# MEDICAL EXPENDITURE PANEL SURVEY

# MEDICAL PROVIDER COMPONENT

## EVENT FORM

## FOR

## HOSPITAL PROVIDERS

### FOR

### REFERENCE YEAR 2017

### OMB STATEMENT

DCS: READ THIS ALOUD ONLY IF REQUESTED BY RESPONDENT.

PRESS NEXT TO CONTINUE IN THIS EVENT FORM

PRESS BREAKOFF TO DISCONTINUE

### SECTION 1 – MEDICAL RECORDS – LOCATION OF SERVICES

**A1.** The (first/next) time (PATIENT NAME) received services during calendar year 2017, 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?_____)

[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 2017**

ADMIT:

    Month:_____
    Day:_____
    Year:_____

DISCHARGE:

    Month:_____
    Day:_____
    Year:_____

NOT YET DISCHARGED = 1

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, OTHERWISE CONTINUE TO A2c

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

**A2c.** What was the date of this visit?

**REFERENCE PERIOD – CALENDAR YEAR 2017**

Month:_____
Day:_____
Year:_____

DK/REF/RETRIEVABLE – 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.

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

[IF A3=NO, DK/REF/RETRIEVABLE – SKIP TO A4a
IF A3=YES, ASK EF1]

## 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?

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 DESCRIBE) What other type of physician?


**EF6.** ENTER ANY COMMENTS ABOUT THIS SBD INCLUDING ADDITIONAL SERVICE(S) TO THE ONE SELECTED IN EF2

# 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:_____

DK/REF/RETRIEVABLE – CONTINUE TO A4c

## 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 A4c
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 (VISIT 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/RETRIEVABLE (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/RETRIEVABLE (GO TO A5d)


**A5c.** What were the admit and discharge dates of that stay?

    ADMIT:

        Month:_____
        Day:_____
        Year:_____

    DISCHARGE:

        Month:_____
        Day:_____
        Year:_____

    NOT YET DISCHARGED = 1

    DK/REF/RETRIEVABLE – 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 2017 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


**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/RETRIEVABLE NOT ALLOWED
A5d - [SYSTEM WILL SET UP AS A LOOP, SO NO LIMIT ON NUMBER OF DATES REQUIRED]
A5d - DK/REF/RETRIEVABLE – CONTINUE TO A5e
A5e - DK/REF/RETRIEVABLE – 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/RETRIEVABLE 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/RETRIEVABLE – CONTINUE TO A6b.]

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

>**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?

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 A6b is DK/REF/RETRIEVABLE – 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 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 A8 is answered, GO TO C2a. If NODRG (A8=1) GO TO A9. DK/REF/RETRIEVABLE – 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/RETRIEVABLE – 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-CM CODES WITH FORMAT # #. # OR # #. # # FOR THIS QUESTION.

      CODE:_____ DESCRIPTION:_____
      CODE:_____ DESCRIPTION:_____

CODE:_____ DESCRIPTION:_____
CODE:_____ DESCRIPTION:_____


**C2a.** What was the **full established charge** for this 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 (VISIT DATE) and now for this (visit/these visits).

RECORD PAYMENTS FROM ALL THAT APPLY

[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.

IF ANY OF THE PAYMENTS IS A LUMP SUM THAT IS NOT YET ALLOCATED, ENTER F8 IN THE APPROPRIATE FIELD(S).

      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? _____)

[If C4 is DK/REF/RETRIEVABLE – CONTINUE TO C5]


**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?

**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 *(now 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 AND CHARGES


*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**

    i. Patient or Patient's Family? ........YES=1 NO=2
    j. Medicare? ........YES=1 NO=2
    k. Medicaid? ........YES=1 NO=2
    l. Private Insurance? ........YES=1 NO=2
  m. VA/Champva? ........YES=1 NO=2
    n. Tricare? ........YES=1 NO=2
    o. Worker 's Comp? ........YES=1 NO=2
    p. 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 ANY LUMP SUM ASSOCIATED WITH THE SOURCES OF PAYMENT?

    YES = 1
    NO = 2

[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/RETRIEVABLE – CONTINUE TO C7b]

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

      YES = 1
      NO = 2

**C7c.** How much was the co-payment?

      $_____._____

[If C7b is DK/REF/RETRIEVABLE – 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/RETRIEVABLE – CONTINUE TO C7d.
If C7d is DK/REF/RETRIEVABLE – 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 adjustment activity that has taken place between (VISIT DATE) and now for (this visit/these visits).

RECORD PAYMENTS FROM ALL THAT APPLY.

[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; ..................... $_____.____
h. Something else?....................... $_____.____
   (IF SOMETHING ELSE: What was that? _____)

[If A1 = 2, 3, or 4 GO TO BOX 3. If A1 = 1 or 5 GO TO FINISH SCREEN.]
If DK/REF/RETRIEVABLE – CONTINUE TO BOX 2.]

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 or additional payment information): COMPLETE = 1, PARTIAL = 2, MISSING =3, N/A = 4
   ◦ Lump Sum Payment: COMPLETE = 1, PARTIAL = 2, MISSING =3, N/A = 4

## SECTION 19 – FINISH SCREEN

**PRESS VALIDATE TO COMPLETE THIS EVENT FORM.**