OMB#: 0935-0098
EXPIRES: 12/31/98

AGENCY ID: _____

AGENCY NAME: _____

PATIENT ID: _____

PATIENT NAME: _____

FORM ___ OF ___

MEDICAL EXPENDITURE SURVEY
MEDICAL PROVIDER SURVEY

HOME CARE PROVIDER BOOKLET
PANEL 1 - YEAR 1

INTRODUCTION: [PATIENT NAME] reported that (he/she) received home care services from someone in this organization during the calendar year 1996.

1. During calendar year 1996, what was the (first/next) month during which your records show that home care services were provided to (PATIENT NAME)?

   MONTH: _____

2. 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.]

   ICD-9 or DSM-IV codes (or descriptions)

   |__| _____

   |__| _____

   |__| _____ |__|__| OFFICE USE ONLY

   |__| _____

   |__| _____

2a. Which of these was the principal diagnosis?

   IF ONLY ONE DIAGNOSIS, GO TO Q3. IF MORE THAN ONE DIAGNOSIS:

   - CHECK BOX FOR PRINCIPAL DIAGNOSIS
   - CIRCLE '999.95' IF PRINCIPAL DIAGNOSIS NOT KNOWN 999.95

   |__|__|__|. |__|__| OFFICE USE ONLY

3. 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:		VISITS:
|__| HOME HEALTH AIDE	_____	OR	_____
|__| HOMEMAKER	_____	OR	_____
|__| I.V./INFUSION THERAPY	_____	OR	_____
|__| NURSE/NURSE PRACTITIONER	_____	OR	_____
|__| NURSE'S AIDE	_____	OR	_____
|__| OCCUPATIONAL THERAPIST	_____	OR	_____
|__| PERSONAL CARE ATTENDANT	_____	OR	_____
|__| PHYSICAL THERAPIST	_____	OR	_____
|__| RESPIRATORY THERAPIST	_____	OR	_____
|__| SOCIAL WORKER	_____	OR	_____
|__| SPEECH THERAPIST	_____	OR	_____
|__| OTHER. SPECIFY: _____	_____	OR	_____

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

   |__| Revenue center codes

   |__| CPT-4 codes (including modifier):

DESCRIPTION	CODES
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

   |__|__| OFFICE USE ONLY

5a. 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 Q. 3 ABOVE) who provided services during (MONTH)].*

5b. 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 in their records for purposes of budgeting or cost analysis. This kind of information is sometimes call a "charge equivalent*." *Could you give me the charge equivalents for these procedures?*]

FULL ESTABLISHED CHARGES FOR:

PERSONNEL SERVICES: $_____.__

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

6. 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: $_____.__

7. 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 (Q11a)

8. 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 QUESTION 5 AND CODE CAPITATED.]

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

b. Medicare $_____.__

c. Medicaid $_____.__

d. Private Insurance $_____.__

e. VA $_____.__

f. CHAMPVA/CHAMPUS $_____.__

g. OTHER (SPECIFY): _____ $_____.__

9. (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 (Q9) EQUAL TOTAL CHARGES (Q6)?
YES..... 1 (Q2)
NO 2 (Q10)

10. It appears that the total payments were (less than/more than) total charges. What is the reason for that discrepancy? [CODE 1 (YES) FOR ALL REASONS MENTIONED.]

PAYMENTS LESS THAN CHARGES:

Adjustment or discount	YES	NO
Medicare or Medicaid limit or adjustment	1	2
Contractual arrangement with insurer or managed care organization	1	2
Courtesy discount	1	2
Insurance write-off	1	2
Other (Specify:) _____	1	2
Expecting additional payment		
Patient or Patient's Family	1	2
Medicare	1	2
Medicaid	1	2
Private Insurance	1	2
VA	1	2
CHAMPVA/CHAMPUS	1	2
Other (Specify:)_____	1	2
Charity care or sliding scale	1	2
Bad debt	1	2

PAYMENTS MORE THAN CHARGES:

Medicare or Medicaid adjustment	1	2
Other (Specify:) _____	1	2

GO TO Q12

CAPITATED BASIS

11a. What kind of insurance plan covered the patient during (MONTH)? Was it:

[CODE ALL THAT APPLY]

Medicare; 1
Medicaid;..... 2
Private Insurance; or 3
Something else (SPECIFY:) 4
_____
VA/CHAMPVA/CHAMPUS 5
DON'T KNOW..... 8
NO INSURANCE/NONE..... 9

11b. Was there a co-payment for any of the services provided during (MONTH)?

YES 1
NO ..... 2 (GO TO Q12)

11c. What was the total of all co-payments for (MONTH)?

$_____.__

11d. Who paid these co-payments?

PATIENT OR PATIENT'S FAMILY.. 1
MEDICARE 2
MEDICAID 3
PRIVATE INSURANCE 4
OTHER (SPECIFY:) 5
_____
DON'T KNOW..... 8

12. Have we covered all of the months (PATIENT NAME) received home care services during the calendar year 1996?

YES, ALL MONTHS COVERED 1 (Q13)

NO, NEED TO COVER ADDITIONAL MONTHS..... 2 (Q1 - NEXT EVENT FORM)

13. 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 (Q14)

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?

_____

_____

_____

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