Form Approved
OMB No. 0935-0118
Exp. Date 12/31/2015

**Attachment 78**

**MEDICAL EXPENDITURE PANEL SURVEY**

**MEDICAL PROVIDER COMPONENT**

**EVENT FORM**

**FOR**

**HOME CARE - NON-HEALTH CARE PROVIDERS**

**FOR**

**REFERENCE YEAR 2014**

**OMB HYPERLINK ON FIRST SCREEN**

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 3 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.)

OMB No. 0935-0118; Exp. Date XX/XX/XXXX

**BILLING**

[Page 2 – BILLING (1 of 1)]

Did you bill for the services provided in (PATIENT NAME)’s home during the calendar year 2014 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**

[Page 3 – VISIT DATE (1 of 1)]

|  |  |
| --- | --- |
| D1. During calendar year 2014, 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 2014 | MONTH: MONTH YEAR**OR**BEGIN DATE:  MONTH DAY YEAREND DATE:  MONTH DAY YEAR |

**SERVICES/CHARGES**

 [Page 4 – SERVICES/CHARGES (1 of 3)]

|  |  |
| --- | --- |
| 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 VISITS1. Home Health Aide **R\_HHAIDHR** / **R\_HHAIDMN** OR **R\_HHAIDVS**2. Homemaker **R\_HMAKEHR** / **R\_HMAKEMN** OR **R\_HHMAKEVS** (INCLUDE HOUSEKEEPER) 3. I.V./Infusion  TherapIST **R\_IVTHERHR** / **R\_IVTHERMN** OR **R\_IVTHERVS**4. Nurse/ Nurse Practitioner **R\_NURSEHR** / **R\_NURSEMN** OR **R\_NURSEVS**5. Nurse’s Aide **R\_NURAIDHR** / **R\_NURAIDMN** OR **R\_NURAIDVS**6. Occupational  Therapist **R\_OCCTHHR** / **R\_OCCTHMN** OR **R\_OCCTHVS**7. Personal Care  Attendant **R\_PERCARHR** / **R\_PERCARMN** OR **R\_PERCARVS**8. Physical Therapist **R\_PHYSTHHR** / **R\_PHYSTHMN** OR **R\_PHYSTHVS**9. Respiratory  Therapist **R\_RESPTHHR** / **R\_RESPTHMN** OR **R\_RESPTHVS**10. Social Worker **R\_SOCWRKHR** / **R\_SOCWRKMN** OR **R\_SOCWRKVS**11. Speech Therapist **R\_SPECTHHR** / **R\_SPECTHMN** OR **R\_SPECTHVS**12. YARD WORKER **R\_YARDWKHR** / **R\_YARDWKMN** OR 13. DRIVER **R\_DRIVERHR** / **R\_DRIVERMN** OR **R\_DRIVERVS**14. BABYSITTER **R\_BABSITHR** / **R\_BABSITMN** OR **R\_BABSITVS**15. Other (Specify): **R\_OTHHCR**  **R\_OTHHCRHR** / **R\_OTHHCRMN** OR **R\_OTHHCRVS** |
| 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?)  |

**SERVICES/CHARGES (2 of 3)**

|  |  |
| --- | --- |
| 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. | **TOTAL CHARGES: $** |

NOTE: WE NEVER ENTER $0 FOR A CHARGE

**SOURCES OF PAYMENT**

[Page 6 – SOURCES OF PAYMENT (1 of 1)]

|  |  |  |
| --- | --- | --- |
| 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. |  SOURCE 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?) | PAYMENT AMOUNT$$$$$$$$ |
| 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.  | **TOTAL PAYMENTS**  | **$** |

C4a(h) – “Other Specify” menu

 Auto or Accident Insurance

 CHDP/CHIP

 Indian Health Service

 State Public Mental Plan

 State/County Local program

 Other

**VERIFICATION OF PAYMENT**

[Page 7 – VERIFICATION OF PAYMENT (1 of 1)]

C5a. I recorded that the payment(s) you received equal YES, FINAL PAYMENTS RECORDED IN C4a AND C5 =1

 the charges. I would like to make sure that I have NO =2

 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.

**PAYMENTS LESS THAN CHARGES** *(UNDERPAYMENT)*

 **[Page 10 – SOURCES OF PAYMENT (1 of 1)]**

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

ELIGVET2**.**

It appears that the total payment was less than the total charges. Is that because the person is an eligible veteran?

YES=1

NO=2

DCS:  IF THE POC IS CONFUSED BY THE QUESTION, ANSWER THE QUESTION “NO”

**DIFFERENCE BETWEEN PAYMENTS AND CHARGES**

**[Page 8–DIFFERENCE BETWEEN PAYMENTS AND CHARGES (1 of 1)]**

|  |  |
| --- | --- |
| Are you expecting additional payment from:IF THE ONLY PAYMENT FOR THIS EVENT WAS A LUMP SUM, ANSWER “NO” TO ALL OPTIONSADJEXTRA It appears that the total payment was more than the total charges. Is that correct?DCS: IF THE ANSWER IS “NO” PLEASE GO BACK TO C5 (VERIFY TOTAL PAYMENTS) TO RECONFIRM CHARGES AND PAYMENTS AS NEEDED. | **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; or YES=1, NO=2 p. Something else? YES=1, NO=2  (IF SOMETHING ELSE: What was that?)    YES=1 NO=2 |

**LUMP SUM PAYMENTS**

CHECK WAS THIS EVENT COVERED BY A LUMP SUM?

YES

NO

**FINISH SCREEN**

PRESS VALIDATE TO COMPLETE THIS EVENT FORM.