MEDICAL EXPENDITURE PANEL SURVEY
MEDICAL PROVIDER COMPONENT

EVENT FORM

FOR
HOME CARE - NON-HEALTH CARE PROVIDERS

FOR
REFERENCE YEAR 2023

OMB

PRESS 1 TO CONTINUE

PRESS BREAKOFF TO DISCONTINUE

BILLING

Did you bill for the services provided in (PATIENT NAME)'s home during the calendar year 2023 by month, by 60-day period, or by week?

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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
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(IF SOME OTHER PERIOD: What was that?)

DK/REF – CONTINUE TO D1

VISIT DATE

D1. During calendar year 2023, what (was the (first/next) month/was the begin/was the end date) of the (first/next) 60-day period/(was the begin/was the end) date of the (first/next) OTHER PERIOD/ (was the begin/was the end date of the (first/next) weekly period) during which your records show that services were provided in (PATIENT NAME)'s home?

REFERENCE PERIOD – CALENDAR YEAR 2023

MONTH:

     Month:_____
     Year: _____

OR

BEGIN DATE:

     MM/DD/YYYY

END DATE:

     MM/DD/YYYY

DCS: ENTER A DATE IN FORMAT MM/DD/YYYY. INCLUDE LEADING 0's FOR SINGLE DIGIT MONTHS AND DAYS.

DK/REF – CONTINUE TO D2

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 ONE; PROBE AS NEEDED.

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

    1.   HOME HEALTH AID

        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): _____

      HOURS/MINUTES__OR VISITS___

D3. I need a description of the services provided (during (MONTH)/from (BEGIN DATE) through (END DATE)).

      CLEANING OR YARDWORK 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 SERVICES? YES=1, NO=2

D2 - DK/REF – CONTINUE TO D3
D3 – DK/REF– CONTINUE TO C2

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 – 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.

IF NONE, ENTER ZERO (0).

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

      C4a - DK/REF – CONTINUE TO C5

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 ENTRIES ABOVE AS NEEDED.

    1. YES
    2. NO

C5 – IF RESPONSE = 2, DISPLAY HARD CHECK: "IF INCORRECT, CORRECT ENTRIES AS NEEDED."

<div align="center">

VERIFICATION OF PAYMENT
</div>

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 (GO TO LUMP SUM PAYMENT QUESTION)
   NO = 2 (GO BACK TO C4a)

<div align="center">

PAYMENTS LESS THAN CHARGES *(UNDERPAYMENT)*
</div>

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"

    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

C6_additional

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 payment was 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 ALLOWABLE and SKIP TO END OF EVENT FORM

FINISH SCREEN

ENTER 1 TO FINALIZE CASE.