Form Approved
OMB No. 0935-0118
Exp. Date 01/31/2013

MEDICAL EXPENDITURE PANEL SURVEY

MEDICAL PROVIDER COMPONENT

MEDICAL EVENT FORM

FOR

HOME CARE - NON-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

(Public reporting burden for this collection of information is estimated to average 5 minutes per response, the estimated time required to complete the survey. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: AHRQ Reports Clearance Officer Attention: PRA, Paperwork Reduction Project (0935-0118) AHRQ, 540 Gaither Road, Room # 5036, Rockville, MD 20850.)

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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?)

_____

D1. 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 services were provided in (PATIENT NAME)'s home?

MONTH: _____ YEAR: 2010

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; PROBE AS NEEDED.

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 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. YARD WORKER	_____ / _____	OR	_____
13. DRIVER	_____ / _____	OR	_____
14. BABYSITTER	_____ / _____	OR	_____
15. Any other types of home care persons providing service? (SPECIFY): _____	_____ / _____	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: **$_____.__**

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? 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?

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

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 C4a)

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 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 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)

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 D4)

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 D4)

[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 D4)

D4. Do you have any more medical events for (PATIENT NAME) for 2010?

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

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

_____

_____

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