Form Approved
OMB No. 0935-0118
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MEDICAL EXPENDITURE PANEL SURVEY

MEDICAL PROVIDER COMPONENT

MEDICAL EVENT FORM

FOR

HOME CARE - HEALTH CARE PROVIDERS

FOR

REFERENCE YEAR 2010

VERSION 1.0

Revision History

Version	Author/Title	Date	Comments
1.0	Multiple RTI and SSS authors	3/25/10	

1. VERIFY ALL PATIENT(S)

First, I'd like to review the patient(s) in our study who reported receiving care from your practice or facility during 2010. I'm going to read their names to you, and for each one please confirm whether the patient received health care services from you during the calendar year 2010.

For each of the patient(s) you confirm as receiving care during the calendar year 2010, I'll need to ask about services you provided and charges for those services. I will ask about each confirmed patient individually.

READ EACH PATIENT NAME FROM THE LIST. IF THE PERSON ON THE PHONE SAYS "NO", ASK: Did the patient receive services in some year other than 2010, or do you have no records at all?

FOR EACH LISTED PATIENT, CHOOSE A RESPONSE FROM THE DROP-DOWN LIST IN THE PATIENT CONFIRMATION COLUMN BELOW.

ONCE YOU CONFIRM A PATIENT FOR 2010, CLICK ON THE NAME OF THAT PATIENT AND COMPLETE THE EVENT FORM(S) FOR THAT PATIENT.

2. PATIENT DISAVOWAL

Finally, I need to review with you the patient(s) in the list who you indicated did not receive care during the calendar year 2010.

3. CLOSE OUT THE CALL

Thank you for your time.

INTRODUCTION: (PATIENT NAME) reported that (he/she) received home care services from someone in this organization during the calendar year 2010.

1 CONFIRM PATIENT RECEIVED SERVICES (GO TO HOWBILL)

2 PROVIDER KNOWS PATIENT BUT NO EVENTS RECORDED FOR 2010 (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)

OMB SECTION

DCS: READ THIS ALOUD ONLY IF REQUESTED BY RESPONDENT.

PRESS NEXT TO CONTINUE IN THIS EVENT FORM

PRESS BREAKOFF TO DISCONTINUE

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OMB No. 0935-0118; Exp. Date 1/31/2013

HOWBILL: How did you bill for the services provided in (PATIENT NAME)'s home during the calendar year 2010? 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?)

_____

E1. During calendar year 2010, 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 home care services were provided to (PATIENT NAME)?

MONTH: _____ YEAR: 2010

OR

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

E2. I need to know the diagnosis for (PATIENT NAME) (during (MONTH)/from (BEGIN DATE) through (END DATE)). I would prefer the ICD-9 codes (or DSM-IV codes), if they are available.

IF CODES ARE NOT USED, RECORD DESCRIPTIONS.

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

CODE	DESCRIPTION
_____	_____
_____	_____
_____	_____
_____	_____

Any more diagnoses?

YES……1
(GO BACK TO E2)
NO……..2
(GO TO E3)

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.

	HOURS/MINUTES:		VISITS:
1. HOME HEALTH AIDE	_____ / _____	OR	_____
2. HOMEMAKER	_____ / _____	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. YARD WORKER	___ __ / _____	OR	_____
13. DRIVER	_ ____ / _____	OR	_____
14. BABYSITTER	_ ____ / _____	OR	_____
15. ANY OTHER HOME CARE PERSONNEL? (SPECIFY): _____	_____ / _____	OR	_____

16. CHECK HERE IF CURRENT BILLING PERIOD PROVIDED JUST DURABLE MEDICAL EQUIPMENT |__|

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.

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

[SYSTEM WILL SET UP AS A LOOP, SO NO LIMIT ON CPT-4 CODES REQUIRED]

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

Any more services?

YES……1
(GO BACK TO E4)
NO……..2
(GO TO C1a)

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?

FULL ESTABLISHED CHARGES FOR:

PERSONNEL SERVICES: $_____.____

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.

ALL OTHER CHARGES: $_____.____
(NON-PERSONNEL CHARGES)

☐ INCLUDED WITH PERSONNEL CHARGES

C2. I show the total of all of the full, established charges for (PATIENT NAME) (during (MONTH)/from (BEGIN DATE) through (END DATE)) as [SYSTEM WILL COMPUTE AND DISPLAY TOTAL]. Is that correct?

YES……1
(GO TO C3)
NO……..2
(GO BACK TO C1a)

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 organization 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)

C4. 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? Please include all payments that have taken place between (MONTH of 2010/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?

[SYSTEM WILL SET UP "SOMETHING ELSE" AS A LOOP, SO NO LIMIT REQUIRED]

[DCS ONLY] IF PROVIDER VOLUNTEERS THAT PATIENT PAYS A SET DOLLAR AMOUNT FOR ALL CHARGES (FOR (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.

RECORD PAYMENTS FROM ALL APPLICABLE PAYERS.

a. Patient or Patient's Family; $_____.____

b. Medicare; $_____.____

c. Medicaid; $_____.____

d. Private Insurance; $_____.____

e. VA/Champva; $_____.____

f. Tricare; $_____.____

g. Worker's Comp; or $_____.____

h. Any more sources?
(IF ANY MORE SOURCES: 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.

