

(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).

B2a. Was the visit on (DATE) covered by a **global fee**, that is, was it included in a charge that covered services on other dates as well? YES 1
NO 2 (B4a)

[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, No {GLOFEE}

B2b. What other dates of service were covered by this global fee? Please include dates before or after 1998 if they were included in the global fee. MO DAY YR TYPE IF TYPE 96, SPECIFY:
 ___ / ___ 19 _____
 ___ / ___ 19 _____
 ___ / ___ 19 _____
 ___ / ___ 19 _____
 ___ / ___ 19 _____
 ___ / ___ 19 _____

[IF THERE ARE MORE THAN 8 DATES, USE A CONTINUATION SHEET.]

Other Dates of Service {GFEEBEGM}
{GFEEBEGD}
{GFEEBEGY}

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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)?

Global Fee Type {GFTYPE}
Global Fee Type Specify, Text {WHSPC}

B2d. Do you expect (PATIENT NAME) will receive any future services that will be covered by this same global fee? YES 1
NO 2

Yes, No {GFEEFUTS}

GO TO B4a

	CODE	DESCRIPTION	
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.	_	_____	OFFICE USE ONLY
	_	_____	
[IF CODES ARE NOT USED, RECORD DESCRIPTIONS.]	_	_____	
	_	_____	
[IF THERE ARE MORE THAN 8 DIAGNOSES, USE A CONTINUATION SHEET.]	_	_____	
	_	_____	
Condition Code Number {ICDCND#}	_	_____	
Condition Description, Text {ICDPDS#}	_	_____	
	_	_____	
	_	_____	

B4b. Which of these was the principal diagnosis? IF ONLY ONE DIAGNOSIS, GO TO B5a.
IF MORE THAN ONE DIAGNOSIS:
 CHECK BOX FOR PRINCIPAL DIAGNOSIS
 CIRCLE '-8' IF PRINCIPAL DIAGNOSIS IS NOT KNOWN..... -8

Principal Diagnosis {ICDPRIN}

B5a. I need to know what services 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 DESCRIPTION OF SERVICES AND PROCEDURES PROVIDED.]

[IF THERE ARE MORE THAN 11 SERVICES, USE A CONTINUATION SHEET.]

CPT-4 Code Number {MCPT#}
Description of Services, Text {MCPTDS#}

CPT-4 (including modifier)

Full established charge at time of visit or charge equivalent

- a. _____ \$_____.
- b. _____ \$_____.
- c. _____ \$_____.
- d. _____ \$_____.
- e. _____ \$_____.
- f. _____ \$_____.
- g. _____ \$_____.
- h. _____ \$_____.
- i. _____ \$_____.
- j. _____ \$_____.
- k. _____ \$_____.

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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 equivalents for these procedures?*]

Full Established Charge {MCPTCH#}

C2. [IF NOT VOLUNTEERED, ASK:] And what was the total? [IF NOT AVAILABLE, COMPUTE.]

TOTAL CHARGES

\$_____.

Total Charges {TOTLCHRG}

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.

- FEE-FOR-SERVICE BASIS 1
- CAPITATED BASIS..... 2 (C7a)
- BOTH 3

[INTERVIEWER: IF IN DOUBT, CODE FEE-FOR-SERVICE.]

Fee-for-Service Basis,
Capitated Basis,
Both {FEEORCAP}

- C4. From what sources has the practice received payment for (this visit/these visits) and how much was paid by each source?
- | | |
|--------------------------------|-----------|
| a. Patient or patient's family | \$ _____. |
| b. Medicare | \$ _____. |
| c. Medicaid | \$ _____. |
| d. Private Insurance | \$ _____. |
| e. VA | \$ _____. |
| f. CHAMPVA/CHAMPUS | \$ _____. |
| g. WORKER'S COMP | \$ _____. |
| h. OTHER (SPECIFY):
_____ | \$ _____. |
- IF NAME OF INSURER OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance?
- INTERVIEWER: IF RESPONSE IS THE PATIENT PAYS A MONTHLY PREMIUM, GO BACK TO C3 AND CHANGE CODE TO 2 (CAPITATED BASIS).
- | | |
|---------------------|------------|
| Patient or Family | {PATPAYM} |
| Medicare | {CAREPAYM} |
| Medicaid | {AIDPAYM} |
| Private Insurance | {PINSPAYM} |
| VA | {VAPAYM} |
| CHAMPVA/CHAMPUS | {CHAMPAYM} |
| Worker's Comp | {WORKPAYM} |
| Other | {OTHRPAYM} |
| Other Specify, Text | {OTPAYMOS} |

C5. [IF NOT VOLUNTEERED, ASK:] And what was the total? [IF NOT AVAILABLE, COMPUTE.]

TOTAL PAYMENTS \$ _____.

