OMB#: 0935-0098
EXPIRES: 12/31/98

CMS/ID/NORC ID:
PATIENT NAME: PATIENT ID:
PROVIDER NAME:
PROVIDER ID:
OTHER PROVIDER NAME:
EVENT TYPE: # OF EVENTS:
WAVE: BATCH: REGION:

OF EVENTS THIS BOOKLET _____
BOOK _____ OF _____

MEDICAL EXPENDITURE PANEL SURVEY

MEDICAL PROVIDER SURVEY

MEDICAL EVENT BOOKLET

FOR

OFFICE-BASED PROVIDERS

PANEL 1 - YEAR 1

OFFICE USE ONLY			
Editor Initials:	Edit Date:	/	/ 97
Retrieval/Clarification Need? (circle one)	YES	NO	
Retrieval/Clarification Complete? (circle one)	YES	NO	
Re-Edit Initials	Re-Edit Date:	/	/ 97
CADE Initials:	CADE Date:	/	/ 97
Verification Case? (circle one)	YES	NO	
Ver Initials:	Ver Date:	/	/ 97

(PATIENT NAME) reported that (he/she) received health care services from someone in this practice during the calendar year 1996.

1. During this period, what is the (first/next) visit date in your records for (PATIENT NAME)?

_____/_____/_____
MO DAY YR

GLOBAL FEE

2a. 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 (Q3)

2b. 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	MO DAY YR
____/____/____	____/____/____
____/____/____	____/____/____
____/____/____	____/____/____
____/____/____	____/____/____
____/____/____	____/____/____
____/____/____	____/____/____
____/____/____	____/____/____
____/____/____	____/____/____

|__|__|
OFFICE USE ONLY

2c. Do you expect (PATIENT NAME) will receive any future services that will be covered by this same global fee?

YES..... 1
NO 2

2d. Did (PATIENT NAME) receive the services covered by this global fee in a:
[CODE ALL THAT APPLY]

	YES	NO
Physician'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

GO TO Q4a

3. 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

4a. 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.]

4b. Which of these was the principal diagnosis?

DIAGNOSIS:

|__| _____ |__| _____

|__| _____ |__| _____

|__| _____ |__| _____

|__|__|
OFFICE USE ONLY

IF ONLY ONE DIAGNOSIS, GO TO Q5a.
IF MORE THAN ONE DIAGNOSIS:
- CHECK BOX FOR PRINCIPAL DIAGNOSIS
- CIRCLE '999.95' IF PRINCIPAL DIAGNOSIS NOT KNOWN 999.95

|__|__|__| . |__|__|
OFFICE USE ONLY

GLOBAL FEE

YES 1
NO 2 (Q3)

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

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

|__|__|
OFFICE
USE ONLY

YES 1
NO 2

	YES	NO
Physician'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

GO TO Q4a

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

DIAGNOSIS:

|__| _____ |__| _____

|__| _____ |__| _____

|__| _____ |__| _____

|__|__|
OFFICE
USE ONLY

IF ONLY ONE DIAGNOSIS, GO TO Q5a.
IF MORE THAN ONE DIAGNOSIS:
- CHECK BOX FOR PRINCIPAL DIAGNOSIS
- CIRCLE '999.95' IF PRINCIPAL DIAGNOSIS NOT KNOWN 999.95

|__|__|__| . |__|__|
OFFICE USE ONLY

YES 1
NO 2 (Q3)

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

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

|__|__|
OFFICE
USE ONLY

YES 1
NO 2

	YES	NO
Physician'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

GO TO Q4a

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

DIAGNOSIS:

|__| _____ |__| _____

|__| _____ |__| _____

|__| _____ |__| _____

|__|__|
OFFICE
USE ONLY

IF ONLY ONE DIAGNOSIS, GO TO Q5a.
IF MORE THAN ONE DIAGNOSIS:
- CHECK BOX FOR PRINCIPAL DIAGNOSIS
- CIRCLE '999.95' IF PRINCIPAL DIAGNOSIS NOT KNOWN 999.95

|__|__|__| . |__|__|
OFFICE USE ONLY

5a. 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.]

5b. 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?*]

	CPT-4 (including modifier)	Full established charge at time of visit or charge equivalent
a.	_____	$_____.__
b.	_____	$_____.__
c.	_____	$_____.__
d.	_____	$_____.__
e.	_____	$_____.__
f.	_____	$_____.__
g.	_____	$_____.__

|__|__| OFFICE USE ONLY

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

TOTAL CHARGES **$_____.__**

7. 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.]

