Form Approved
OMB No. 0935-0118
Exp. Date 01/31/2013

MEDICAL EXPENDITURE PANEL SURVEY

MEDICAL PROVIDER COMPONENT

MEDICAL EVENT FORM

FOR

SEPARATELY BILLING DOCTORS

FOR

REFERENCE YEAR 2010

VERSION 1.0

Revision History

Version	Author/Title	Date	Comments
1.0	Multiple RTI and SSS authors	3/25/10	

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.

OMB SECTION

DCS: READ THIS ALOUD ONLY IF REQUESTED BY RESPONDENT.

PRESS NEXT TO CONTINUE IN THIS EVENT FORM

PRESS BREAKOFF TO DISCONTINUE

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OMB No. 0935-0118; Exp. Date 1/31/2013

(HOSPITAL NAME) reported that (PATIENT NAME) received health care services from someone in this practice during (an outpatient visit/an emergency room visit/an inpatient stay) on (DATE).

1 PROVIDER CONFIRMS THIS EVENT FOR THIS PATIENT (GO TO B2a)

2 PROVIDER HAS RECORD OF PROVIDING CARE TO PATIENT BUT NOT FOR THIS EVENT (GO TO FINISH SCREEN)

3 PROVIDER KNOWS ABOUT EVENT BUT WAS NOT INVOLVED/DID NOT BILL (E.G. REFERRING PHYSICIANS OR COPIED PHYSICIANS) (GO TO FINISH SCREEN)

4 PROVIDER MAY (OR MAY NOT) KNOW PATIENT OR BEEN INVOLVED IN THIS EVENT (E.G. DEPARTMENT HEADS OR PHYSICIANS SUGGESTED FOR FOLLOW-UP) (GO TO FINISH SCREEN)

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 B5a)
B2b.	What other dates of service were covered by this global fee? Please include dates before or after 2010 if they were included in the global fee. ADMINISTER B2c FOR EACH DATE OF SERVICE COVERED BY THE GLOBAL FEE [SYSTEM WILL SET UP AS A LOOP, SO NO LIMIT ON NUMBER OF DATES REQUIRED]	MO DAY YR 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 B5a)

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 DESCRIPTIONS 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)?

IF PROVIDER APPLIED THE CHARGE FOR THIS SERVICE TO SOME **OTHER** SERVICE ON THIS DATE, ENTER -4.

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

Any more services?

NO……..2
(GO TO C2)

C2. I show the total charges as [SYSTEM WILL COMPUTE AND DISPLAY TOTAL]. Is that correct?

CHARGES
Service charge: CPT4 code: Charges

Charge=$____.__
Total amount=$____.__

NO……..2
(GO BACK TO B5a)

C3. Was the practice reimbursed for (this visit/these visits) on a fee-for-service basis or a 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 (ADMIT DATE/VISIT DATE) and now for this (stay/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.

[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; or $_____.__

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

C5. I show the total payment as [SYSTEM WILL COMPUTE AND DISPLAY TOTAL]. Is that correct?

IF THE ONLY PAYMENT FOR THIS EVENT WAS A LUMP SUM, PAYMENT SHOULD BE "ZERO."

CHARGES
Service charge: CPT4 code: Charges

Charge=$____.__
Total Amount=$____.__

TOTAL PAYMENTS
[NAME OF PAYER]

$_____.__

NO……..2

(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 B10a)

YES, OTHER PAYERS……..2 (GO TO C5a)

NO…….. ….3 (GO TO UNDERPAYMENT SECTION IF PAYMENTS LESS THAN CHARGES; GO TO C6 OVERPAYMENT SECTION IF PAYMENTS MORE THAN CHARGES)

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 B10a)
NO……2 (GO BACK TO C4)

UNDERPAYMENT

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=2
d. This was bad debt YES=1 NO=2

[IF a=1 GO TO C6_ADJUSTMENTS.
IF b=1 GO TO C6_ADDITIONAL.
IF a=1 AND b=1 GO TO BOTH C6_ADJUSTMENTS AND C6_ADDITIONAL.
IF (a=2 AND b=2 AND c=2 AND D=2) GO TO C6_ADJUSTMENTS, C6_ADDITIONAL, AND C6 EXCEEDED.
IF BOTH c=1 and d=1 WITH NO OTHER SELECTION, GO TO LSP CHECK.
IF c=1 OR d=1 WITH NO OTHER SELECTION, GO TO LSP CHECK.]

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 (ADMIT DATE/VISIT DATE) and now for this (stay/visit).

CODE 1 (YES) FOR ALL REASONS MENTIONED.

C6 ADJUSTMENTS

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?)

_____

C6 ADDITIONAL

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?)

_____

C6 EXCEEDED *(Note: this is displayed only if all responses to PLC1 are "No.")*

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

C6 OVERPAYMENT

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 LSP CHECK)

LSPCHECK

WAS THIS EVENT COVERED BY A LUMP SUM?

YES	1 (GO TO LSPREVIEW)
NO	2 (GO TO B10A)

LSPREVIEW

WAS CURRENT MEDICAL EVENT COVERED BY A PAYMENT NOT ALREADY DEPICTED HERE?

YES, I NEED TO RECORD A NEW PAYMENT	1 (GO TO LSP DETAIL)
NO, PAYMENT ALREADY SHOWN ABOVE	2 (GO TO B10A)

[PREVIOUSLY REPORTED LUMP PAYMENTS, PAYER, AND AMOUNT WILL LIST ABOVE RESPONSE OPTIONS.]

LSP DETAIL

LSP1. How much was that payment? Amount_____

LSP2. Who made the payment?

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: PLEASE SPECIFY)
_____

LSP3. Where else was the payment applied? I will record the date and total charge of those other events where payment was applied.

Month: ___

Day: ___

Year: ____

Charge: _____

Were there any other events where this payment was applied?

YES	1 (GO BACK TO LSP3)
NO	2 (GO TO LSPANYMORE)

LSP ANYMORE

Were there any other events where this payment was applied?

YES	1 (GO BACK TO LSP1)
NO	2 (GO TO B10A)

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?

PLEASE READ EACH ITEM ALOUD. CHOOSE RESPONSE FOR ALL ITEMS.

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 B10a)

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 (ADMIT DATE/VISIT DATE) and now for this (stay/visit).

RECORD PAYMENTS FOR 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?) _____	$_____.__

B10a. Do you have any more medical events for (PATIENT) for 2010?

YES, ALL EVENTS COVERED.....1 (GO TO B10b)
NO, NEED TO COVER ADDITIONAL EVENTS..... 2 (GO TO NEXT FORM FOR THIS PATIENT)

B10b. GO TO NEXT PATIENT FOR THIS PROVIDER.

B10c. IF NO MORE PATIENTS, THANK THE RESPONDENT AND END THE CALL.