

MEDICAL EXPENDITURE PANEL SURVEY MEDICAL PROVIDER COMPONENT

EVENT FORM FOR SEPARATELY BILLING DOCTORS FOR REFERENCE YEAR 2024

OMB

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DCS: READ THIS ALOUD ONLY IF REQUESTED BY RESPONDENT. PRESS NEXT TO CONTINUE IN THIS EVENT FORM

PRESS BREAKOFF TO DISCONTINUE

INTRODUCTION

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 [FILL_FIRSTNEXT] encounter with this patient? ENTER A DATE IN THIS FORMAT: MM/DD/YYYY

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

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?

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 (GO TO B2b)

NO = 2 (GO TO B5a)

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

3040 East Cornwallis Road

P.O. Box 12194

Research Triangle Park, NC 27709-2194

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.

DK/REF (GO TO B5a)

B2b. What other dates of service were covered by this global fee? Please include dates before or after 2024 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: ____

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)
- 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 B5a.]

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: _____
CPT-4 CODE: _____	DESCRIPTION: _____
CPT-4 CODE: _____	DESCRIPTION: _____
CPT-4 CODE: _____	DESCRIPTION: _____

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

NOTE: WE NEVER ENTER \$0 FOR A CHARGE

IF PROVIDER APPLIED THE CHARGE FOR THIS SERVICE TO SOME OTHER SERVICE ON THIS DATE, ENTER -4

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

\$ _____.
\$ _____.
\$ _____.
\$ _____.
\$ _____.
\$ _____.
\$ _____.

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

IF INCORRECT, CORRECT ENTRIES SHOWN ABOVE AS NEEDED

YES = 1
NO = 2

[If B5a is DK/REF – CONTINUE TO B5b.
If B5b is DK/ REF – CONTINUE TO C2.]

REIMBURSEMENT TYPE

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)

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

SELECT 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.

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; \$ ____.
- h. Or something else? \$ ____.

(IF SOMETHING ELSE: What was that? _____ \$ ____.

TOTAL PAYMENTS \$ ____.

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?

YES = 1

NO = 2

IF NO, CORRECT ENTRIES ABOVE AS NEEDED.

TOTAL PAYMENTS \$ ____.

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

NO =2

DIFFERENCE BETWEEN PAYMENTS AND 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

C6_Additional: 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?

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.

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? _____)

C7a(g) – “Other Specify” menu

- Auto or Accident Insurance
- 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 (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? _____)

C7d(e) – Include the following options in a drop-down menu for the “Other Specify”:

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

[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

[If DK/REF – GO TO LUMP SUM PAYMENT CHECK]

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 (VISITDATE) 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. Or something else? \$ _____.__

(IF SOMETHING ELSE: What was that? _____ \$ _____.__

(h.) "Other Specify" menu

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

LUMP SUM PAYMENTS

LSPCHECK Was any lump sum associated with the sources of payment?

YES = 1

NO = 2

ENCOUNTER

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

YES = 1

NO = 2

FINISH SCREEN

PRESS VALIDATE TO COMPLETE THIS EVENT FORM.