Attachment 82

MEDICAL EXPENDITURE PANEL SURVEY

MEDICAL PROVIDER COMPONENT

EVENT FORM

FOR

HOME CARE - NON-HEALTH CARE PROVIDERS

FOR

REFERENCE YEAR 2017

OMB SECTION

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 2017 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 2017, 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 2017

MONTH: MONTH 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; PROBE AS NEEDED.

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

	HOURS/MINUTES	VISITS
1. HOME HEALTH AIDE		
2. HOMEMAKER (INCLUDE HOUSEKEEPER)		
3. I.V./INFUSION THERAPIST		
4. NURSE/ NURSE PRACTITIONER		
5. NURSE'S AIDE		
6. OCCUPATIONAL THERAPIST		
7. PERSONAL CARE ATTENDANT		
8. PHYSICAL THERAPIST		
9. RESPIRATORY THERAPIST		

	HOURS/MINUTES	VISITS
10. SOCIAL WORKER		
11. SPEECH THERAPIST		
12. YARD WORKER		
13. DRIVER		
14. BABYSITTER		
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?)

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

TOTAL CHARGES: $

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

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.

SOURCE	PAYMENT AMOUNT
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) / (BEGIN DATE) through (END DATE)) as [SYSTEM WILL COMPUTE AND DISPLAY TOTAL]. Is that correct?
IF NO, CORRECT PREVIOUS ENTRIES 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 LSPCHECK)
YES, OTHER PAYERS - 2 (GO TO C5a)
NO, PAYMENTS < CHARGES - 3 (GO TO PLC3)
NO, PAYMENTS > CHARGES - 3 (GO TO ADJEXTRA**)**

VERIFICATION OF PAYMENT

C5a. I recorded that the payment(s) you received equal the charges. 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 C4a AND C5 =1
NO =2

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
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; or YES=1, NO=2
p. Something else? YES=1, NO=2

(IF SOMETHING ELSE: What was that?)

ADJEXTRA
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.

YES=1, NO=2

LUMP SUM PAYMENTS

LSPCHECK WAS THIS EVENT COVERED BY A LUMP SUM?
YES
NO

FINISH SCREEN

PRESS VALIDATE TO COMPLETE THIS EVENT FORM.