Form Approved
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MEDICAL EXPENDITURE PANEL SURVEY

MEDICAL PROVIDER COMPONENT

MEDICAL EVENT FORM

FOR

OFFICE-BASED PROVIDERS

FOR

REFERENCE YEAR 2009

VERSION 2.0

Revision History

Version	Author/Title	Date	Comments
1.0	Multiple RTI and SSS authors	12/23/08	
2.0	Multiple RTI and SSS authors	04/01/09	Changes from Version 1.0 marked in yellow highlighting

(PATIENT NAME) reported that (he/she) received health care services from someone in this practice during the calendar year 2009.

1 CONFIRM PATIENT RECEIVED SERVICES (GO TO B1)

2 PROVIDER KNOWS PATIENT BUT NO EVENTS RECORDED FOR 2009 (GO TO NEXT PATIENT, PAIR IS FINAL)

3 PROVIDER DOES NOT KNOW PATIENT (GO TO NEXT PATIENT, REVIEW TO SEE IF DISAVOWAL IS ELIGIBLE FOR CONVERSION)

B1. During this period, what is the (first/next) visit date in your records for (PATIENT NAME)? _____/_____/ _____ MO DAY YR

GLOBAL FEE

B2a. Was the visit on (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: Examples would be a surgeon's fee covering surgery as well as pre- and post-operative care, or an obstetrician's fee covering normal delivery as well as pre- and post-natal care.

YES..... 1
NO..... 2 (GO TO B3)

B2b. What other dates of service were covered by this global fee? Please include dates before or after 2009 if they were included in the global fee.

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

MO DAY YR (DATE FROM B1)	TYPE	IF TYPE 96, SPECIFY:
____/_____/_____	_____	_____
____/_____/_____	_____	_____
____/_____/_____	_____	_____
____/_____/_____	_____	_____
____/_____/_____	_____	_____
____/_____/_____	_____	_____
____/_____/_____	_____	_____
____/_____/_____	_____	_____
____/_____/_____	_____	_____

B2c. Did (PATIENT NAME) receive the services on (DATE) in a:

Physician' s Office (TYPE=MV);
Hospital as an Inpatient (TYPE=SH);
Hospital Outpatient Department (TYPE=SO);
Hospital Emergency Room (TYPE=SE); or
Somewhere else (TYPE=96)?

B2d. Do you expect (PATIENT NAME) will receive any future services that will be covered by this same global fee?

YES..... 1
NO..... 2

(GO TO B4a)

B3. Did (PATIENT NAME) receive the services on (DATE) in a:

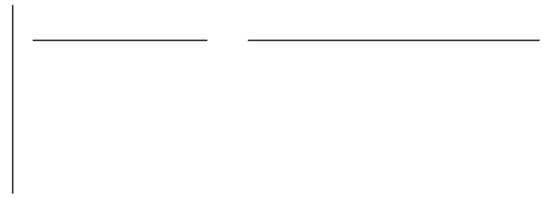
Physician's Office;..... 1
Hospital as an Inpatient;..... 2
Hospital Outpatient Department;..... 3
Hospital Emergency Room; or..... 4
Somewhere else?..... 5
(IF SOMEWHERE ELSE:
Where was that?)
_____

B4a. I need the diagnoses for (this visit/these visits). I would prefer the ICD-9 codes (or the DSM-4 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]

CODE	DESCRIPTION
_____	_____
_____	_____
_____	_____
_____	_____



B5a. 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.

[SYSTEM WILL SET UP AS A LOOP, SO NO LIMIT ON CPT-4 CODES REQUIRED]

B5b. 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 physician's billing system 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 practices 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(s) for (this/these) procedure(s)?

VERIFY: (Is this/Are these) the full established charge(s) or "list price" for (this/these) service(s)? IF NOT, RECORD FULL ESTABLISHED CHARGES

	CODE	DESCRIPTION	Full established charge at time of visit or charge equivalent
a.	_____	_____	$_____.____
b.	_____	_____	$_____.____
c.	_____	_____	$_____.____
d.	_____	_____	$_____.____
e.	_____	_____	$_____.____
f.	_____	_____	$_____.____
g.	_____	_____	$_____.____
h.	_____	_____	$_____.____
i.	_____	_____	$_____.____
j.	_____	_____	$_____.____
k.	_____	_____	$_____.____

TOTAL CHARGES **$**_____**.**___

C2. I show the total charge as [SYSTEM WILL COMPUTE AND DISPLAY TOTAL]. Is that correct?
IF NO, CORRECT ENTRIES ABOVE AS NEEDED.

C3. Was the practice reimbursed for (this visit/these visits) 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.

IF IN DOUBT, CODE FEE-FOR-SERVICE.

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

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

SELECT ALL THAT APPLY

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

[SYSTEM WILL SET UP "SOMETHING ELSE" AS A LOOP, SO NO LIMIT REQUIRED]

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?)
_____ $_____.____

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.

