

PATIENT ID: _____	{HHRKUID}
PROVIDER ID: _____	{PDDIRID}
PROVIDER NAME: _____	{PROVNAME}

FORM _____ OF _____

{FORMNUM} {FORMTOT}

MEDICAL EXPENDITURE PANEL SURVEY

MEDICAL PROVIDER COMPONENT

MEDICAL EVENT FORM

FOR

OFFICE-BASED PROVIDERS

FOR

REFERENCE YEAR 1999

(PATIENT NAME) reported that (he/she) received health care services from someone in this practice during the calendar year 1999.

B1. During this period, what is the (first/next) visit date in your records for (PATIENT NAME)? _____ / _____ /19____ IF GLOBAL FEE, RECORD TYPE:
 MO DAY YR

Visit Date {EVNTBEGM}
 {EVNTBEGD}
 {EVNTBEGY}

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?
 YES..... 1
 NO..... 2 (B3)

[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 1999 if they were included in the global fee.
 MO DAY YR TYPE IF TYPE 96, SPECIFY:
 ____/____/____ _____
 ____/____/____ _____
 ____/____/____ _____
 ____/____/____ _____
 ____/____/____ _____
 ____/____/____ _____

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

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

OFFICE USE ONLY

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

B3. Did (PATIENT NAME) receive the services on (DATE) in a:

Physician's Office,
Hospital as an Inpatient,
Hospital Outpatient Department,
Hospital Emergency Room,
Somewhere else,

{RCSR#}

Somewhere else Specify, Text {RCSP#}

Physician's Office..... 1
Hospital as an Inpatient 2
Hospital Outpatient Department 3
Hospital Emergency Room or 4
Somewhere else?
(Specify:)..... 5

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.]

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

Check box {CKBX#}
Condition Code Number {ICDCND#}
Condition Description, Text {ICDPDS#}

CODE	DESCRIPTION
_	_____
_	_____
_	_____
_	_____
_	_____
_	_____
_	_____
_	_____
_	_____
_	_____

|_|_|
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B4b. Which of these was the principal diagnosis?

Principal Diagnosis {ICDPRIN}

IF ONLY ONE DIAGNOSIS, GO TO B5a.

IF MORE THAN ONE DIAGNOSIS:

- CHECK BOX FOR PRINCIPAL DIAGNOSIS
- CIRCLE '-8' IF PRINCIPAL DIAGNOSIS NOT KNOWN -8

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 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#}

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 {TOTLCHRG}

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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TOTAL CHARGES \$ _____.

CAPITATED BASIS

		YES	NO
C7a. What kind of insurance plan covered the patient for (this visit/these visits)? Was it:			
	a. Medicare	1	2
	b. Medicaid	1	2
	c. Private Insurance.....	1	2
	d. VA	1	2
	e. CHAMPVA/CHAMPUS.....	1	2
	f. Worker's Comp or.....	1	2
	g. Something else? (Specify:)	1	2
<hr/>			
Medicare	{COVCARE}		
Medicaid	{COVAID}		
Private Insurance	{COVPINS}		
VA	{COVVA}		
CHAMPVA/CHAMPUS	{COVCHAM}		
Worker's Comp	{COVWORK}		
Something else	{COVOTHR}		
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}	

		YES	NO
C7d. Who paid the co-payment?			
IF NAME OF INSURER OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance?			
	a. Patient or patient's family	1	2
	b. Medicare	1	2
	c. Medicaid.....	1	2
	d. Private Insurance.....	1	2
	e. Other (Specify:)	1	2
Patient or Family	{CPAYPAT}		
Medicare	{CPAYCARE}		
Medicaid	{CPAYAID}		
Private Insurance	{CPAYPINS}		
Other	{CPAYOTHR}		
Other Specify, Text	{CPAYOTOS}		

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

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

Patient or Family {OTHPAT}
 Medicare {OTHCARE}
 Medicaid {OTHAID}
 Private Insurance {OTHPINS}
 VA {OTHVA}
 CHAMPVA/CHAMPUS {OTHCHAM}
 Worker's Comp {OTHWORK}
 Other {OTHOTHR}
 Other Specify, Text {OTHOTOS}

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:) \$ _____

BOX2

{GOTORVIS}

BOX 2
GLOBAL FEE SITUATION
 (B2a=YES) 1 (B8)
 RECORDED 5 OR FEWER
 EVENTS 2 (B8)
 RECORDED 6 OR MORE
 EVENTS 3 (B6a)

REPEATING IDENTICAL VISITS

B6a. Were there any other visits for this patient during 1999 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 (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 therapy.*]

Yes, No {OTHIDVIS}

B6b. During 1999 how many other visits were there for which the services and charges were identical to those on (DATE OF THIS EVENT)? # OF VISITS _____

Number of Identical Visits {VISNUM}