FEE-FOR-SERVICE BASIS 1
CAPITATED BASIS..... 2 (Q11a)

8. 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 Q7 AND CHANGE CODE TO 2 (CAPITATED BASIS).

a.	Patient or patient's family	$_____.__
b.	Medicare	$_____.__
c.	Medicaid	$_____.__
d.	Private Insurance	$_____.__
e.	VA	$_____.__
f.	CHAMPVA/CHAMPUS	$_____.__
g.	OTHER (SPECIFY): _____	$_____.__

TOTAL PAYMENTS **$_____.__**

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

BOX 1
DO TOTAL PAYMENTS EQUAL TOTAL CHARGES?
YES..... 1 (BOX 2)
NO..... 2 (Q10)

CPT-4 (including modifier)	Full established charge at time of visit or charge equivalent	
a. _____	$_____.__	
b. _____	$_____.__	
c. _____	$_____.__	
d. _____	$_____.__	
e. _____	$_____.__	
f. _____	$_____.__	|__|__| OFFICE USE ONLY
g. _____	$_____.__	

TOTAL CHARGES **$_____.__**

FEE-FOR-SERVICE BASIS 1
CAPITATED BASIS..... 2 (Q11a)

a. Patient or patient's family	$_____.__
b. Medicare	$_____.__
c. Medicaid	$_____.__
d. Private Insurance	$_____.__
e. VA	$_____.__
f. CHAMPVA/CHAMPUS	$_____.__
g. OTHER (SPECIFY): _____	$_____.__

TOTAL PAYMENTS **$_____.__**

BOX 1
DO TOTAL PAYMENTS EQUAL TOTAL CHARGES?
YES ..... 1 (BOX 2)
NO 2 (Q10)

CPT-4 (including modifier)	Full established charge at time of visit or charge equivalent	
a. _____	$_____.__	
b. _____	$_____.__	
c. _____	$_____.__	
d. _____	$_____.__	
e. _____	$_____.__	
f. _____	$_____.__	|__|__| OFFICE USE ONLY
g. _____	$_____.__	

TOTAL CHARGES **$_____.__**

FEE-FOR-SERVICE BASIS 1
CAPITATED BASIS..... 2 (Q11a)

a. Patient or patient's family	$_____.__
b. Medicare	$_____.__
c. Medicaid	$_____.__
d. Private Insurance	$_____.__
e. VA	$_____.__
f. CHAMPVA/CHAMPUS	$_____.__
g. OTHER (SPECIFY): _____	$_____.__

TOTAL PAYMENTS **$_____.__**

BOX 1
DO TOTAL PAYMENTS EQUAL TOTAL CHARGES?
YES ..... 1 (BOX 2)
NO 2 (Q10)

10. 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		
Medicare or Medicaid limit or adjustment.	1	2
Contractual arrangement with insurer or managed care organization	1	2
Courtesy discount	1	2
Insurance write-off	1	2
Other (Specify:)_____	1	2
Expecting additional payment		
Patient or Patient's Family	1	2
Medicare	1	2
Medicaid	1	2
Private Insurance	1	2
VA	1	2
CHAMPVA/CHAMPUS	1	2
Other (Specify:)_____	1	2
Charity care or sliding scale	1	2
Bad debt	1	2
PAYMENTS MORE THAN CHARGES:		
Medicare or Medicaid Adjustment	1	2
Other (Specify:)	1	2

_____

GO TO BOX 2

CAPITATED BASIS

11a. What kind of insurance plan covered the patient for (this visit/these visits)? Was it:

[CODE ALL THAT APPLY]

Medicare; 1
Medicaid; 2
Private Insurance; or 3
Something else? (SPECIFY:) 4
_____
VA/CHAMPVA/CHAMPUS 5
DON'T KNOW 8
NO INSURANCE/NONE 9

11b. Was there a co-payment for (this visit/these visits)?

YES 1
NO 2 (Q11e)

11c. How much was the co-payment?

$_____.__

11d. Who paid the co-payment?

[CODE ALL THAT APPLY]

PATIENT OR PATIENT'S FAMILY 1
MEDICARE 2
MEDICAID 3
PRIVATE INSURANCE 4
OTHER
(SPECIFY:) _____ 5
DON'T KNOW 8

11e. Do your records show any other payments for (this visit/these visits)?

