ATTACHMENT 83

MEDICAL EXPENDITURE PANEL SURVEY

MEDICAL PROVIDER COMPONENT

EVENT FORM

FOR

OFFICE-BASED PROVIDERS

FOR

REFERENCE YEAR 2017

SECTION 1 – OMB

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, 5600 Fishers Lane, Rockville, MD 20857.)

SECTION 2 – VISIT DATE

OMB Statement

B1. What is the (first/next) date of service in your records during this period, for (PATIENT NAME)? MONTH DAY YEAR

REFERENCE PERIOD – CALENDAR YEAR 2017

SECTION 2 – LOCATION OF SERVICES RECEIVED

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

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

SECTION 3 – GLOBAL FEE

B2a. 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?

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 the 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 DATA FOR ANY OTHER PAIRS, AND COMPLETE A ROC DETAILING THE SITUATION WITH THIS PAIR.

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

B2b. What other dates of service were covered by this global fee? Please include dates before or after 2017 if they were included in the global fee.

MONTH DAY YEAR TYPE SPECIFY:

ADMINISTER B2c FOR EACH DATE OF SERVICE COVERED BY THE GLOBAL FEE

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

Physician' s Office
Hospital as an Inpatient
Hospital Outpatient Department
Hospital Emergency Room
Somewhere else
IF SOMEWHERE ELSE: Where was that?

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 - DIAGNOSES

B4a. I need the diagnoses for (this visit/these visits). 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

SECTION 5 – SERVICES/CHARGES

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?

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 PROVIDER APPLIED THE CHARGE FOR THIS SERVICE TO SOME OTHER SERVICE, ENTER -4.

CPT-4 CODE	DESCRIPTION	What was the full established charge, or charge equivalent, for this service?
		$

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

SECTION 6 – SOURCES OF PAYMENT

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, this is also called Per Member Per Month.

IF IN DOUBT, CODE FEE-FOR-SERVICE.

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

SECTION 7 – SOURCES OF PAYMENT

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/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).

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	
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?

IF NO, CORRECT ENTRIES ABOVE AS NEEDED.

YES=1, NO=2

BOX 1

DO TOTAL PAYMENTS EQUAL TOTAL CHARGES?

YES, AND ALL PAID BY PATIENT OR PATIENT'S FAMILY – 1 (GO TO LSPCHECK)
YES, OTHER PAYERS - 2 (GO TO C5a)
NO, PAYMENTS < CHARGES - 3 (GO TO PLC1)
NO, PAYMENTS > CHARGES - 3 (GO TO ADJEXTRA**)**

SECTION 8 – 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 =
NO =2

SECTION 9 – PAYMENTS LESS THAN CHARGES

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

SECTION 10 – DIFFERENCE BETWEEN PAYMENTS AND CHARGES

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?

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 11 – LUMP SUM PAYMENTS

LSPCHECK WAS ANY LUMP SUM ASSOCIATED WITH THE SOURCES OF PAYMENT?

YES

NO

SECTION 12 – 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?

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?

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

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

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

YES=1, NO=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 adjustment activity that has taken place between (VISIT DATE) and now for (this visit/these visits).

RECORD PAYMENTS FROM 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?	
h. Something else? (IF SOMETHING ELSE: What was that?)	

BOX 2

BOX 2
IF FEEORCAP = 1 ASK LSPCHECK AND FINISH SCREEN **IF FEEOR CAP = 2 GO TO FINISH SCREEN** **AFTER VALIDATION USER RETURNS TO CMS AND IS ASKED “ANYMORE EVENTS?”**

FINISH SCREEN

PRESS VALIDATE TO COMPLETE THIS EVENT FORM.