MEDICAL EXPENDITURE PANEL SURVEY

MEDICAL PROVIDER COMPONENT

MEDICAL EVENT FORM

FOR

HOME CARE - NON-HEALTH CARE PROVIDERS

FOR

REFERENCE YEAR 2009

INTRODUCTION: (PATIENT NAME) reported that (he/she) received home care services from someone in this organization during the calendar year 2009.

1 CONFIRM PATIENT RECEIVED SERVICES (GO TO HOWBILL)

2 PROVIDER KNOWS PATIENT BUT NO EVENTS RECORDED FOR 2009 (GO TO NEXT PATIENT, PAIR IS FINAL)

3 PROVIDER DOES NOT KNOW PATIENT (GO TO NEXT PATIENT, REVIEW TO SEE IF DISAVOWAL IS ELIGIBLE FOR CONVERSION)

HOWBILL: How did you bill for the services provided in (PATIENT NAME)'s home during the calendar year 2009? Was it:

1 By month; [REFERENCES TO BILLING PERIOD IN EVENT FORM WILL BE BY MONTH]

2 By 60-day episode; or [REFERENCES TO BILLING PERIOD IN EVENT FORM WILL BE BY 60-DAY EPISODE]

3 By some other period? [REFERENCES TO BILLING PERIOD IN EVENT FORM WILL BE BY WHAT'S SPECIFIED]

(IF SOME OTHER PERIOD: What was that?)

_____

D1. During calendar year 2009, what
(was the (first/next) month/
were the begin and end dates of the (first/next) 60-day episode/
were the begin and end dates of the (first/next) OTHER PERIOD)
during which your records show that services were provided in (PATIENT NAME)'s home?

MONTH: _____ YEAR: 2009

OR

BEGIN DATE: MONTH / DAY / YEAR
END DATE: MONTH / DAY / YEAR

D2. I need to know which type or types of persons provided services at (PATIENT NAME)'s home (during (MONTH)/from (BEGIN DATE) through (END DATE)) and either the number of hours or the number of visits for each type.

SELECT ALL THAT APPLY

EXPLAIN IF NECESSARY: By type of person I mean a housekeeper, therapist, nurse aide, yard worker, and so forth.

	HOURS/MINUTES:		VISITS:
1. HOME CARE AID	_____ / _____	OR	____
2. HOMEMAKER (INCLUDE HOUSEKEEPER)	_____ / _____	OR	____
3. I.V./ INFUSION THERAPIST	_____ / _____	OR	____
4. NURSE/NURSE PRACTITIONER	_____ / _____	OR	____
5. NURSE'S AIDE	_____ / _____	OR	____
6. OCCUPATIONAL THERAPIST	_____ / _____	OR	____
7. PERSONAL CARE ATTENDANT	_____ / _____	OR	____
8. PHYSICAL THERAPIST	_____ / _____	OR	____
9. RESPIRATORY THERAPIST	_____ / _____	OR	_____
10. SOCIAL WORKER	_____ / _____	OR	_____
11. SPEECH THERAPIST	_____ / _____	OR	_____
12. OTHER (SPECIFY): _____	_____ / _____	OR	_____
21. YARD WORKER	_____ / _____	OR	_____
22. DRIVER	_____ / _____	OR	_____
23. BABYSITTER	_____ / _____	OR	_____

D3. I need a description of the services provided (during (MONTH)/from (BEGIN DATE) through (END DATE)).

	YES	NO
CLEANING OR YARD WORK.....	1	2
TRANSPORTATION	1	2
SHOPPING.....	1	2
EMOTIONAL SUPPORT PERSON OR ONE-ON-ONE BUDDY.....	1	2
SUPPORT GROUPS.....	1	2
CHILD CARE.....	1	2
OTHER (SPECIFY): _____.....	1	2

C2. What were the charges for the services provided to (PATIENT NAME) (during (MONTH)/from (BEGIN DATE) through (END DATE))?

TOTAL CHARGES: **$**_____**.**__

VERIFY: Is this the total charge for (this/these) service(s)? IF NOT, RECORD TOTAL CHARGE.

C4a. From which of the following sources did the organization receive payment for the charges (for (MONTH)/from (BEGIN DATE) through (END DATE)) and how much was paid by each source?

SELECT ALL THAT APPLY

[DCS ONLY] IF NAME OF INSURER, PUBLIC, OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance?

