Form Approved
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MEDICAL EXPENDITURE PANEL SURVEY
MEDICAL PROVIDER COMPONENT
EVENT FORM
FOR
HOME CARE - HEALTH CARE PROVIDERS
FOR
REFERENCE YEAR 2011

OMB

DCS: READ THIS ALOUD ONLY IF REQUESTED BY RESPONDENT.

PRESS NEXT TO CONTINUE IN THIS EVENT FORM

PRESS BREAKOFF TO DISCONTINUE

BILLING

Did you bill for the services provided in (PATIENT NAME)'s home during the calendar year 2011 by month, by 60-day period, or by week?

BY MONTH ..... = 1
BY 60-DAY PERIOD ..... = 2
BY SOME OTHER PERIOD?
(USE THIS RESPONSE ONLY IF PROVIDER ABSOLUTELY CANNOT CALCULATE COSTS BY MONTH)..... = 3
BY WEEK ..... = 4

(IF SOME OTHER PERIOD: What was that?)

VISIT DATE

E1. During calendar year 2011, what (was the (first/next) month/were the begin and end dates of the (first/next) 60-day period/were the begin and end dates of the (first/next) OTHER PERIOD/were the begin and end dates of the (first/next) weekly period) during which your records show that services were provided in (PATIENT NAME)'s home?

REFERENCE PERIOD – CALENDAR YEAR 2011

MONTH:

Month:_____
Day:_____
Year:_____

OR

BEGIN DATE:

Month:_____
Day:_____
Year:_____

END DATE:

Month:_____
Day:_____
Year:_____

DIAGNOSES

E2. 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. RECORD UP TO FIVE ICD-9 CODES OR DESCRIPTIONS.

ICD-9 CODE_____ DESCRIPTION:_____

CHECK HERE IF THIS IS AN ICD-10 CODE

[SYSTEM WILL ALLOW FOR A MAXIMUM OF 5 ICD-9 CODES TO BE COLLECTED
CONTINUE TO B5a.]

SERVICES/CHARGES

E3. I need to know which types of home care personnel provided care to (PATIENT NAME) (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.

1. HOME HEALTH AIDE

   HOURS/MINUTES_____ VISITS_____

2. HOMEMAKER

   HOURS/MINUTES_____ VISITS_____

3. I.V./INFUSION THERAPIST

   HOURS/MINUTES_____ VISITS_____

4. NURSE/ NURSE PRACTIONER

   HOURS/MINUTES_____ VISITS_____

5. NURSE'S AIDE

   HOURS/MINUTES_____ VISITS_____

6. OCCUPATIONAL THERAPIST

   HOURS/MINUTES_____ VISITS_____

7. PERSONAL CARE ATTENDANT

   HOURS/MINUTES_____ VISITS_____

8. PHYSICAL THERAPIST

   HOURS/MINUTES_____ VISITS_____

9. RESPIRATORY THERAPIST

HOURS/MINUTES_____ VISITS_____

10. SOCIAL WORKER

HOURS/MINUTES_____ VISITS_____

11. SPEECH THERAPIST

HOURS/MINUTES_____ VISITS_____

12. YARD WORKER

HOURS/MINUTES_____ VISITS_____

13. DRIVER

HOURS/MINUTES_____ VISITS_____

14. BABYYSITTER

HOURS/MINUTES_____ VISITS_____

15. Any other home care personnel?

YES 1
NO 2

16. DURABLE MEDICAL EQUIPMENT?

YES 1
NO 2

E4. I need the services provided (during (MONTH)/from (BEGIN DATE) through (END DATE)). I would prefer either the CPT-4 codes or the revenue codes, if they are available.

RECORD CPT-4 CODE OR REVENUE CODE. IF CODES ARE NOT USED, RECORD DESCRIPTION OF SERVICES AND PROCEDURES PROVIDED.

IF ENTERING A CPT-4 CODE, ENTER UP TO 8 CHARACTERS. IF CPT-4 CODE BEGINS WITH W, X, Y OR Z, ENTER A DESCRIPTION INSTEAD.

CPT-4 CODE:_____ REVENUE CODE: _____ DESCRIPTION:_____
CPT-4 CODE:_____ REVENUE CODE: _____ DESCRIPTION:_____
CPT-4 CODE:_____ REVENUE CODE: _____ DESCRIPTION:_____
CPT-4 CODE:_____ REVENUE CODE: _____ DESCRIPTION:_____

C1a. Could you tell me the **full established charges** -- before any adjustments or discounts -- for all services provided by home care personnel (during (MONTH)/from (BEGIN DATE) through (END DATE)).

EXPLAIN IF NECESSARY: This would be the charges for the (READ TYPES OF PERSONNEL FROM E3 ABOVE) who provided services (during (MONTH)/from (BEGIN DATE) through (END DATE)).

EXPLAIN IF NECESSARY: The **full established charge** is the charge maintained in the organization'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 organizations that don't charge on the basis of services provided 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?

