MEDICAL EXPENDITURE PANEL SURVEY
MEDICAL PROVIDER COMPONENT EVENT FORM

FOR
HOME CARE - HEALTH CARE PROVIDERS

FOR
REFERENCE YEAR 2023

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 [FILL_YR] by month, or by 60- day period?

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

(IF SOME OTHER PERIOD: What was that?)

DK/REF – CONTINUE TO E1

VISIT DATE

E1. During calendar year [FILL_YR], 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 [FILL YR]

MONTH:
Month:_____
Year: _____

OR

BEGIN DATE:
Month:_____
Day: _____
Year: _____
END DATE:
Month:_____
Day: _____
Year: _____

DK/REF – CONTINUE TO E2

DIAGNOSES

E2. I need the diagnoses for (PATIENT NAME) (during (MONTH)/from (BEGIN DATE) through (END DATE)). I would prefer the ICD-10 codes or the DSM-5 codes, if they are available.

IF CODES ARE NOT USED, RECORD DESCRIPTIONS. RECORD UP TO FIVE ICD-10 CODES OR DESCRIPTIONS.

ICD-10 CODE_____DESCRIPTION:____

[SYSTEM WILL ALLOW FOR A MAXIMUM OF 5 ICD-10 TO BE COLLECTED]

Any more Diagnoses?

1. YES
2. NO

DK/REF – CONTINUE TO E3

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 ONE

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

1. HOME HEALTH AIDE

   HOURS/MINUTES__OR VISITS___

2. HOMEMAKER

   HOURS/MINUTES__OR VISITS___

3. I.V./INFUSION THERAPIST

   HOURS/MINUTES__OR VISITS___

4. NURSE/ NURSE PRACTITIONER

   HOURS/MINUTES__OR VISITS___

5. NURSE'S AIDE

   HOURS/MINUTES__OR VISITS___

6. OCCUPATIONAL THERAPIST

   HOURS/MINUTES__OR VISITS___

7. PERSONAL CARE ATTENDANT

   HOURS/MINUTES__OR VISITS___

8. PHYSICAL THERAPIST

   HOURS/MINUTES__OR VISITS___

9. RESPIRATORY THERAPIST

   HOURS/MINUTES__OR VISITS___

10. SOCIAL WORKER

    HOURS/MINUTES__OR VISITS___

11. SPEECH THERAPIST

    HOURS/MINUTES__OR VISITS___

12. YARD WORKER

HOURS/MINUTES__OR VISITS___

13. DRIVER

HOURS/MINUTES__OR VISITS___

14. BABYSITTER

HOURS/MINUTES__OR VISITS___

15. Any other home care personnel?

YES = 1
NO = 2

16. DURABLE MEDICAL EQUIPMENT?

YES = 1
NO = 2

_____CHECK HERE IF CURRENT BILLING PERIOD PROVIDED JUST DURABLE MEDICAL EQUIPMENT

E3 - DK/REF – CONTINUE TO E4

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. HIT ENTER/LEAVE EMPTY IF ENTERING REVENUE CODE OR DESCRIPTION.

CPT-4 CODE:_____REVENUE CODE:__DESCRIPTION:____
CPT-4 CODE:_____REVENUE CODE:__DESCRIPTION:____
CPT-4 CODE:_____REVENUE CODE:__DESCRIPTION:____
CPT-4 CODE:_____REVENUE CODE:__DESCRIPTION:____

Any more Services?

1. YES
2. NO

DK/REF – CONTINUE 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?

NOTE: WE NEVER ENTER $0 FOR A CHARGE

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.

IF NO CHARGE: Some facilities that don't charge for each individual service 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 total of the charge equivalents for everything other than personnel services, including durable medical equipment, drugs, supplies, and so forth?

IF THOSE COSTS WERE INCLUDED IN PERSONNEL CHARGES, RECORD 0.00

IF PREVIOUS COSTS WERE RECORDED AS 0.00 BECAUSE THEY WERE INCLUDED IN PERSONNEL CHARGES, ENTER 1.

IF THERE SIMPLY WERE NO NON-PERSONNEL CHARGES, ENTER 0.

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
NO = 2

[C1a - DK/REF – CONTINUE TO C1b
C1b - DK/REF – CONTINUE TO C2
C2 - DK/REF – CONTINUE TO C3]

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; this is also called Per Member Per Month.

IF IN DOUBT, CODE FEE-FOR-SERVICE

Fee-for-service basis = 1 (GO TO C4)
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.

IF NONE, ENTER ZERO (0).

[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? _____ $____._____)

Any more sources?

1. YES
2. NO

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 ENTRIES ABOVE AS NEEDED.

1. YES
2. NO

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 C4)

PAYMENTS LESS THAN CHARGES

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

IF THE ONLY PAYMENT FOR THIS EVENT WAS A LUMP SUM, ANSWER "NO"

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
e. Person is an eligible veteran YES=1 NO=2

DIFFERENCE BETWEEN PAYMENTS AND CHARGES

Are you expecting additional payment from:

IF THE ONLY PAYMENT FOR THIS EVENT WAS A LUMP SUM, ANSWER "NO" TO ALL OPTIONS

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? _____)

ADJEXTRA

It appears that the total payments were more than the total charges. Is that correct?

YES = 1
NO = 2

DCS: IF THE ANSWER IS "NO" PLEASE GO BACK TO C5 (VERIFY TOTAL PAYMENTS) TO RECONFIRM CHARGES AND PAYMENTS AS NEEDED

LUMP SUM PAYMENTS

LSPCHECK

WAS THIS EVENT COVERED BY A LUMP SUM?

YES = 1
NO = 2

DK/REF ALLOWABLE and SKIP TO END OF EVENT FORM

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?

OTHER SPECIFY: PROBE FOR SOURCE OF FUNDSAND TYPE OF PLAN.

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)

C7b - [IF C7b=2 GO TO C7e]
C7a - DK/REF – CONTINUE TO C7b
C7b - DK/REF – 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 – CONTINUE TO C7d.
If C7d is DK/REF – CONTINUE TO C7e.]

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

[If DK/REF – GO TO EXIT.]

C7f. From which of the following other sources has your organization received payment 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:

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

RECORD PAYMENTS FROM APPLICABLE PAYERS.

Patient or Patient's Family $_____._____
Medicare $_____._____
Medicaid $_____._____
Private Insurance $_____._____
VA/ChampVA $_____._____
Tricare $_____._____
Worker's Comp; $_____._____
Or something else? $_____._____

(IF SOMETHING ELSE: What was that? _____ $____._____)

Any more sources?

1. YES
2. NO

[If DK/REF – CONTINUE TO EXIT.]

FINISH SCREEN

ENTER 1 TO FINALIZE CASE.