YES 1
NO ..... 2 (BOX 2)

11f. 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, PROBE: And is that Medicare, Medicaid, or private insurance?

a. Patient or patient's family $_____.__
b. Medicare $_____.__
c. Medicaid $_____.__
d. Private Insurance $_____.__
e. VA $_____.__
f. CHAMPVA/CHAMPUS $_____.__
g. OTHER (SPECIFY):
_____ $_____.__

BOX 2
GLOBAL FEE SITUATION
(Q2a=YES) 1 (Q13)
RECORDED FEWER THAN 6 EVENTS 2 (Q13)
OTHERWISE 3 (Q12a)

PAYMENTS LESS THAN CHARGES: YES NO

Adjustment or discount

Medicare or Medicaid limit or adjustment	1	2
Contractual arrangement with insurer or managed care organization	1	2
Courtesy discount	1	2
Insurance write-off	1	2
Other (Specify:)_____	1	2

Expecting additional payment

Patient or Patient's Family	1	2
Medicare	1	2
Medicaid	1	2
Private Insurance	1	2
VA	1	2
CHAMPVA/CHAMPUS	1	2
Other (Specify:)_____	1	2
Charity care or sliding scale	1	2
Bad debt	1	2

PAYMENTS MORE THAN CHARGES:

Medicare or Medicaid Adjustment	1	2
Other (Specify:)	1	2

_____

GO TO BOX 2

PAYMENTS LESS THAN CHARGES: YES NO

Adjustment or discount

Medicare or Medicaid limit or adjustment.	1	2
Contractual arrangement with insurer or managed care organization	1	2
Courtesy discount	1	2
Insurance write-off	1	2
Other (Specify:)_____	1	2

Expecting additional payment

Patient or Patient's Family	1	2
Medicare	1	2
Medicaid	1	2
Private Insurance	1	2
VA	1	2
CHAMPVA/CHAMPUS	1	2
Other (Specify:)_____	1	2
Charity care or sliding scale	1	2
Bad debt	1	2

PAYMENTS MORE THAN CHARGES:

Medicare or Medicaid Adjustment	1	2
Other (Specify:)	1	2

_____

GO TO BOX 2

CAPITATED BASIS

Medicare;	1	
Medicaid;	2	
Private Insurance; or	3	
Something else? (SPECIFY:)	4	
_____		
VA/CHAMPVA/CHAMPUS	5	
DON'T KNOW	8	
NO INSURANCE/NONE	9	
YES	1	
NO	2	(Q11e)
$_____.__		
PATIENT OR PATIENT'S FAMILY	1	
MEDICARE	2	
MEDICAID	3	
PRIVATE INSURANCE	4	
OTHER (SPECIFY:) _____	5	
DON'T KNOW	8	
YES	1	
NO	2	(BOX 2)

a. Patient or patient's family	$_____.__
b. Medicare	$_____.__
c. Medicaid	$_____.__
d. Private Insurance	$_____.__
e. VA	$_____.__
f. CHAMPVA/CHAMPUS	$_____.__
g. OTHER (SPECIFY): _____	$_____.__

Medicare;	1	
Medicaid;	2	
Private Insurance; or	3	
Something else? (SPECIFY:)	4	
_____		
VA/CHAMPVA/CHAMPUS	5	
DON'T KNOW	8	
NO INSURANCE/NONE	9	
YES	1	
NO	2	(Q11e)
$_____.__		
PATIENT OR PATIENT'S FAMILY	1	
MEDICARE	2	
MEDICAID	3	
PRIVATE INSURANCE	4	
OTHER (SPECIFY:) _____	5	
DON'T KNOW	8	
YES	1	
NO	2	(BOX 2)

a. Patient or patient's family	$_____.__
b. Medicare	$_____.__
c. Medicaid	$_____.__
d. Private Insurance	$_____.__
e. VA	$_____.__
f. CHAMPVA/CHAMPUS	$_____.__
g. OTHER (SPECIFY): _____	$_____.__

BOX 2
GLOBAL FEE SITUATION
(Q2a=YES) 1 (Q13)
RECORDED FEWER THAN 6 EVENTS..... 2 (Q13)
OTHERWISE 3 (Q12a)

BOX 2
GLOBAL FEE SITUATION
(Q2a=YES)..... 1 (Q13)
RECORDED FEWER THAN 6 EVENTS 2 (Q13)
OTHERWISE..... 3 (Q12a)

REPEATING IDENTICAL VISITS

12a. Were there any other visits for this patient during 1996 for which the services and charges were identical to the services and charges for the visit on (DATE OF THIS EVENT)?

