OMB#: 0935-0098

PATIENT ID:
PROVIDER ID:
CMS/ID/NORC ID:
PROVIDER NAME:
EVENT TYPE:
OF EVENTS:

TOTAL NUMBER OF FORMS _____

MEDICAL EXPENDITURE PANEL SURVEY

MEDICAL PROVIDER SURVEY

MEDICAL EVENT BOOKLET

FOR

OFFICE-BASED PROVIDERS

REFERENCE YEAR 1997

(PATIENT NAME) reported that (he/she) received health care services from someone in this practice during the calendar year 1997.

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

Visit Date

__________/__________/__________
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.*]

Global fee

YES 1
NO 2 (Q3)

2b. What other dates of service were covered by this global fee? Please include dates before or after 1997 if they were included in the global fee.

Other Dates of Service

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

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

Yes, No

YES 1
NO 2

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

Physician's Office
Hospital as an Inpatient
Admit date - Stay 1
Discharge date - Stay 1
Admit date - Stay 2
Discharge date - Stay 2
Admit date - Stay 3
Discharge date - Stay 3
Hospital Outpatient Department
Hospital Emergency Room
Somewhere else
Somewhere else Specify, Text

	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 ______/____/____
c. Stay 3 ____/____/____ to ______/____/____

|__|__|
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	YES	NO
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,
Hospital as an Inpatient,
Hospital Outpatient Department,
Hospital Emergency Room,
Somewhere else,

Somewhere else Specify, Text

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?

Check box
Condition Code Number
Condition Description, Text

DIAGNOSIS:

|__| ____________________
|__| ____________________
|__| ____________________
|__| ____________________
|__| ____________________
|__| ____________________
|__| ____________________
|__| ____________________

|__|__|
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Principal Diagnosis
Principal Diagnosis, Text

IF ONLY ONE DIAGNOSIS, GO TO Q5a.
IF MORE THAN ONE DIAGNOSIS:

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

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 Code Number
Description of Services, Text
Full Established Charge

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

Total Charges

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,
Capitated Basis,
Both

FEE-FOR-SERVICE BASIS 1
CAPITATED BASIS.................................. 2 (Q11a)
BOTH 3

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 OR HMO, 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).

Patient or Family Payment
Medicare Payment
Medicaid Payment
Private Insurance Payment
VA payment
CHAMPVA/CHAMPUS Payment
Worker's Comp Payment
Other Source of Payment
Other Source Specify, Text

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): $___________.___
____

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

Total Payments

TOTAL PAYMENTS $___________.___

BOX 1

BOX 1
DO TOTAL PAYMENTS EQUAL TOTAL CHARGES?
YES .... 1 (BOX 2)
NO 2 (Q10)
IF Q7 = 3........ 3 (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.]

Adjustment or discount
Medicare or Medicaid limit
Contractual arrangement
Courtesy discount
Insurance write-off
Worker's Comp
Other
Other Specify, Text
Expecting additional payment
Patient or Family
Medicare
Medicaid
Private Insurance
VA
CHAMPVA/CHAMPUS
Worker's Comp
Other
Other Specify, Text
Charity care or sliding scale
Bad debt
Payments more than charges
Medicare or Medicaid adjustment
Other
Other Specify, Text

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
Worker's Comp limit or adjustment	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
WORKER'S COMP	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]
IF NAME OR INSURER OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance?

Medicare
Medicaid
Private Insurance
Something else
Something else Specify, Text
VA/CHAMPVA/CHAMPUS
Worker's Comp
Don't Know
No insurance/None

Medicare;	1
Medicaid;..	2
Private Insurance; or................................	3
Something else? (SPECIFY:)	4
________________________________	
VA/CHAMPVA/CHAMPUS	5
WORKER'S COMP	6
DON'T KNOW	8
NO INSURANCE/NONE	9

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

Yes, No

YES	1
NO	2 (Q11e)

11c. How much was the co-payment? **Co-payment amount**	$ ___________.___
11d. Who paid the co-payment? [CODE ALL THAT APPLY] IF NAME OR INSURER OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance? **Patient or Family** **Medicare** **Medicaid** **Private insurance** **Other** **Other Specify, Text** **Don't Know**	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, No**	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? **Patient or Family** **Medicare** **Medicaid** **Private Insurance** **VA** **CHAMPVA/CHAMPUS** **Worker's Comp** **Other** **Other Specify, Text**	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): _____________________ $___________.__

BOX 2

GLOBAL FEE SITUATION (Q2a=YES)...............................1 (Q13)
RECORDED 5 OR FEWER EVENTS..................................2 (Q13)
RECORDED 6 OR MORE EVENTS..................................3 (Q12a)

BOX 2

REPEATING IDENTICAL VISITS

12a. Were there any other visits for this patient during 1997 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, No**	YES .... 1 NO 2 (Q13)
12b. During 1997 how many other visits were there for which the services and charges were identical to those on (DATE OF THIS EVENT)? **Number of Identical Visits**	# 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.] **Other Identical Visit Dates**	MO/DAY/YR MO/DAY/YR MO/DAY/YR ___/____/___ ___/____/___ ___/____/___ (×10 rows) |__|__| OFFICE USE ONLY

13. Have we covered all of this patient's visits during the calendar year 1997? **Yes, all events covered,** **No, need to cover additional events**	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 more events reported,** **Fewer events reported** **Explanation of discrepency, Text**	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 1997, 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.