OMB#: 0935-0108

PATIENT LABEL

FORM ___ OF ___

MEDICAL EXPENDITURE SURVEY

MEDICAL PROVIDER COMPONENT

HOME CARE EVENT BOOKLET FOR HEALTH CARE PROVIDERS

FOR

REFERENCE YEAR 2005

INTRODUCTION: [PATIENT NAME] reported that (he/she) received home care services from someone in this organization during the calendar year 2005.

E1. During calendar year 2005, what was the (first/next) month during which your records show that home care services were provided to (PATIENT NAME)?

MONTH: _____ YEAR: 2005

E2. I need to know the diagnosis for [PATIENT NAME] during [MONTH]. I would prefer the ICD-9 codes (or DSM-IV codes), if they are available.

[IF CODES ARE NOT USED, RECORD DESCRIPTIONS.]

[IF THERE ARE MORE THAN 4 DIAGNOSES, USE A CONTINUATION SHEET.]

	CODE	DESCRIPTION
|__|	_____	_____
|__|	_____	_____
|__|	_____	_____
|__|	_____	_____

|__|__|
OFFICE USE ONLY

IF ONLY ONE DIAGNOSIS, GO TO E3. IF MORE THAN ONE DIAGNOSIS:

E2a. Which of these was the principal diagnosis?

- CHECK BOX FOR PRINCIPAL DIAGNOSIS
- CIRCLE '-8' IF PRINCIPAL DIAGNOSIS NOT KNOWN ..... -8

E3. I need to know which types of home care personnel provided care to (PATIENT NAME) during (MONTH) and either the number of hours or the number of visits for each type.

	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	_____

|__| DURABLE MEDICAL EQUIPMENT ONLY

E4. I need the services provided during (MONTH). I would prefer either the CPT-4 codes or the revenue codes, if they are available.

[IF CODES ARE USED, CIRCLE WHICH TYPE OF CODE IS USED. IF CODES ARE NOT USED, RECORD DESCRIPTION OF SERVICES AND PROCEDURES PROVIDED.]

[IF THERE ARE MORE THAN 8 SERVICES, USE A CONTINUATION SHEET.]

CPT-4 CODE	DESCRIPTION	REVENUE CENTER CODE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

|__|__| OFFICE USE ONLY

C1a. Could you tell me the full established charges -- before any adjustments or discounts -- for all services provided by home care personnel during (MONTH).

[EXPLAIN IF NECESSARY: *This would be the charges for the (READ TYPES OF PERSONNEL FROM E3 ABOVE) who provided services during (MONTH).]*

C1b. And could you tell me the full established charges for everything <u>other</u> than personnel during (MONTH), 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.]*

[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?*]

C2. IF NOT VOLUNTEERED, ASK: And what was the total of all of the full, established charges for (PATIENT NAME) during (MONTH) ? [IF NOT AVAILABLE, COMPUTE.]

FULL ESTABLISHED CHARGES FOR:

PERSONNEL SERVICES: $_____.____

ALL OTHER CHARGES: $_____.____
(NON-PERSONNEL CHARGES)

TOTAL CHARGES: $_____.____

C3. Was your organization reimbursed for the charges during (MONTH) 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.*

[INTERVIEWER: IF IN DOUBT, CODE FEE-FOR-SERVICE.]

FEE-FOR-SERVICE BASIS..... 1

CAPITATED BASIS 2 (C7a)

C4. From what sources did the organization receive payment for the charges for (MONTH) and how much was paid by each source?

[INTERVIEWER NOTE: IF PAYMENT WAS A SET DOLLAR AMOUNT FOR ALL CHARGES FOR THE MONTH, GO BACK TO C3 AND CHANGE CODE TO 2 (CAPITATED BASIS).]

IF NAME OF INSURER OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance?

a. Patient or patient's family $_____.____

b. Medicare $_____.____

c. Medicaid $_____.____

d. Private Insurance $_____.____

e. VA $_____.____

f. TRICARE/CHAMPVA/ CHAMPUS $_____.____

g. WORKER'S COMP $_____.____

h. OTHER (SPECIFY): _____ $_____.____

C5. (IF NOT VOLUNTEERED, ASK:) And what was the total of all payments received for (MONTH)? (IF NOT AVAILABLE, COMPUTE.)

TOTAL PAYMENTS: $_____.____

BOX 1
DO TOTAL PAYMENTS (C5) EQUAL TOTAL CHARGES (C2)?
YES 1 (E5)
NO 2 (C6)

C6. It appears that the total payments were (less than/more than) the total charges. What is the reason for that difference? [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	1	2
h. Other (Specify:) _____	1	2
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	1	2
n. TRICARE/CHAMPVA/CHAMPUS	1	2
o. WORKER'S COMP	1	2
p. Other (Specify:) _____	1	2
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	1	2
v. Other (Specify:) _____	1	2

GO TO E5

CAPITATED BASIS

C7a. What kind of insurance plan covered the patient during (MONTH)? Was it:

IF NAME OF INSURER OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance?

		YES	NO
a.	Medicare;	1	2
b.	Medicaid;	1	2
c.	Private Insurance;	1	2
d.	VA;	1	2
e.	TRICARE/CHAMPVA/CHAMPUS;	1	2
f.	Worker's Comp; or	1	2
g.	Something else? (SPECIFY:)_____	1	2

C7b. Was there a co-payment for any of the services provided during (MONTH)?

YES 1
NO 2 (C7e)

C7c. What was the total of all co-payments for (MONTH)?

$_____.__

C7d. Who paid these co-payments?

IF NAME OF INSURER OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance?

		YES	NO
a.	PATIENT OR PATIENT'S FAMILY	1	2
b.	MEDICARE	1	2
c.	MEDICAID	1	2
d.	PRIVATE INSURANCE	1	2
e.	OTHER (SPECIFY:) _____	1	2

C7e. Do your records show any other payments for any of the services provided during (MONTH)?

YES 1
NO 2 (E5)

C7f. From what other sources has the organization received payment and how much was paid by each source?

IF NAME OF INSURER OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance?

a. Patient or patient's family	$_____.____
b. Medicare	$_____.____
c. Medicaid	$_____.____
d. Private Insurance	$_____.____
e. VA	$_____.____
f. TRICARE/CHAMPVA/ CHAMPUS	$_____.____
g. WORKER'S COMP	$_____.____
h. OTHER (SPECIFY): _____	$_____.____

E5. Have we covered all of the months (PATIENT NAME) received home care services during the calendar year 2005?

YES, ALL MONTHS COVERED..... 1 (E6)

NO, NEED TO COVER ADDITIONAL MONTHS ..... 2 (E1 - NEXT EVENT FORM)

E6. IF ALL MONTHS 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.

NO DIFFERENCE OR PROVIDER REPORTED MORE MONTHS OF HOME CARE SERVICE THAN HOUSEHOLD 1 (E7)

PROVIDER RECORDED FEWER VISITS..... 2

PROBE: (PATIENT NAME) reported (NUMBER) months of home care service. Do you have any information in your records that would explain this discrepancy?

_____

_____

_____

E7. GO TO NEXT PATIENT FOR THIS PROVIDER.
IF NO MORE PATIENTS, THANK THE RESPONDENT AND END THE CALL.