

PATIENT LABEL

FORM ___ OF ___

Date(s) of Service: _____

Event Type: _____

**MEDICAL EXPENDITURE SURVEY
MEDICAL PROVIDER COMPONENT**

**HOME CARE EVENT BOOKLET
FOR HEALTH CARE PROVIDERS**

FOR

REFERENCE YEAR 2008

Was MR abstracted for this event?	Yes	No
Date MR Abstracted:	_____ / _____ / _____	
Affix SMS label sticker here:		
Was PA abstracted for this event?	Yes	No
Date PA Abstracted:	_____ / _____ / _____	
Affix SMS label sticker here:		

INTRODUCTION: [PATIENT NAME] reported that (he/she) received home care services from someone in this organization during the calendar year 2008.

E1. During calendar year 2008, what was the (first/next) month during which your records show that home care services were provided to (PATIENT NAME)?

MONTH: _____ YEAR: 2008

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.

CODE DESCRIPTION

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

OFFICE USE ONLY

[IF CODES ARE NOT USED, RECORD DESCRIPTIONS. RECORD A MAXIMUM OF 5 DIAGNOSES.]

[

E2a. OMITTED

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.

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

OFFICE USE ONLY

[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.]

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

FULL ESTABLISHED CHARGES FOR:

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

PERSONNEL SERVICES: \$ _____.

C1b. And could you tell me the full established charges for everything other than personnel during (MONTH), including durable medical equipment, drugs, supplies, and so forth?

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

[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.]

TOTAL CHARGES: \$ _____.

(Is this/Are these) the total full established charge(S) or "list price" for (this/these) service(s)? IF NOT, RECORD FULL ESTABLISHED CHARGE.

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/CHAMPVA \$ _____.
- f. TRICARE \$ _____.
- g. WORKER'S COMP \$ _____.
- h. OTHER (SPECIFY):
_____ \$ _____.

TOTAL PAYMENTS: \$ _____.

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

GO TO BOX 1

BOX 1

DO TOTAL PAYMENTS EQUAL TOTAL CHARGES?

YES, AND ALL PAID BY PATIENT OR PATIENT'S FAMILY..... 1 (E5)

YES, OTHER PAYERS.....2 (C5a)

NO.....3 (C6)

IF, AFTER VERIFICATION, PAYMENTS DO NOT EQUAL CHARGES COMPLETE C6 AND GO TO E5

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 [READ 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 (E5)

NO.....2 (BACK TO C4)

CAPITATED BASIS

		<u>YES</u>	<u>NO</u>
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?	a. Medicare;.....	1	2
	b. Medicaid;	1	2
	c. Private Insurance;	1	2
	d. VA/CHAMPVA;	1	2
	e. TRICARE;.....	1	2
	f. Worker's Comp; or	1	2
	g. Something else? (SPECIFY):.....	1	2
	<hr/>		
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?		<u>YES</u>	<u>NO</u>
	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/CHAMPVA	\$ _____.	
	f. TRICARE	\$ _____.	
	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 2008?

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.