MEDICAL EXPENDITURE PANEL SURVEY
MEDICAL PROVIDER COMPONENT
EVENT FORM
FOR
HOME CARE - NON-HEALTH CARE PROVIDERS
FOR
REFERENCE YEAR 2016

OMB

(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, 5600 Fishers Lane, Rockville, MD 20857)

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 2016 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?)

DK/REF/RETRIEVABLE – CONTINUE TO D1

VISIT DATE

D1. During calendar year 2016, 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 2016

MONTH:

Month: _____
Day: _____
Year: _____

OR

BEGIN DATE:

Month: _____
Day: _____
Year: _____

END DATE:

Month: _____
Day: _____
Year: _____

SERVICES/CHARGES

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

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 _____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. Other (Specify):

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
- (IF OTHER WHAT WAS THAT?)

  ANY MORE TYPES OF HOME CARE PERSONS PROVIDING SERVICE?
  YES=1, NO=2

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

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 charge equivalents for these services?

VERIFY: IS THIS THE TOTAL CHARGE FOR (THIS/THESE) SERVICE(S)?
IF NOT, RECORD TOTAL CHARGE.

NOTE: WE NEVER ENTER $0 FOR A CHARGE

TOTAL CHARGES: $_____.____

C2 - DK/REF/RETRIEVABLE – CONTINUE TO C4a

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? _____)

C4a(h) – "Other Specify" menu
Auto or Accident Insurance
Indian Health Service
State Public Mental Plan
State/County Local program
Other

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

VERIFICATION OF PAYMENT

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 C4a.

- 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 *(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
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

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/RET ALLOWABLE and SKIP TO END OF EVENT FORM

FINISH SCREEN

PRESS VALIDATE TO COMPLETE THIS EVENT FORM.