IF THE ONLY PAYMENT FOR THIS EVENT WAS A LUMP SUM, PAYMENT SHOULD BE "ZERO."

CHARGES
Service charge: Charge=$.
Charges Total Amount=$.

TOTAL PAYMENTS: $_____.____

[NAME OF PAYER]

YES ..... 1 (GO TO BOX 1)
NO……..2 (GO BACK TO C4)

BOX 1

DO TOTAL PAYMENTS EQUAL TOTAL CHARGES?

YES, AND ALL PAID BY PATIENT OR PATIENT'S FAMILY…… 1 (GO TO E5)

YES, OTHER PAYERS……2 (GO TO C5a)

NO…….. ……3 (GO TO UNDERPAYMENT SECTION IF PAYMENTS LESS THAN CHARGES; GO TO C6 OVERPAYMENT SECTION IF PAYMENTS MORE THAN CHARGES)

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 E5)

NO……..……2 (GO BACK TO C4)

UNDERPAYMENT

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 GO TO C6_ADJUSTMENTS.

IF b=1 GO TO C6_ADDITIONAL.

IF a=1 AND b=1 GO TO BOTH C6_ADJUSTMENTS AND C6_ADDITIONAL.

IF (a=2 AND b=2 AND c=2 AND D=2) GO TO C6_ADJUSTMENTS, C6_ADDITIONAL, AND C6 EXCEEDED.

IF BOTH c=1 and d=1 WITH NO OTHER SELECTION, GO TO LSP CHECK.

IF c=1 OR d=1 WITH NO OTHER SELECTION, GO TO LSP CHECK.]

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 (MONTH of 2010/BEGIN DATE) and now for this care.

CODE 1 (YES) FOR ALL REASONS MENTIONED.

C6 ADJUSTMENTS

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?)

_____

C6 ADDITIONAL

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?)

_____

C6 EXCEEDED *(Note: this is displayed only if all responses to PLC1 are "No.")*

q. **Charity care or sliding scale;**	1	2
r. **Bad debt;**	1	2

C6 OVERPAYMENT

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?)

_____

(GO TO LSPCHECK)

LSPCHECK

WAS THIS EVENT COVERED BY A LUMP SUM?

YES	1 (GO TO LSPREVIEW)
NO	2 (GO TO E5)

LSPREVIEW

WAS CURRENT MEDICAL EVENT COVERED BY A PAYMENT NOT ALREADY DEPICTED HERE?

YES, I NEED TO RECORD A NEW PAYMENT	1 (GO TO LSP DETAIL)
NO, PAYMENT ALREADY SHOWN ABOVE	2 (GO TO E5)

[PREVIOUSLY REPORTED LUMP PAYMENTS, PAYER, AND AMOUNT WILL LIST ABOVE RESPONSE OPTIONS.]

LSP DETAIL

LSP1. How much was that payment? Amount_____

LSP2. Who made the payment?

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:
PLEASE SPECIFY)
_____

LSP3. Where else was the payment applied? I will record the date and total charge of those other events where payment was applied.

Month: ___

Day: ___

Year: ____

Charge: _____

Were there any other events where this payment was applied?

YES	1 (GO BACK TO LSP3)
NO	2 (GO TO LSPANYMORE)

LSP ANYMORE

Were there any other events where this payment was applied?

YES	1 (GO BACK TO LSP1)
NO	2 (GO TO E5)

CAPITATED BASIS

C7a. What kind of insurance plan covered the patient (during (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?

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

	YES	NO
a. Medicare;	1	2
b. Medicaid;	1	2
c. Private Insurance;	1	2
d. VA/Champva;	1	2
e. Tricare;	1	2
f. Worker's Comp; or	1	2
g. Something else?	1	2

(IF SOMETHING ELSE: What was that?)

_____

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

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

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

$_____.__

C7d. Who paid these co-payments? Was it:

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

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

	YES	NO
a. Patient or Patient's Family;	1	2
b. Medicare;	1	2
c. Medicaid;	1	2
d. Private Insurance; or	1	2
e. Something else?	1	2

(IF SOMETHING ELSE: What was that?)

_____

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

YES 1
NO ..... 2 (GO TO EXIT SCREEN)

C7f. From which of the following other sources has the organization received payment and how much was paid by each source? Please include all payments that have taken place between (MONTH of 2010/BEGIN DATE) and now for this care.

RECORD PAYMENTS FROM ALL 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; or	$_____.____
h. Something else?	
(IF SOMETHING ELSE: What was that?)	
_____	$_____.____

E5. Do you have any more medical events for (PATIENT NAME) for 2010?

YES, ALL (MONTHS/60-DAY EPISODES/OTHER PERIODS) COVERED..... 1 (GO TO E6)

NO, NEED TO COVER ADDITIONAL (MONTHS/60-DAY EPISODES/OTHER PERIODS) ..... 2 (GO TO E1 - NEXT EVENT FORM)

E6. 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 E7)

PROVIDER RECORDED FEWER VISITS..... 2

RECONCILIATION SCREEN

[DCS ONLY] PROBE: (PATIENT NAME) reported (NUMBER) months of home care service during 2010, 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
_____

_____

E7. GO TO NEXT PATIENT FOR THIS PROVIDER.
IF NO MORE PATIENTS, THANK THE RESPONDENT AND END THE CALL.