Form Approved
OMB Number 0935-0118
Expiration Date 12/31/2018

# MEDICAL EXPENDITURE PANEL SURVEY

# MEDICAL PROVIDER COMPONENT

## EVENT FORM

## FOR

## OFFICE-BASED PROVIDERS

### FOR

### REFERENCE YEAR 2018

#### 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 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, 5600 Fishers Lane, Rockville, MD 20857.)

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

**SECTION 2 VISIT DATE**

**B1.** What is the (first/next) visit date in your records for (PATIENT NAME)?

REFERENCE PERIOD – CALENDAR YEAR 2018

Month:_____
Day:_____
Year:_____

DK/REF – CONTINUE TO B3

**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?_____)

DK/REF NOT ALLOWED

**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?

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.

YES = 1
NO = 2 (GO TO B4a)
DK/REF (GO TO B4a)

**B2b.** What other dates of service were covered by this global fee? Please include dates before or after 2018 if they were included in the global fee

[SYSTEM WILL SET UP AS A LOOP, SO NO LIMIT ON NUMBER OF DATES REQUIRED]

MONTH:_____/DAY:_____/YEAR:_____ TYPE:_____ IF TYPE 96, SPECIFY:_____
MONTH:_____/DAY:_____/YEAR:_____ TYPE:_____ IF TYPE 96, SPECIFY:_____
MONTH:_____/DAY:_____/YEAR:_____ TYPE:_____ IF TYPE 96, SPECIFY:_____
MONTH:_____/DAY:_____/YEAR:_____ TYPE:_____ IF TYPE 96, SPECIFY:_____
MONTH:_____/DAY:_____/YEAR:_____ TYPE:_____ IF TYPE 96, SPECIFY:_____

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

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

- Physician's Office (TYPE=MV)
- Hospital as an Inpatient (TYPE=SH)
- Hospital Outpatient Department (TYPE=SO)
- Hospital Emergency Room (TYPE=SE)
- Somewhere else (TYPE=96)? (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

[If B2b is DK/REF – CONTINUE TO B2c for dates with at least YEAR specified, otherwise GO TO B2d.

If B2c is DK/REF – CONTINUE TO B2d.

If B2d is DK/REF – CONTINUE TO B4a.]

## 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.

CPT-4 CODE:_____ DESCRIPTION:_____

**B5b.** What was the full established charge, or charge equivalent, for this service?

**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

$_____.____

**C2.** I show the total charges as [SYSTEM WILL COMPUTE AND DISPLAY TOTAL] / I show the charge as undetermined. / I show the charge as [SYSTEM WILL COMPUTE AND DISPLAY TOTAL], although one or more charges are missing. Is that correct?

IF INCORRECT, CORRECT ENTRIES SHOWN ABOVE AS NEEDED

[If B5a is DK/REF – CONTINUE TO B5b.

If B5b is DK/REF – CONTINUE TO C2.]

## 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.

IF IN DOUBT, CODE FEE-FOR-SERVICE

FEE-FOR-SERVICE BASIS = 1
CAPITATED BASIS = 2 (go to C7a)

## 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).

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; ..... $_____.____

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.

## 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 =1 (GO TO BOX 2)
NO =2 (GO BACK TO C4)

## 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

**C6_Additional**

Are you expecting additional payment from:

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)?

YES = 1
NO = 2 (GO TO C7e)

If C7a is DK/REF – CONTINUE TO C7b.
If C7b is DK/REF – 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?

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?_____)

If C7c is DK/REF – CONTINUE TO C7d.
If C7d is DK/REF – CONTINUE TO C7e.]

**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?

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?_____)

**PRESS VALIDATE TO COMPLETE THIS EVENT FORM.**
**AFTER VALIDATION USER RETURNS TO CMS AND IS ASKED "ANY MORE EVENTS?"**