[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 or mental health therapy or weekly or monthly allergy shots.*]

YES 1
NO 2 (Q13)

12b. During 1996 how many other visits were there for which the services and charges were identical to those on (DATE OF THIS EVENT)?

OF VISITS_____

12c. Please tell me the dates of those other visits.
[IF THERE WERE MORE THAN 30 IDENTICAL VISITS, ENTER THE DATES FOR THE FIRST 30.]

MO/DAY/YR	MO/DAY/YR	MO/DAY/YR
___/____/___	___/____/___	___/____/___
___/____/___	___/____/___	___/____/___
___/____/___	___/____/___	___/____/___
___/____/___	___/____/___	___/____/___
___/____/___	___/____/___	___/____/___
___/____/___	___/____/___	___/____/___
___/____/___	___/____/___	___/____/___
___/____/___	___/____/___	___/____/___
___/____/___	___/____/___	___/____/___
___/____/___	___/____/___	___/____/___

|__|__|
OFFICE USE ONLY

13. Have we covered all of this patient's visits during the calendar year 1996?

YES, ALL EVENTS COVERED 1 (Q14a)
NO, NEED TO COVER ADDITIONAL EVENTS ..... 2 (Q1-NEXT COLUMN)

14a. 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 (Q14b)

PROVIDER REPORTED FEWER EVENTS 2
PROBE: (PATIENT NAME) reported (NUMBER) visits to (PROVIDER) during 1996, but I have only recorded (NUMBER) visits. Do you have any information in your records that would explain this?

_____
_____
_____

14b. GO TO NEXT PATIENT FOR THIS PROVIDER.

14c. IF NO MORE PATIENTS, THANK THE RESPONDENT AND END THE CALL.

REPEATING IDENTICAL VISITS

YES 1
NO 2 (Q13)

OF VISITS_____

MO/DAY/YR	MO/DAY/YR	MO/DAY/YR
___/____/___	___/____/___	___/____/___
___/____/___	___/____/___	___/____/___
___/____/___	___/____/___	___/____/___
___/____/___	___/____/___	___/____/___
___/____/___	___/____/___	___/____/___
___/____/___	___/____/___	___/____/___
___/____/___	___/____/___	___/____/___
___/____/___	___/____/___	___/____/___
___/____/___	___/____/___	___/____/___
___/____/___	___/____/___	___/____/___

|__|__| OFFICE USE ONLY

YES, ALL EVENTS COVERED 1 (Q14a)
NO, NEED TO COVER ADDITIONAL EVENTS ..... 2 (Q1-NEXT COLUMN)

NO DIFFERENCE OR PROVIDER REPORTED MORE EVENTS THAN HOUSEHOLD 1 (Q14b)

PROVIDER REPORTED FEWER EVENTS 2
PROBE: (PATIENT NAME) reported (NUMBER) visits to (PROVIDER) during 1996, but I have only recorded (NUMBER) visits. Do you have any information in your records that would explain this?

_____
_____
_____

YES 1
NO 2 (Q13)

OF VISITS_____

MO/DAY/YR	MO/DAY/YR	MO/DAY/YR
___/____/___	___/____/___	___/____/___
___/____/___	___/____/___	___/____/___
___/____/___	___/____/___	___/____/___
___/____/___	___/____/___	___/____/___
___/____/___	___/____/___	___/____/___
___/____/___	___/____/___	___/____/___
___/____/___	___/____/___	___/____/___
___/____/___	___/____/___	___/____/___
___/____/___	___/____/___	___/____/___
___/____/___	___/____/___	___/____/___

|__|__| OFFICE USE ONLY

YES, ALL EVENTS COVERED 1 (Q14a)
NO, NEED TO COVER ADDITIONAL EVENTS ..... 2 (Q1-NEXT FORM FOR THIS PATIENT)

NO DIFFERENCE OR PROVIDER REPORTED MORE EVENTS THAN HOUSEHOLD 1 (Q14b)

PROVIDER REPORTED FEWER EVENTS 2
PROBE: (PATIENT NAME) reported (NUMBER) visits to (PROVIDER) during 1996, but I have only recorded (NUMBER) visits. Do you have any information in your records that would explain this?

_____
_____
_____

_____/_____/_____
MO DAY YR

_____/_____/_____
MO DAY YR