

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 2000

(PATIENT NAME) reported that (he/she) received health care services from someone in this practice during the calendar year 2000.

B1. During this period, what is the (first/next) visit date in your records for (PATIENT NAME)? _____ / _____ / _____ 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 2000 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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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..... 1
 Hospital as an Inpatient 2
 Hospital Outpatient Department 3
 Hospital Emergency Room or 4
 Somewhere else?
 (Specify):..... 5

**Physician's Office,
 Hospital as an Inpatient,
 Hospital Outpatient Department,
 Hospital Emergency Room,
 Somewhere else,** {RCSRV}
Somewhere else Specify, Text {RCSPC}

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#}

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 {TOTLCHRG}

TOTAL CHARGES \$ _____.

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}
TRICARE/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. TRICARE/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 BOX 2

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}
- Medicaid** {COVAID}
- Private Insurance** {COVPINS}
- VA** {COVVA}
- TRICARE/CHAMPVA/CHAMPUS** {COVCHAM}
- Worker's Comp** {COVWORK}
- Something else** {COVOTHR}
- Something else Specify, Text** {COVOTOS}

- a. Medicare 1 2
- b. Medicaid 1 2
- c. Private Insurance..... 1 2
- d. VA 1 2
- e. TRICARE/CHAMPVA/CHAMPUS..... 1 2
- f. Worker's Comp or..... 1 2
- g. Something else? (Specify:)..... 1 2

C7b. Was there a co-payment for (this visit/these visits)?

Yes, No {ANYCOPAY}

- YES..... 1
- NO..... 2 (C7e)

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}
- Medicare** {CPAYCARE}
- Medicaid** {CPAYAID}
- Private Insurance** {CPAYPINS}
- Other** {CPAYOTHR}
- Other Specify, Text** {CPAYOTOS}

- 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

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** {OTHPCARE}
- Medicaid** {OTHSAID}
- Private Insurance** {OTHPINS}
- VA** {OTHVA}
- TRICARE/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. TRICARE/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 2000 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 2000 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}

B6c. Please tell me the dates of those other visits. MO/DAY/YR MO/DAY/YR MO/DAY/YR
 [IF THERE WERE MORE THAN 30 IDENTICAL VISITS, USE A CONTINUATION SHEET.]

Other Identical Visit Dates	{EVNTBEGM}	____/____/20____	____/____/20____	____/____/20____
	{EVNTBEGD}	____/____/20____	____/____/20____	____/____/20____
	{EVNTBEGY}	____/____/20____	____/____/20____	____/____/20____
		____/____/20____	____/____/20____	____/____/20____
		____/____/20____	____/____/20____	____/____/20____
		____/____/20____	____/____/20____	____/____/20____
		____/____/20____	____/____/20____	____/____/20____
		____/____/20____	____/____/20____	____/____/20____

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B8. Have we covered all of this patient's visits during the calendar year 2000? YES, ALL EVENTS COVERED 1 (B9a)
 NO, NEED TO COVER ADDITIONAL EVENTS..... 2 (B1-NEXT EVENT FORM)

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

B9a. IF ALL EVENTS ARE RECORDED FOR THIS PATIENT, REVIEW NUMBER OF EVENTS REPORTED BY HOUSEHOLD. NO DIFFERENCE OR PROVIDER REPORTED MORE EVENTS THAN HOUSEHOLD 1 (B9b)

PROVIDER REPORTED FEWER EVENTS 2
 PROBE: (PATIENT NAME) reported (NUMBER) visits to (PROVIDER) during 2000, but I have only recorded (NUMBER) visits. Do you have any information in your records that would explain this discrepancy?

B9b. GO TO NEXT PATIENT FOR THIS PROVIDER.

B9c. IF NO MORE PATIENTS, THANK THE RESPONDENT AND END THE CALL.