NOTE: WE NEVER ENTER $0 FOR A CHARGE

$_____.____

C1b. And could you tell me the **full established charges** for everything **other** than personnel services (during (MONTH)/from (BEGIN DATE) through (END DATE)), including durable medical equipment, drugs, supplies, and so forth?

EXPLAIN IF NECESSARY: This would include charges for anything **other** than the services of the home care personnel you just told me about.

IF THOSE COSTS WERE INCLUDED IN PERSONNEL CHARGES, RECORD 0.00 AND CHECK THE BOX.

NOTE: WE NEVER ENTER $0 FOR A CHARGE

$_____.____

___ CHECK HERE IF INCLUDED WITH PERSONNEL CHARGES

C2. I show the total of all of the full, established charges for (PATIENT NAME) AS [SYSTEM WILL COMPUTE AND DISPLAY TOTAL] / I show the charge as undetermined. / I show the charge as [SYSTEM WILL COMPUTE AND DISPLAY TOTAL], although one or more charges are missing. Is that correct?

IF INCORRECT, CORRECT ENTRIES SHOWN ABOVE AS NEEDED

YES 1
NO 2

[If C1a is DK/REF/RETRIEVABLE – CONTINUE TO C1b.
If C1b is DK/REF/RETRIEVABLE – CONTINUE TO C2.]

REIMBURSEMENT TYPE

C3. Was your organization reimbursed for the charges (during (MONTH)/from (BEGIN DATE) through (END DATE)) 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.

IF IN DOUBT, CODE FEE-FOR-SERVICE

Fee-for-service basis 1
Capitated basis ..... 2 (go to C7a)

SOURCES OF PAYMENT

C4. From which of the following sources did your organization receive payment for the charges (for (MONTH)/from (BEGIN DATE) through (END DATE)) and how much was paid by each source? Please include all payments that have taken place between (MONTH/BEGIN DATE) and now for this care.

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

[DCS ONLY] IF PROVIDER VOLUNTEERS THAT PATIENT PAYS A SET DOLLAR AMOUNT FOR ALL CHARGES (DURING (MONTH)/FROM (BEGIN DATE) THROUGH (END DATE)), VERIFY: So, you receive a set dollar amount for all charges (for (MONTH)/from (BEGIN DATE) through (END DATE)) rather than payment for the specific service? IF YES: GO BACK TO C3 AND CODE AS CAPITATED BASIS.

IF THE ONLY PAYMENT FOR THIS EVENT WAS A LUMP SUM, ANSWER “NO” BELOW.

a. Patient or Patient’s Family ..... $_____.____
b. Medicare ..... $_____.____
c. Medicaid ..... $_____.____
d. Private Insurance ..... $_____.____
e. VA/Champva ..... $_____.____
f. Tricare ..... $_____.____
g. Worker’s Comp; ..... $_____.____
h. Or something else? ..... $_____.____
(IF SOMETHING ELSE: What was that? _____)

C5. I show the total of all payments received for (MONTH) / (BEGIN DATE) through (END DATE)) as [SYSTEM WILL COMPUTE AND DISPLAY TOTAL]. Is that correct?

NO, CORRECT ENTRIES ABOVE AS NEEDED.

YES=1, NO=2

[If C4 is DK/REF/RETRIEVABLE – CONTINUE TO C5.
If C5 is DK/REF/RETRIEVABLE – CONTINUE TO BOX 1.]

BOX 1

DO TOTAL PAYMENTS EQUAL TOTAL CHARGES?

YES, AND ALL PAID BY PATIENT OR PATIENT'S FAMILY..... **– 1 (GO TO LSPCHECK)**
YES, OTHER PAYERS..... **- 2 (GO TO C5a)**
NO, PAYMENTS < CHARGES ..... **- 3 (GO TO PLC1)**
NO, PAYMENTS > CHARGES ..... **- 3 (GO TO Q6_EXCEEDED)**

VERIFICATION OF PAYMENT

C5a. I recorded that the payment(s) you received equal the charge(s). 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 C4.

YES, FINAL PAYMENTS RECORDED IN C4 AND C5..... = 1 (GO TO LUMP SUM PAYMENT QUESTION)
NO ..... = 2 (GO BACK TO C4a)

PAYMENTS LESS THAN CHARGES

PLC1. It appears that the total payments were less than the total charge. Is that because...

a. There were adjustments or discounts ..... YES=1 NO=2
b. You are expecting additional payment .... YES=1 NO=2
c. This was charity care or sliding scale ..... YES=1 NO=2
d. This was bad debt ..... YES=1 NO=2

[If [a=1 and b=1] or [a=2 and b=2 and c=2 and d=2] then show both C6_adjustments **and** C6_additional.
If both c=1 **and** d=1 with no other selection, show neither C6_adjustments or C6_additional.
If both c=1 **or** d=1 with no other selection, show neither C6_adjustments or C6_additional.]

