Form Approved
OMB No. 0935-0118
Exp. Date 12/31/2015

ATTACHMENT 83

MEDICAL EXPENDITURE PANEL SURVEY

MEDICAL PROVIDER COMPONENT

EVENT FORM

FOR

SEPARATELY BILLING DOCTORS

FOR

REFERENCE YEAR 2014

SECTION 1 – OMB
OMB HYPERLINK ON FIRST SCREEN

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 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, 540 Gaither Road, Room # 5036, Rockville, MD 20850.)

OMB No. 0935-0118; Exp. Date XX/XX/XXXX

SECTION 2 – INTRODUCTION

[PAGE 1 – INTRODUCTION (1 of 1)]

Again we are asking about [PATIENT NAME] who received health care services from someone in this practice during [an inpatient stay from BEGIN DATE to END DATE/a long term stay from BEGIN DATE to END DATE/an institutional stay].

Within this stay, when did you have your [first/next] encounter with this patient?

MM/DD/YYYY

Again we are asking about [PATIENT NAME] who received health care services from someone in this practice during [an outpatient visit on DATE/an emergency room visit on DATE/a visit on DATE].

ENTER A DATE IN THIS FORMAT: MM/DD/YYYY

MM/DD/YYYY

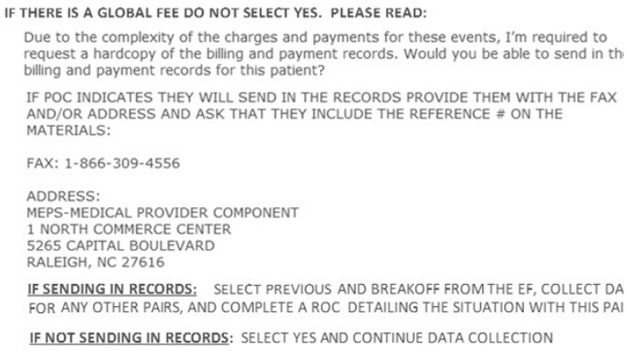
SECTION 3 – GLOBAL FEE

[Page 2 – GLOBAL FEE (1 of 2)]

GLOBAL FEE

B2a. Was the visit on (FILL_VISITDATE) covered by a **global fee**, that is, was it included in a charge that covered services received on other dates as well? YES=1, NO=2

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.



IF THERE IS A GLOBAL FEE DO NOT SELECT YES. PLEASE READ:

Due to the complexity of the charges and payments for these events, I'm required to request a hardcopy of the billing and payment records. Would you be able to send in th billing and payment records for this patient?

IF POC INDICATES THEY WILL SEND IN THE RECORDS PROVIDE THEM WITH THE FAX AND/OR ADDRESS AND ASK THAT THEY INCLUDE THE REFERENCE # ON THE MATERIALS:

FAX: 1-866-309-4556

ADDRESS:
MEPS-MEDICAL PROVIDER COMPONENT
1 NORTH COMMERCE CENTER
5265 CAPITAL BOULEVARD
RALEIGH, NC 27616

IF SENDING IN RECORDS: SELECT PREVIOUS AND BREAKOFF FROM THE EF, COLLECT DA FOR ANY OTHER PAIRS, AND COMPLETE A ROC DETAILING THE SITUATION WITH THIS PAI

IF NOT SENDING IN RECORDS: SELECT YES AND CONTINUE DATA COLLECTION

DK/REF/RETRIEVABLE – GO TO B5a

[Page 3 – GLOBAL FEE (2 of 2)]

	MONTH	DAY	YEAR	TYPE	IF TYPE=96 SPECIFY:
B2b. What other dates of service were covered by this global fee? Please include dates before or after 2014 if they were included in the global fee. ADMINISTER B2c FOR EACH DATE OF SERVICE COVERED BY THE GLOBAL FEE					

B2c. Did (PATIENT NAME) receive the services on GLOBAL FEE 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)?

- IF SOMEWHERE ELSE: Where was that?

