Form Approved
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MEDICAL EXPENDITURE PANEL SURVEY
MEDICAL PROVIDER COMPONENT
EVENT FORM
FOR
HOME CARE - NON-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

D1. 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:_____

SERVICES/CHARGES

D2. 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

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

CLEANING OR YARD WORK
YES=1, NO=2

TRANSPORTATION
YES=1, NO=2

SHOPPING
YES=1, NO=2

EMOTIONAL SUPPORT PERSON OR
ONE-ON-ONE BUDDY
YES=1, NO=2

SUPPORT GROUPS
YES=1, NO=2

CHILD CARE
YES=1, NO=2

OTHER (SPECIFY):_____
YES=1, NO=2

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

NOTE: WE NEVER ENTER $0 FOR A CHARGE

$_____.____

SOURCES OF PAYMENT

C4a. 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.

SELECT ALL THAT APPLY

[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.

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

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?

IF NO, CORRECT PREVIOUS ENTRIES 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)**

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

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.]

FINISH SCREEN

PRESS VALIDATE TO COMPLETE THIS EVENT FORM.