[SYSTEM WILL ALLOW FOR A MAXIMUM OF 20 SOURCES OF PAYMENT TO BE COLLECTED]

OTHER SPECIFY: PROBE FOR SOURCE OF FUNDS AND TYPE OF PLAN.

a. Patient or Patient's Family; **$**_____**.**__

b. Medicare; **$**_____**.**__

c. Medicaid; **$**_____**.**__

d. Private Insurance; **$**_____**.**__

e. VA/Champva; **$**_____**.**__

f. Tricare; **$**_____**.**__

g. Worker's Comp; or **$**_____**.**__

h. Something else?
(IF SOMETHING ELSE: What was that?)
_____ **$**_____**.**__

C5. I show the total of all payments received (for (MONTH)/from (BEGIN DATE) through (END DATE)) as [SYSTEM WILL COMPUTE AND DISPLAY TOTAL]. Is that correct?
IF NO, CORRECT ENTRIES ABOVE AS NEEDED.

TOTAL PAYMENTS: **$**_____**.**__

BOX 1

DO TOTAL PAYMENTS EQUAL TOTAL CHARGES?

YES, AND ALL PAID BY PATIENT OR PATIENT'S FAMILY…… 1 (GO TO D4)

YES, OTHER PAYERS……2 (GO TO C5a)

NO…….. ……3 (GO TO C6)

IF, AFTER VERIFICATION, PAYMENTS DO NOT EQUAL CHARGES COMPLETE C6 AND GO TO D4

C5a I recorded that the payment(s) you received equal the charges. I would like to make sure that I have this recorded correctly. I recorded that the total payment is [SYSTEM WILL DISPLAY TOTAL PAYMENT FROM C5]. Does this total payment include any other amounts such as adjustments or discounts, or is this the final payment?
IF NECESSARY, READ BACK AMOUNT(S) RECORDED IN C4a.

YES, FINAL PAYMENTS RECORDED IN C4a AND C5……..1 (GO TO D4)

NO……..2 (GO BACK TO C4a)

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.

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; or	1	2
h. Something else? ……..	1	2

(IF SOMETHING ELSE: What was that?)

_____

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/Champva;	1	2
n. Tricare;	1	2
o. Worker's Comp; or	1	2
p. Something else? ……..	1	2

(IF SOMETHING ELSE: What was that?)

_____

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; or	1	2
v. Something else?	1	2

(IF SOMETHING ELSE: What was that?)

_____

D4. Have we covered all of the (months/60-day episodes/OTHER PERIODS) your organization provided services to (PATIENT NAME) during the calendar year 2009?

YES, ALL (MONTHS/60-DAY EPISODES/OTHER PERIODS) COVERED..... 1 (GO TO D5)

NO, NEED TO COVER ADDITIONAL (MONTHS/60-DAY EPISODES/OTHER PERIODS)……..2 (GO TO D1-NEXT EVENT FORM)

D5. IF ALL (MONTHS/60-DAY EPISODES/OTHER PERIODS) ARE COMPLETED FOR THIS PATIENT, REVIEW NUMBER OF MONTHS OF HOME CARE SERVICE REPORTED BY HOUSEHOLD. IF FEWER MONTHS OF SERVICE ARE REPORTED BY THE HOME CARE ORGANIZATION, PROBE TO EXPLAIN THE DIFFERENCE.

[SYSTEM WILL COMPUTE NUMBER OF MONTHS REPORTED BY THE HOME CARE ORGANIZATION AND COMPARE IT TO THE NUMBER OF MONTHS REPORTED BY HOUSEHOLD]

NO DIFFERENCE OR PROVIDER REPORTED MORE MONTHS OF HOME CARE SERVICE THAN HOUSEHOLD ..... 1 (GO TO D6)

PROVIDER RECORDED FEWER VISITS:..... 2

[DCS ONLY] PROBE: (PATIENT NAME) reported (NUMBER) months of home care service during 2009, but I have only recorded (NUMBER) months. Do you have any information in your records that would explain this discrepancy?

DON'T KNOW……1
UNACCESSIBLE ARCHIVED RECORDS….2
ACCESSIBLE ARCHIVED RECORDS…….. 3
COLLECT CONTACT INFORMATION FOR PERSON WITH RECORDS

OTHER (SPECIFY):…….. 4

_____

_____

D6. GO TO NEXT PATIENT FOR THIS PROVIDER.
IF NO MORE PATIENTS, THANK THE RESPONDENT AND END THE CALL.