Form Approved
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MEDICAL EXPENDITURE PANEL SURVEY

MEDICAL PROVIDER COMPONENT

MEDICAL EVENT FORM

FOR

HOME CARE - HEALTH CARE PROVIDERS

FOR

REFERENCE YEAR 2009

VERSION 2.0

Revision History

Version	Author/Title	Date	Comments
1.0	Multiple RTI and SSS authors	12/23/08	
2.0	Multiple RTI and SSS authors	04/01/09	Changes from Version 1.0 marked with yellow highlighting

INTRODUCTION: (PATIENT NAME) reported that (he/she) received home care services from someone in this organization during the calendar year 2009.

1 CONFIRM PATIENT RECEIVED SERVICES (GO TO HOWBILL)

2 PROVIDER KNOWS PATIENT BUT NO EVENTS RECORDED FOR 2009 (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)

HOWBILL: How did you bill for the services provided in (PATIENT NAME)'s home during the calendar year 2009? 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 2009, 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: 2009

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
_____	_____
_____	_____
_____	_____
_____	_____

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

	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. OTHER (SPECIFY): _____	_____ / _____	OR	_____
21. YARD WORKER	_____ / _____	OR	_____
22. DRIVER	____ / _____	OR	_____
23. BABYSITTER	____ / _____	OR	_____

OR

|__| DURABLE MEDICAL EQUIPMENT ONLY

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
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

VERIFY: (Is this/Are these) the full established charge(s) or "list price" for (this/these) service(s)? IF NOT, RECORD FULL ESTABLISHED 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? IF NO, CORRECT ENTRIES ABOVE AS NEEDED.

TOTAL CHARGES: $_____.____

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 2009/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?

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

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

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.

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?)
_____ $_____.____

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.

TOTAL PAYMENTS: $_____.____

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 C6)

IF, AFTER VERIFICATION, PAYMENTS DO NOT EQUAL CHARGES COMPLETE C6 AND GO TO E5

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)

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 2009/BEGIN DATE) and now for this care.

CODE 1 (YES) FOR ALL REASONS MENTIONED.

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?) _____		
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?) _____		
q. **Charity care or sliding scale;**.....	1	2
r. **Bad debt;**.....	1	2
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 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 E5)

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 2009/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.

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. Have we covered all of the (months/60-day episodes/OTHER PERIODS) (PATIENT NAME) received home care services during the calendar year 2009?

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

[DCS ONLY] PROBE: (PATIENT NAME) reported (NUMBER) months of home care service during 2009, 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.