**Attachment 78**

**8**

**MEDICAL EXPENDITURE PANEL SURVEY**

**MEDICAL PROVIDER COMPONENT**

**EVENT FORM**

**FOR**

**HOME CARE - 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 [FILL_YR] by month, or by 60-day period? Was it:

| | |
|---|---|
| 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?)

## 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) during which your records show that home care services were provided to (PATIENT NAME)?

REFERENCE PERIOD – CALENDAR YEAR [FILL_YR]

MONTH:

MONTH YEAR

**OR**

BEGIN DATE:

MONTH DAY YEAR

END DATE:

MONTH DAY YEAR

## DIAGNOSES

E2. I need to know the diagnosis for (PATIENT NAME) (during (MONTH)/from (BEGIN DATE) through (END DATE)). I would prefer the ICD-10 codes or 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

Any more diagnoses?

1 YES

2 NO

## 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 ALL THAT APPLY

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 | | |
| 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 | | |
| 10. SOCIAL WORKER | | |
| 11. SPEECH THERAPIST | | |
| 12. YARD WORKER | | |
| 13. DRIVER | | |
| 14. BABYSITTER | | |
| 15. Any other home care personnel? | | |
| 16. DURABLE MEDICAL EQUIPMENT | | |

CHECK HERE IF CURRENT BILLING PERIOD PROVIDED JUST DURABLE MEDICAL EQUIPMENT

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.

| CPT-4 CODE | REVENUE CODE | DESCRIPTION |
|---|---|---|

Any more services?

1 YES
2 NO

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: $

ALL OTHER CHARGES: $

€ INCLUDED WITH PERSONNEL CHARGES

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 AND CHECK THE BOX.

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?

**TOTAL CHARGES: $**

## 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?

FEE-FOR-SERVICE BASIS =1
CAPITATED BASIS =2

EXPLAIN IF NECESSARY:
**Fee-for-service** means that the organization was reimbursed on the basis of the service 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.

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IF IN DOUBT, CODE FEE-FOR-SERVICE.

## 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.

[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.

| 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?) | $ |

Any more sources?
1 YES
2 NO

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 LSPCHECK)**
**YES, OTHER PAYERS - 2 (GO TO C5a)**
**NO, PAYMENTS < CHARGES - 3 (GO TO PLC1)**
**NO, PAYMENTS > CHARGES - 3 (GO TO** ADJEXTRA**)**

## 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
NO =2

## 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" TO ALL OPTIONS.

| | |
|---|---|
| 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 payments were 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?

1 YES

2 NO

**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 FUNDS AND 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; or 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

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; or YES=1, NO=2
e. Something else? YES=1, NO=2
(IF SOMETHING ELSE: What was that?)

C7e. Do your records show any other payments for any of the services provided (for (MONTH)/from (BEGIN DATE) through (END DATE))?

YES=1, NO=2

**FINISH SCREEN**

PRESS VALIDATE TO COMPLETE THIS EVENT FORM.