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

MEDICAL EXPENDITURE PANEL SURVEY

MEDICAL PROVIDER COMPONENT

MEDICAL EVENT FORM

FOR

OFFICE-BASED PROVIDERS

FOR

REFERENCE YEAR 2010

VERSION 1.0

Revision History

Version	Author/Title	Date	Comments
1.0	Multiple RTI and SSS authors	03/25/10	

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.

Do you have any medical events for (PATIENT NAME) for 2010?

1 CONFIRM PATIENT RECEIVED SERVICES (GO TO B1)

2 PROVIDER KNOWS PATIENT BUT NO EVENTS RECORDED FOR 2010 (GO TO NEXT PATIENT, RETURN TO DISAVOWAL QUESTIONS FOR THIS PATIENT AFTER COLLECTING MEDICAL EVENTS FOR ALL PATIENTS.)

3 PROVIDER DOES NOT KNOW PATIENT (GO TO NEXT PATIENT, RETURN TO DISAVOWAL QUESTIONS FOR THIS PATIENT AFTER COLLECTING MEDICAL EVENTS FOR ALL PATIENTS.)

OMB SECTION

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 5 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 1/31/2013

B1. During this period, what is the (first/next) visit date in your records for (PATIENT NAME)?
REFERENCE PERIOD – CALENDAR YEAR 2010

_____/_____/ _____
MO DAY YR

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?)

_____

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 B4a)

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.

[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 this 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?
_____

Any more dates?

YES ..... 1 (GO BACK TO B2b)
NO ..... 2 (GO TO B2d)

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)

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. RECORD UP TO FIVE ICD-9 CODES OR DESCRIPTIONS.

CODE	DESCRIPTION
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_☐__CHECK HERE IF THIS IS AN ICD-10 CODE.

Any more diagnoses?

YES……1 (GO BACK TO B4a)
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, DESCRIBE SERVICES AND PROCEDURES PROVIDED. ENTER UP TO 8 CHARACTERS.

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

[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 PROVIDE APPLIED THE CHARGE FOR THIS SERVICE TO SOME OTHER SERVICE, 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?

YES……1
(GO BACK TO B5a)
NO……..2
(GO TO C2)

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

CHARGES
Service charge: CPT4 code:
Charges

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

YES……1
(GO TO C3)
NO……..2
(GO BACK TO B5a)

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/these visits).

[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.

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.

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: Charge=$____.__
Charges **Total Amount=$____.__**

TOTAL PAYMENTS
[NAME OF PAYER] **$_____.__**

YES……1

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 BOX 2)

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 BOX 2)
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 (VISIT DATE) and now for (this visit/these visits).

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 BOX 2)

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 BOX 2)

[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 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? (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?

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? (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 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.

RECORD PAYMENTS FOR APPLICABLE PAYERS.

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

ANY MORE SOURCES?: 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. Any more sources? (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 2010 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 2010 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. Do you have any more medical events for (PATIENT) for 2010?

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

RECONCILIATION SCREEN:
[DCS ONLY] PROBE: (PATIENT NAME) reported (NUMBER) visits to (PROVIDER) during 2010, 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.