**MEDICAL PROVIDER COMPONENT**
**FOR REFERENCE YEAR 2009**

# CONTACT GUIDE FOR OFFICE-BASED PROVIDERS

**VERSION 2.0**

**Revision History**

| Version | Author/Title | Date | Comments |
|---|---|---|---|
| 1.0 | Multiple RTI and SSS authors | 12/23/08 | |
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**MEDICAL PROVIDER COMPONENT**
**FOR REFERENCE YEAR 2009**

**CONTACT GUIDE FOR OFFICE-BASED PROVIDERS**

**A1.** [A1] (ASK IF NOT OBVIOUS) Have I reached (PROVIDER)?

☐ YES → CONTINUE WITH A2

☐ NO → VERIFY TELEPHONE NUMBER, ADDRESS, AND NAME OF PROVIDER. IF PROVIDER IS DIFFERENT, RECORD PROBLEM AND TERMINATE CALL. CONTACT DIRECTORY ASSISTANCE. IF NO BETTER TELEPHONE NUMBER CAN BE FOUND, MARK FOR SUPERVISOR REVIEW.

**A2.** [A2] May I please have the name and telephone number of the office manager or the person who can help me with billing records from 2009?

☐ SPEAKING TO PERSON WHO DID THE BILLING IN 2009 → RECORD NAME AND VERIFY TELEPHONE NUMBER

(May I please have your name?) (IF ONLY FIRST NAME GIVEN PROBE FOR FULL NAME)

NAME: _____

The telephone number that I dialed is (FILL TELEPHONE NUMBER). Is that the best number at which to reach you?

TELEPHONE NUMBER: (_____) _____ EXT: _____

YES → CONTINUE WITH A3
NO → MAKE CORRECTIONS AS NECESSARY, THEN CONTINUE WITH A3

☐ OFFICE MANAGER → RECORD NAME AND TELEPHONE NUMBER

NAME:_____

TELEPHONE NUMBER: (_____)_____ EXT: _____

Will you please transfer me to them?

YES → CONTINUE WITH A3

NO → TERMINATE CALL, CONTACT OFFICE MANAGER, CONTINUE WITH A3

☐ INTERNAL BILLING DEPARTMENT → RECORD NAME AND TELEPHONE NUMBER

NAME:_____

TELEPHONE NUMBER: (_____)_____ EXT: _____

Will you please transfer me to them?

YES → CONTINUE WITH A3

NO → TERMINATE CALL, CONTACT BILLING DEPARTMENT, CONTINUE WITH A3

☐ BILLING IS PERFORMED BY AN OUTSIDE BILLING SERVICE → ASK TO SPEAK TO SOMEONE AT THE PROVIDER OFFICE WHO DEALS WITH THE OUTSIDE BILLING SERVICE → RECORD NAME AND TELEPHONE NUMBER

NAME:_____

TELEPHONE NUMBER: (_____)_____ EXT: _____

Will you please transfer me to them?

YES → CONTINUE WITH A3

NO → TERMINATE CALL, CONTACT PERSON WHO DEALS WITH BILLING SERVICE, CONTINUE WITH A3

☐ NO BILLING DEPARTMENT; NOT CLEAR WHO TO SPEAK TO → RECORD PROBLEM; TERMINATE CALL AND MARK FOR SUPERVISOR REVIEW

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**A3.** [A3] (Hello,) my name is (YOUR NAME) and I am calling on behalf of the U.S. Department of Health and Human Services. We are conducting MEPS which is a study about how people in the United States use and pay for health care. First, let me verify that this is a doctor's office and not a hospital.

| | | |
|---|---|---|
| PHYSICIAN'S OFFICE, PUBLICLY-FUNDED CLINIC, URGENT CARE CENTER..... | ☐ | → CONTINUE TO A4 |
| HOSPITAL, HOSPITAL SATELLITE CLINIC, HOSPITAL | | TERMINATE CALL AND CODE APPROPRIATELY |
| OUTPATIENT DEPARTMENT, SURGI-CENTER..... | ☐ | |
| HOME CARE PROVIDER..... | ☐ | |
| LONG-TERM CARE FACILITY SUCH AS A NURSING HOME... | ☐ | |
| SOMETHING ELSE..... | ☐ | |

(SPECIFY): _____

**A4.** [A4] And is there at least one physician in the practice who is a Medical Doctor or a Doctor of Osteopathy?

YES .....1 (GO TO A5)
NO .....2 (GO TO A4a)
GAVE A SPECIALTY…… 3 (GO TO A4b)

**A4a.** [A4] For this study, we are only asking about care provided by or supervised by Medical ..... Doctors and Doctors of Osteopathy. Thank you very much for your time.
END CONTACT, CODE AS PROVIDER NOT ELIGIBLE

**A4b.** [N/A] CHECK SCREEN TO VERIFY THAT SPECIALTY PROVIDED IS AN MD/DO. IF MD/DO CONTINUE, ELSE END CONTACT, CODE AS PROVIDER NOT ELIGIBLE

