

(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).

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 (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 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}

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 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 {GFEVTYPE}
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.]

_	_____	_____
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[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?

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 IS 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#}

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 hospital's master fee schedule 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 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 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}

TOTAL CHARGES \$ _____.

C3. Was the practice reimbursed for (this visit/these visits) on a fee-for-service basis or a capitated basis?

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

[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.

[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 {TOTLPAYM}

TOTAL PAYMENTS \$ _____

BOX 1
DO TOTAL PAYMENTS EQUAL
TOTAL CHARGES?
 YES..... 1 (B10a)
 NO 2 (C6)

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.]

Adjustment or discount

- Medicare {DISCARE}
- Medicaid {DISCAID}
- Contractual arrangement {DISCNT}
- Courtesy discount {DISCRTS}
- Insurance write-off {DISINSU}
- Worker's Comp {DISWORK}
- Eligible veteran {ELIGVET}
- 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}

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

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..... 1 2
- n. CHAMPVA/CHAMPUS..... 1 2
- o. Worker's Comp..... 1 2
- p. Other (Specify:) _____ 1 2

q. **Charity care or sliding scale** _____ 1 2

r. **Bad debt** 1 2

PAYMENTS MORE THAN CHARGES: .

- s. Medicare Adjustment 1 2
- t. Medicaid Adjustment 1 2
- u. Private insurance adjustment 1 2
- v. 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? | 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 |
-
- | | | |
|-------------------------------------|------------------|--|
| 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}

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 (Specify:): 1 2
Other Specify, Text	{CPAYOTOS}	

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?

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:) \$ _____.
 _____ \$ _____

B10a. ARE ALL EVENTS REPORTED BY (HOSPITAL) FOR THIS PATIENT COVERED?

Yes, all events covered,
No, need to cover additional events
 {ALLEVNTS}

YES, ALL EVENTS COVERED..... 1
 NO, NEED TO COVER ADDITIONAL
 EVENTS 2

(NEXT FORM FOR THIS PATIENT)

B10b. GO TO NEXT PATIENT FOR THIS PROVIDER.

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