MEDICAL EXPENDITURE PANEL SURVEY

MEDICAL PROVIDER COMPONENT

MEDICAL EVENT FORM

FOR

SEPARATELY BILLING DOCTORS

FOR

REFERENCE YEAR 2009

(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 CONFIRM PATIENT RECEIVED SERVICES (GO TO B2a)

2 PROVIDER KNOWS PATIENT BUT NO EVENTS RECORDED FOR (DATE) (GO TO NEXT DATE FOR PATIENT. IF NO MORE DATES FOR THIS PATIENT, 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)

4 OTHER DISAVOWAL (SPECIFY): _____

(GO TO NEXT DATE FOR PATIENT. IF NO MORE DATES FOR THIS PATIENT, GO TO NEXT PATIENT, PAIR IS FINAL)

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 2009 if they were included in the global fee.

[SYSTEM WILL ALLOW FOR A MAXIMUM OF 100 DATES TO BE COLLECTED]

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 ALLOW FOR A MAXIMUM OF 100 CPT-4 CODES TO BE COLLECTED]

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 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?

SELECT ALL THAT APPLY

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

[SYSTEM WILL ALLOW FOR A MAXIMUM OF 20 SOURCES OF PAYMENT TO BE COLLECTED]

OTHER SPECIFY: PROBE FOR SOURCE OF FUNDS AND TYPE OF PLAN.

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?) _____	$_____.__
TOTAL PAYMENTS	**$_____.__**

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

G (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 C6)

IF, AFTER VERIFICATION, PAYMENTS DO NOT EQUAL CHARGES COMPLETE C6 AND GO TO B10a

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)

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C6. It appears that the total payments were (less than/more than) the total charges. What is the reason for that difference?

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? (IF SOMETHING ELSE: What was that?) _____	1	2
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? (IF SOMETHING ELSE: What was that?) _____	1	2
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? (IF SOMETHING ELSE: What was that?) _____	1	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? (IF SOMETHING ELSE: What was that?) _____	1	2

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? (IF SOMETHING ELSE: What was that?) _____	1	2

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?

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?) _____	$_____.__

B10a. ARE ALL EVENTS REPORTED BY (HOSPITAL) FOR THIS PATIENT COVERED?

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.