CMS ID/NORC ID:  
PATIENT ID:  
PROVIDER NAME:  
PROVIDER ID:  
OTHER PROVIDER NAME:  
EVENT TYPE:  
# OF EVENTS:  
WAVE:  
BATCH:  
REGION:  
EVENT DATE:  _____/_____/_____ (to _____/_____/_____)  

# OF EVENTS IN BOOKLET  
FORM _______ OF _______

MEDICAL EXPENDITURE PANEL SURVEY  
MEDICAL PROVIDER SURVEY  
MEDICAL EVENT FORM  
FOR  
SEPARATELY BILLING DOCTORS  
PANEL 1 - YEAR 1

OFFICE USE ONLY

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(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).

1a. 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?

   [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
   NO ........................................................................ 2 (Q2a)

1b. What other dates of service were covered by this global fee? Please include dates before or after 1996 if they were included in the global fee.

   MO   DAY   YR
   __/____/____
   __/____/____
   __/____/____
   __/____/____
   __/____/____
   __/____/____
   __/____/____

   OFFICE USE ONLY

1c. Do you expect (PATIENT NAME) will receive any future services that will be covered by this same global fee?

   YES ........................................................................ 1
   NO ........................................................................ 2

1d. Did (PATIENT NAME) receive the services covered by this global fee in a:

   [CODE ALL THAT APPLY]

   Gasian’s Office: .............................................. 1 2
   Hospital as an Inpatient: ...................... 1 2
   SPECIFY ADMIT & DISCHARGE DATES:
   a. Stay 1 ___/____/____ to ___/____/____
   b. Stay 2 ___/____/____ to ___/____/____
   Hospital Outpatient Department; ............... 1 2
   Hospital Emergency Room; or .............. 1 2
   Somewhere else?
   (SPECIFY:) _____________________ .. 1 2

2a. 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.]

2b. Which of these was the principal diagnosis?

---

DIAGNOSIS:

IF ONLY ONE DIAGNOSIS, GO TO Q3a.
IF MORE THAN ONE DIAGNOSIS:
■ CHECK BOX FOR PRINCIPAL DIAGNOSIS
■ CIRCLE ’999.95’ IF PRINCIPAL DIAGNOSIS IS NOT KNOWN........999.95

---
3a. I need the 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.]

3b. 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?]

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

5. 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.

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

6. From what sources has the practice received payment for (this visit/these visits) and how much was paid by each source?  

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

INTERVIEWER: IF RESPONSE IS THE PATIENT PAYS A MONTHLY PREMIUM, GO BACK TO Q5 AND CHANGE CODE TO 2 (CAPITATED BASIS).

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

BOX 1

DO TOTAL PAYMENTS EQUAL TOTAL CHARGES?

YES............ 1 (Q10)  
NO............. 2 (Q8)
8. 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:

- Adjustment or discount
  - Medicare or Medicaid limit or adjustment
  - Contractual arrangement with insurer or managed care organization
  - Courtesy discount
  - Insurance write-off
  - Other (Specify:)

- Expecting additional payment
  - Patient or Patient’s Family
  - Medicare
  - Medicaid
  - Private Insurance
  - VA
  - CHAMPVA/CHAMPUS
  - Other (Specify:)

- Charity care or sliding scale
- Bad debt

PAYMENTS MORE THAN CHARGES:

- Medicare or Medicaid Adjustment
- Other (Specify:)

9a. What kind of insurance plan covered the patient for (this visit/these visits)? Was it:

  [CODE ALL THAT APPLY]
  - Medicare
  - Medicaid
  - Private Insurance; or
  - Something else? (SPECIFY):
  - VA/CHAMPVA/CHAMPUS
  - DON’T KNOW
  - NO INSURANCE/NONE
  - VA/CHAMPVA/CHAMPUS
  - DON’T KNOW
  - NO INSURANCE/NONE

9b. Was there a co-payment for (this visit/these visits)?

  YES
  NO

9c. How much was the co-payment?

$___________.

9d. Who paid the co-payment?

  PATIENT OR PATIENT’S FAMILY
  MEDICARE
  MEDICAID
  PRIVATE INSURANCE
  OTHER (SPECIFY)
  DON’T KNOW

9e. Do your records show any other payments for (this visit/these visits)?

  YES
  NO

9f. 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. CHAMPVA/CHAMPUS
  g. OTHER (SPECIFY):

  $___________.

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

  YES, ALL EVENTS COVERED
  NO, NEED TO COVER ADDITIONAL EVENTS

11a. GO TO NEXT PATIENT FOR THIS PROVIDER.

11b. IF NO MORE PATIENTS, THANK THE RESPONDENT AND END THE CALL.