RECORD RESPONSE UNDER "TYPE"

B2d. Do you expect (PATIENT NAME) will receive any future services that will be covered by this same global fee? YES=1, NO=2

SECTION 4 – SERVICES/CHARGES

[Page 4 – SERVICES/CHARGES (1 of 2)]

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

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

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

IF PROVIDER APPLIED THE CHARGE FOR THIS SERVICE TO SOME **OTHER** SERVICE ON THIS DATE, ENTER -4.
NOTE: WE NEVER ENTER $0 FOR A CHARGE

	CPT-4 CODE	DESCRIPTION	What was the full established charge, or charge equivalent, for this service?
a.			$
b			$
c.			$
d.			$
e.			$
f.			$
g			$
h.			$
i.			$
j.			$
k.			$

C2. [I show the total charges as _____ / I show the payment as undetermined. / I show the payment as _____, although one or more payments are missing] Is that correct? IF INCORRECT, CORRECT ENTRIES SHOWN ABOVE AS NEEDED.

TOTAL CHARGES **$**

SECTION 5 – REIMBURSEMENT TYPE

[Page 5 – REIMBURSEMENT TYPE (1 of 1)]

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

FEE-FOR-SERVICE BASIS =1
CAPITATED BASIS =2

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.

SECTION 6 – SOURCES OF PAYMENT

[Page 6 – SOURCES OF PAYMENT (1 of 1)]

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 (FILL DATE) and now for this (stay/visit).

[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.

RECORD PAYMENTS FROM ALL APPLICABLE PAYERS

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

SOURCE	PAYMENT AMOUNT
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 _____ / I show the payment as undetermined. / I show the payment as _____, although one or more payments are missing] Is that correct?

IF NO, CORRECT ENTRIES ABOVE AS NEEDED.

SECTION 7 – VERIFICATION OF PAYMENT

[Page 7 – VERIFICATION OF PAYMENT (1 of 1)]

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?

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

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

.

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

ELIGVET2.

It appears that the total payments were less than the total charges. Is that because the person is an eligible veteran?

YES=1,
NO=2

DCS: IF THE POC IS CONFUSED BY THE QUESTION, ANSWER THE QUESTION "NO"

SECTION 8 – DIFFERENCE BETWEEN PAYMENTS AND CHARGES

[Page 8–DIFFERENCE BETWEEN PAYMENTS AND CHARGES (1 of 1)]

Are you expecting additional payment from:

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?)

It appears that the total payments were more than the total charges. Is that correct?

YES=1,
NO=2

DCS: IF THE ANSWER IS "NO" PLEASE GO BACK TO C5 (VERIFY TOTAL PAYMENTS) TO RECONFIRM CHARGES AND PAYMENTS AS NEEDED.

SECTION 9 – CAPITATED BASIS

[Page 9–CAPITATED BASIS (1 of 4)]

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?

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; or	YES=1, NO=2
g. Something else? (IF SOMETHING ELSE: What was that?)	YES=1, NO=2

C7a(g) – "Other Specify" menu

- Auto or Accident Insurance
- CHDP/CHIP
- Indian Health Service
- State Public Mental Plan
- State/County/Local Program
- Other

C7b. Was there a co-payment for (this visit/these visits)? YES=1, NO=2

[Page 10–CAPITATED BASIS (2 of 4)]

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?

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; or	YES=1, NO=2
e. Something else? (IF SOMETHING ELSE: What was that?)	YES=1, NO=2

C7d(e) – Include the following options in a drop down menu for the "Other Specify";

Auto or Accident Insurance

CHDP/CHIP

Indian Health Service

State Public Mental Plan

State/County/Local Program

Other

[Page 11–CAPITATED BASIS (3 of 4)]

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

YES=1,
NO=2

[Page 12–CAPITATED BASIS (4 of 4)]

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 (FILL_VISITDATE) and now for this (stay/visit).

RECORD PAYMENTS FROM ALL APPLICABLE PAYERS

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

SOURCE	PAYMENT AMOUNT
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?)	$

.

(h) – "Other Specify" menu

Auto or Accident Insurance

CHDP/CHIP

Indian Health Service

State Public Mental Plan

State/County/Local Program

Other

SECTION 10 – LUMP SUM PAYMENTS
[Page 13 – LUMP SUM PAYMENT (1 of 1)]

CHECK WAS ANY LUMP SUM ASSOCIATED WITH THE SOURCES OF PAYMENT?
YES
NO

SECTION 11 – ENCOUNTER
[Page 14 – ENCOUNTER (1 of 1)]

Were any other services provided to (PATIENT NAME) during the inpatient stay of (DATE) that we have not recorded?

1 YES
2 NO

SECTION 12 – FINISH SCREEN
[Page 15 – FINISH SCREEN (1 of 1)]

PRESS VALIDATE TO COMPLETE THIS EVENT FORM.