DIFFERENCE BETWEEN PAYMENTS AND CHARGES

C6. It appears that the total payments were (less than/more than) the total charges. What is the reason for that difference? Please include all adjustment activity that has taken place between (VISIT DATE) and now for (this visit/these visits). Was it a:

C6_adjustments
PAYMENTS LESS THAN CHARGES:
Adjustment or discount

a. Medicare limit or adjustment? ..... YES=1 NO=2
b. Medicaid limit or adjustment? ..... YES=1 NO=2
c. Contractual arrangement with insurer or managed care organization? ..... YES=1 NO=2
d. Courtesy discount? ..... YES=1 NO=2
e. Insurance write-off? ..... YES=1 NO=2
f. Worker's Comp limit or adjustment? ..... YES=1 NO=2
g. Eligible veteran? ..... YES=1 NO=2
h. Something else? ..... YES=1 NO=2
(IF SOMETHING ELSE: What was that? _____)

C6_additional

Expecting additional payment

i. Patient or Patient's Family? ..... YES=1 NO=2
j. Medicare? ..... YES=1 NO=2
k. Medicaid? ..... YES=1 NO=2
l. Private Insurance? ..... YES=1 NO=2
m. VA/Champva? ..... YES=1 NO=2
n. Tricare? ..... YES=1 NO=2
o. Worker's Comp? ..... YES=1 NO=2
p. Something else ..... YES=1 NO=2
(IF SOMETHING ELSE: What was that? _____)

Q6_exceeded

q. Charity care or sliding scale?..... YES=1 NO=2
r. Bad debt?..... YES=1 NO=2

Q6_extra
PAYMENTS MORE THAN CHARGES:

s. Medicare adjustment?..... YES=1 NO=2
t. Medicaid adjustment?..... YES=1 NO=2
u. Private insurance adjustment?..... YES=1 NO=2
v. Something else?..... YES=1 NO=2
(IF SOMETHING ELSE: What was that? _____)

It appears that the total payments were more than the total charges. What is the reason for that difference? Please include all adjustment activity that has taken place between (DATE) and today. Was it (a)

[After C6 - GO TO LUMP SUM PAYMENT QUESTION]

LUMP SUM PAYMENTS

LSPCHECK WAS ANY LUMP SUM ASSOCIATED WITH THE SOURCES OF PAYMENT?

YES 1
NO 2

[GO TO FINISH.]

CAPITATED BASIS

C7a. What kind of insurance plan covered the patient (for (MONTH)/from (BEGIN DATE) through (END DATE))? Was it:

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

a. Medicare? ..... YES=1 NO=2
b. Medicaid? .....YES=1 NO=2
c. Private Insurance? ..... YES=1 NO=2
d. VA?Champva? ..... YES=1 NO=2
e. Tricare? ..... YES=1 NO=2
f. Worker's Comp? ..... YES=1 NO=2
g. Something else? ..... YES=1 NO=2
(IF SOMETHING ELSE: What was that? _____)

C7b. Was there a co-payment for any of the services provided (for (MONTH)/from (BEGIN DATE) through (END DATE))?

YES 1
NO ..... 2 (GO TO C7e)

[If C7a is DK/REF/RETRIEVABLE – CONTINUE TO C7b.
If C7b is DK/REF/RETRIEVABLE – GO TO C7e.]

C7c. What was the total of all co-payments (for (MONTH) /from(BEGIN DATE) through (END DATE))?

$_____.____

C7d. Who paid the co-payment? Was it:

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

a. Patient or Patient's Family? ..... YES=1 NO=2
b. Medicare? ..... YES=1 NO=2
c. Medicaid? ..... YES=1 NO=2
d. Private Insurance? ..... YES=1 NO=2
e. Something else ..... YES=1 NO=2
(IF SOMETHING ELSE: What was that? _____)

If C7c is DK/REF/RETRIEVABLE – CONTINUE TO C7d.
If C7d is DK/REF/RETRIEVABLE – CONTINUE TO C7e.]

C7e. Do your records show any other payments for any of the services provided (for (MONTH)/from (BEGIN DATE) through (END DATE))?

YES 1
NO 2

[If DK/REF/RETRIEVABLE – GO TO FINISH.]

C7f. From which of the following other sources has the practice received payment for (this visit/these visits) and how much was paid by each source? Please include all payments that have taken place between (MONTH/BEGIN DATE) and now for this care. Was it:

RECORD PAYMENTS FROM APPLICABLE PAYERS.

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

a. Patient or Patient's Family ..... $_____.____
b. Medicare ..... $_____.____
c. Medicaid ..... $_____.____
d. Private Insurance ..... $_____.____
e. VA/Champva ..... $_____.____
f. Tricare ..... $_____.____
g. Worker's Comp; ..... $_____.____
h. Or something else? ..... $_____.____
(IF SOMETHING ELSE: What was that? _____)

[If DK/REF/RETRIEVABLE – CONTINUE TO FINISH.]

FINISH SCREEN

PRESS VALIDATE TO COMPLETE THIS EVENT FORM.