section, UNDERPAYMENT)*

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

IF THE ONLY PAYMENT FOR THIS EVENT WAS A LUMP SUM, ANSWER "NO" TO ALL OPTIONS.

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
e. Person is an eligible veteran YES=1 NO=2

SECTION 16 – PATIENT ACCOUNTS – DIFFERENCE BETWEEN PAYMENTS ANDCHARGES

C6_additional
Are you expecting additional payment from:

IF ONLY PAYMENT FOR THIS EVENT WAS A LUMP SUM, ANSWER "NO" TO ALL OPTIONS

Expecting additional payment

a. Patient or Patient's Family?.....YES=1 NO=2
b. Medicare?.....YES=1 NO=2
c. Medicaid?.....YES=1 NO=2
d. Private Insurance?.....YES=1 NO=2
e. VA/Champva?.....YES=1 NO=2
f. Tricare? .....YES=1 NO=2
g. Worker 's Comp? .....YES=1 NO=2
h. Something else.....YES=1 NO=2

(IF SOMETHING ELSE: What was that?___)

ADJEXTRA

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 C5 (VERIFY TOTAL PAYMENTS) TO RECONFIRM CHARGES AND PAYMENTS AS NEEDED.

YES=1, NO=2

SECTION 17 – LUMP SUM PAYMENTS

LSPCHECK WAS THIS EVENT COVERED BY A LUMP SUM?

YES = 1
NO = 2

DK/REF: GO TO FINISH

SECTION 18 – PATIENT ACCOUNTS – CAPITATED BASIS

C7a. What kind of insurance plan covered the patient for (this visit/these visits/this stay)? Was it: [DCS ONLY] IF NAME OF INSURER, PUBLIC, OR HMO, PROBE: And is that Medicare,

Medicaid, or private insurance?

a. Medicare ..... YES=1 NO=2
b. Medicaid ..... YES=1 NO=2
c. Private Insurance..... YES=1 NO=2
d. VA/Champva..... YES=1 NO=2
e. Tricare .....YES=1 NO=2
f. Worker 's Comp..... YES=1 NO=2

g. Something else? ..... YES=1 NO=2

(IF SOMETHING ELSE: What was that?___)

[If C7a is DK/REF/ – CONTINUE TO C7b]

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

YES = 1
NO = 2

C7b - [IF ANYCOPAY=2 GO TO C7e]

C7b - DK/REF – GO TO C7e

C7c. How much was the co-payment?

$_____._____

[If C7b is DK/REF/ – CONTINUE TO C7d]

C7d. Who paid the co-payment? Was it:

[DCS ONLY] IF NAME OF INSURER, PUBLIC, OR HMO, PROBE: And is that Medicare,

Medicaid, or private insurance?

a. Patient or Patient 's Family; ..... YES=1, NO=2
b. Medicare; ..... YES=1, NO=2
c. Medicaid; ..... YES=1, NO=2
d. Private Insurance; ..... YES=1, NO=2
e. Something else? ..... YES=1, NO=2

(IF SOMETHING ELSE: What was that?)

If C7c is DK/REF/ – CONTINUE TO C7d.

If C7d is DK/ REF/ – CONTINUE TO C7e.]

C7e. Do your records show any other payments for (this visit/these visits/this stay)?

YES = 1
NO = 2

C7f. From which of the following other sources has the facility received payment for (this visit/these visits/ this stay) and how much was paid by each source? Please include all payments that have taken place between (VISIT DATE) and now for this visit.

RECORD PAYMENTS FROM APPLICABLE PAYERS

[DCS ONLY] IF NAME OF INSURER, PUBLIC, OR HMO, PROBE: And is that Medicare,

Medicaid, or private insurance?

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?___)

1. What is the name of the PA form received from the provider?
   - Form Name
   - ID
2. Rate the quality and completeness of the following billing information provided with this form:
   - Global Fee COMPLETE = 1, PARTIAL = 2, MISSING =3, N/A =4
   - CPT4/Services and Charges COMPLETE = 1, PARTIAL = 2, MISSING =3, N/A =4
   - Reimbursement Type COMPLETE = 1, PARTIAL = 2, MISSING =3, N/A =4
   - Source of Payment by Reimbursement Type COMPLETE = 1, PARTIAL = 2, MISSING =3, N/A = 4
   - Total Payment by Reimbursement Type COMPLETE = 1, PARTIAL = 2, MISSING =3, N/A = 4
   - Adjustments by Reimbursement Type COMPLETE = 1, PARTIAL = 2, MISSING =3, N/A = 4
   - Expecting Additional Payment by Payment Source (including copayment oradditional payment information) COMPLETE = 1, PARTIAL = 2, MISSING =3, N/A =4
   - Lump Sum Payment COMPLETE = 1, PARTIAL = 2, MISSING =3, N/A =4

RIV1

IS THIS EVENT A REPEATED IDENTICAL VISIT (RIV) EVENT? THAT IS, ARE THERE 10 OR MORE ADDITIONAL EVENTS IDENTICAL TO THIS EVENT, EXCEPT FOR THE DATE OF SERVICE?

IF IN DOUBT, ANSWER NO.

1=YES – THIS EVENT HAS AT LEAST 10 REPEATED IDENTICAL VISITS ASSOCIATED WITH IT.
2=NO

RIV2

RECORD THE DATES OF SERVICE FOR WHICH ALL DATA ARE IDENTICAL TO THIS (FILL DATE OF CURRENT EVENT) EVENT, EXCEPT FOR THE DATE OF SERVICE.

If RIV1 = NO, go to FINISH SCREEN.

For HOSP, If ANYSBDS = 1, skip RIV1 and RIV2.

RIV2: Require minimum of 10 dates, maximum of 200. After 10 dates, a blank followed by an Enter goes to FINISH SCREEN.

RIV1 – DK/REF not allowed for RIV1, but are allowed for RIV2.

SECTION 19 – FINISH SCREEN

ENTER 1 TO FINALIZE THIS CASE.