C5. I show the total payment as [SYSTEM WILL COMPUTE AND DISPLAY TOTAL]. Is that correct?
IF NO, CORRECT ENTRIES ABOVE AS NEEDED.

TOTAL PAYMENTS **$**_____.__

(GO TO BOX 1)

BOX 1
DO TOTAL PAYMENTS EQUAL TOTAL CHARGES?

YES, AND ALL PAID BY PATIENT OR PATIENT'S FAMILY…….. 1 (GO TO BOX 2)

YES, OTHER PAYERS……..2 (GO TO C5a)

NO…….. ….3 (GO TO C6)

IF, AFTER VERIFICATION, PAYMENTS DO NOT EQUAL CHARGES COMPLETE C6 AND GO TO BOX 2

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 (GO TO BOX 2)
NO……2 (GO BACK TO C4)

C6. It appears that the total payments were (less than/more than) the total charges. What is the reason for that difference? Please include all adjustment activity that has taken place between (VISIT DATE) and now for this visit.

CODE 1 (YES) FOR ALL REASONS MENTIONED.

PAYMENTS LESS THAN CHARGES:	YES	NO
Adjustment or discount		
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?) _____		
Expecting additional payment		
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?) _____		
q. **Charity care or sliding scale;**.....	1	2
r. **Bad debt;**.....	1	2
PAYMENTS MORE THAN CHARGES:		
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 BOX 2)

CAPITATED BASIS

C7a. What kind of insurance plan covered the patient for (this visit/these visits)? 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. 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?	1	2

(IF SOMETHING ELSE: What was that?)

_____

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

YES..... 1
NO..... 2(GO TO C7e)

C7c. How much was the co-payment?

$_____.__

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?

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?	1	2

(IF SOMETHING ELSE: What was that?)

_____

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

YES..... 1
NO..... 2 (GO TO BOX 2)

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

SELECT ALL THAT APPLY

[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?) _____	$_____.____

BOX 2

GLOBAL FEE SITUATION (B2a=YES).....	**1**	**(GO TO B8)**
RECORDED 5 OR FEWER EVENTS	**2**	**(GO TO B8)**
RECORDED 6 OR MORE EVENTS	**3**	**(GO TO B6a)**

REPEATING IDENTICAL VISITS

B6a. Were there any other visits for this patient during 2009 for which the services and charges were identical to the services and charges for the visit on (DATE OF THIS EVENT)?

YES.. 1
NO.. 2 (GO TO B8)

EXPLAIN, IF NECESSARY: We are referring here to **repeating identical visits**. These usually occur when the patient has a condition that requires very frequent visits, such as once- or twice-a-week physical or mental health therapy, or weekly or monthly allergy shots.

B6b. During 2009 how many other visits were there for which the services and charges were identical to those on (DATE OF THIS EVENT)?

OF VISITS_____________

B6c. Please tell me the dates of those other visits. [SYSTEM WILL SET UP AS A LOOP, SO NO LIMIT ON NUMBER OF DATES REQUIRED]

MO/DAY/YR	MO/DAY/YR	MO/DAY/YR
___/___ 20__	___/___ 20 __	___/___ 20 __
___/___ 20__	___/___ 20 __	___/___ 20 __
___/___ 20__	___/___ 20 __	___/___ 20 __
___/___ 20__	___/___ 20 __	___/___ 20 __
___/___ 20__	___/___ 20 __	___/___ 20 __
___/___ 20__	___/___ 20 __	___/___ 20 __
___/___ 20__	___/___ 20 __	___/___ 20 __
___/___ 20__	___/___ 20 __	___/___ 20 __
___/___ 20__	___/___ 20 __	___/___ 20 __
___/___ 20__	___/___ 20 __	___/___ 20 __

B8. Have we covered all of this patient's visits during the calendar year 2009?

YES, ALL EVENTS COVERED.................... 1 (GO TO B9A)
NO, NEED TO COVER ADDITIONAL EVENTS.. 2 (GO TO B1- NEXT EVENT FORM)

B9a. IF ALL EVENTS ARE RECORDED FOR THIS PATIENT, REVIEW NUMBER OF EVENTS REPORTED BY HOUSEHOLD.

NO DIFFERENCE OR PROVIDER REPORTED MORE EVENTS THAN HOUSEHOLD... 1 (GO TO B9b)

PROVIDER REPORTED FEWER EVENTS... 2

[DCS ONLY] PROBE: (PATIENT NAME) reported (NUMBER) visits to (PROVIDER) during 2009, but I have only recorded (NUMBER) visits. 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

____

____

____

B9b. GO TO NEXT PATIENT FOR THIS PROVIDER.

B9c. IF NO MORE PATIENTS, THANK THE RESPONDENT AND END THE CALL.