Total Payments {TOTLPAYM}

<p>BOX 1 DO TOTAL PAYMENTS EQUAL TOTAL CHARGES? YES 1 (B10a) NO 2 (C6)</p>

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

- | | |
|-------------------------------------|------------|
| Adjustment or discount | |
| Medicare | {DISCARE} |
| Medicaid | {DISCAID} |
| Contractual arrangement | {DISCNT} |
| Courtesy discount | {DISCRTS} |
| Insurance write-off | {DISINSU} |
| Worker's Comp | {DISWORK} |
| Other | {DISOTH} |
| Other Specify, Text | {DISOTOS} |
| Expecting additional payment | |
| Patient or Family | {EPAYPAT} |
| Medicare | {EPAYCAR} |
| Medicaid | {EPAYAID} |
| Private Insurance | {EPAYPINS} |
| VA | {EPAYVA} |
| CHAMPVA/CHAMPUS | {EPAYCHAM} |
| Worker's Comp | {EPAYWORK} |
| Other | {EPAYOTH} |
| Other Specify, Text | {EPAYOTOS} |
| Charity care or sliding scale | {SLIDSCA} |
| Bad debt | {BADDEB} |
| Payments more than charges | |
| Medicare | {MORECARE} |
| Medicaid | {MORECAID} |
| Private Insurance | {MOREPINS} |
| Other | {PAYMOTH} |
| Other Specify, Text | {PAYMOTOS} |

- | | | |
|---|---|---|
| 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. Other (Specify): _____ | 1 | 2 |

- Expecting additional payment**
- | | | |
|---|---|---|
| h. Patient or Patient's Family | 1 | 2 |
| i. Medicare | 1 | 2 |
| j. Medicaid..... | 1 | 2 |
| k. Private Insurance..... | 1 | 2 |
| l. VA | 1 | 2 |
| m. CHAMPVA/CHAMPUS | 1 | 2 |
| n. WORKER'S COMP | 1 | 2 |
| o. Other (Specify): _____ | 1 | 2 |
| p. Charity care or sliding scale _____ | 1 | 2 |
| q. Bad debt | 1 | 2 |

- PAYMENTS MORE THAN CHARGES:**
- | | | |
|--------------------------------------|---|---|
| r. Medicare Adjustment..... | 1 | 2 |
| s. Medicaid Adjustment..... | 1 | 2 |
| t. Private insurance adjustment..... | 1 | 2 |
| u. Other (Specify): | 1 | 2 |

GO TO B10a

CAPITATED BASIS

C7a. What kind of insurance plan covered the patient for (this visit/these visits)? Was it: YES NO

IF NAME OF INSURER OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance?

Medicare	{COVCARE}	a. Medicare;	1	2
Medicaid	{COVAID}	b. Medicaid;	1	2
Private Insurance	{COVPINS}	c. Private Insurance;	1	2
VA	{COVVA}	d. VA;	1	2
CHAMPVA/CHAMPUS	{COVCHAM}	e. CHAMPVA/CHAMPUS;	1	2
Worker's Comp	{COVWORK}	f. Worker's Comp; or	1	2
Something else	{COVOTHR}	g. Something else? (SPECIFY:)	1	2
Something else Specify, Text	{COVOTOS}	_____		

C7b. Was there a co-payment for (this visit/these visits)? YES 1
NO..... 2 (C7e)

Yes, No {ANYCOPAY}

C7c. How much was the co-payment? \$ _____

Co-payment amount {COPAYAMT}

C7d. Who paid the co-payment? YES NO

IF NAME OF INSURER OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance?

Patient or Family	{CPAYPAT}	a. PATIENT OR PATIENT'S FAMILY	1	2
Medicare	{CPAYCARE}	b. MEDICARE	1	2
Medicaid	{CPAYAID}	c. MEDICAID	1	2
Private Insurance	{CPAYPINS}	d. PRIVATE INSURANCE	1	2
Other	{CPAYOTHR}	e. OTHER		
Other Specify, Text	{CPAYOTOS}	(SPECIFY:) _____	1	2

C7e. Do your records show any other payments for (this visit/these visits)? YES 1
NO..... 2 (B10a)

Yes, No {OTHPAY}

C7f. From what other sources has the practice received payment for (this visit/these visits) and how much was paid by each source? a. Patient or patient's family \$ _____
b. Medicare \$ _____
c. Medicaid \$ _____
d. Private Insurance \$ _____
e. VA \$ _____
f. WORKER'S COMP \$ _____
g. CHAMPVA/CHAMPUS \$ _____
h. OTHER (SPECIFY:) _____
_____ \$ _____

IF NAME OF INSURER OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance?

Patient or Family	{OTHPAT}	a. Patient or patient's family	\$	_____
Medicare	{OTHCARE}	b. Medicare	\$	_____
Medicaid	{OTHCAID}	c. Medicaid	\$	_____
Private Insurance	{OTHPINS}	d. Private Insurance	\$	_____
VA	{OTHVA}	e. VA	\$	_____
CHAMPVA/CHAMPUS	{OTHCHAM}	f. WORKER'S COMP	\$	_____
Worker's Comp	{OTHWORK}	g. CHAMPVA/CHAMPUS	\$	_____
Other	{OTHOTHR}	h. OTHER (SPECIFY:)	\$	_____
Other Specify, Text	{OTHOTOS}	_____	\$	_____

<p>B10a. ARE ALL EVENTS REPORTED BY (HOSPITAL) FOR THIS PATIENT COVERED?</p> <p>Yes, all events covered, No, need to cover additional events {ALLEVNTS}</p>	<p>YES, ALL EVENTS COVERED..... 1</p> <p>NO, NEED TO COVER ADDITIONAL EVENTS 2</p>	<p>(NEXT FORM FOR THIS PATIENT)</p>
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B10b. GO TO NEXT PATIENT FOR THIS PROVIDER.

B10c. IF NO MORE PATIENTS, THANK THE RESPONDENT AND END THE CALL.