**A5.** [A5] CONTROL SYSTEM WILL FLAG IF PROVIDER IS PART OF CONTACT GROUP:

IF CONTACT GROUP..... 1 (GO TO A5a)
IF NOT A CONTACT GROUP..... 2 (GO TO A6)

**A5a.** [A5a] I need to determine if the following providers were associated with this practice during 2009. REVIEW EACH PROVIDER WITH THE POC AND VERIFY WHETHER THE PROVIDER IS IN THE CONTACT GROUP

[CONTINUE WITH A6 FOR PROVIDERS IN THE CONTACT GROUP. PROVIDERS WHO ARE NOT IN CONTACT GROUP WILL BE REMOVED FROM THIS GROUP AND TREATED SEPARATELY WITHIN THE SYSTEM]

**[ALL GO TO A6 EXCEPT OUTSIDE BILLING; IF A2 = OUTSIDE BILLING GO TO A10]**

**A6.** [A6] [NUMBER FROM PATIENT LIST] patient(s) identified (PROVIDER) as a source of health care during 2009. (The/Each) patient signed an authorization form allowing us to contact you for information about the cost of the care they received from (PROVIDER) in 2009. Much of the information we need is within the billing records. I would like to fax the authorization form(s) to you, along with additional information explaining the study.

IF ASKED READ PATIENT NAMES AND OTHER IDENTIFYING INFORMATION FROM THE PATIENT DATA FORM

[READ IF THE RESPONDENT WOULD LIKE TO PROVIDE THE DATA PRIOR TO RECEIVING AUTHORIZATION FORM(S)]: In order to remain HIPAA compliant, I need to send you the authorization form(s) first. Once you have received the form(s), then we can arrange for the collection of the data.

OFFICE MAINTAINS THE INFORMATION:

FAX AUTHORIZATION FORM(S)..... 1 (GO TO A7)
MAIL AUTHORIZATION FORM(S)..... 2 (GO TO A8)

OFFICE DOES NOT MAINTAIN THE INFORMATION:

NEED TO CONTACT BILLING SERVICE..... 3 (GO TO A11)
THIS TYPE OF INFORMATION IS NOT AVAILABLE
(RECORD REASON:) _____ 4 (TERMINATE AND MARK FOR SUPERVISOR REVIEW)

**A7.** [A7] I need to be sure I have the correct information for the fax cover page. Should I address this fax to you?

YES → What is the fax number I can use to send you the authorization form(s)?

FAX NUMBER: (_____)_____

Can I also have your title and department?

TITLE: _____
DEPARTMENT:_____

GO TO A9

NO → Please tell me to whom I should fax this information.

NAME: _____
TITLE:_____
DEPARTMENT:_____
FAX NUMBER: (_____)_____
TELEPHONE NUMBER: (_____)_____ EXT: _____

GO TO A9

**A8.** [A8] I need to make sure that I have the correct mailing information. Should I address the package to you?

YES → What is the mailing address that I can use to send you the authorization form(s)?

TITLE:_____
DEPARTMENT:_____
ADDRESS: _____
_____
CITY: _____ STATE: _____ ZIP: _____

NO→ Can I have that person's information to mail the authorization form(s)?

NAME: _____
TITLE:_____
DEPARTMENT:_____
ADDRESS: _____
_____
CITY: _____ STATE: _____ ZIP: _____

TELEPHONE NUMBER: (_____)_____ EXT: _____

**A9.** [A9] Once you have received the authorization form(s), we will call back to collect the data over the phone. For each date of service in 2009, we are requesting information about charges, payments, diagnoses, and services provided.

What would be the best day and time to call back to collect this information by phone?

DAY:_____ DATE:_____ R's TIME:_____ AM/PM

IF PROVIDER DOESN'T WANT TO PROVIDE DATA OVER THE PHONE, OFFER FAX OR MAIL

You can send us the medical records by either fax or mail.

PROVIDER WILL RESPOND:

BY PHONE..... 1
BY FAX..... 2
BY MAIL..... 3

IF POINT OF CONTACT (POC) WILL RESPOND BY PHONE READ:
Thank you very much. We will allow time for you to receive and review the authorization form(s), and then we will call you back to collect the data.

IF POC WILL RESPOND BY FAX OR MAIL READ:
We hope you can send the records to our office within two weeks. We will include an instruction sheet when we (fax/mail) the authorization form(s). If you have any questions about what to send us, please call our toll-free number on the instruction sheet. We may call again if other patients identify this practice as a source of medical services. Thank you very much for your help.

**A10.** [A6/A11] [NUMBER FROM PATIENT LIST] patient(s) identified (PROVIDER) as a source of health care during 2009. (The/Each) patient signed an authorization form allowing us to contact you for information about the cost of the care they received from (PROVIDER) in 2009. We should be able to get all of the information we need from the billing service. We can also fax you a copy of the authorization form(s) for your files.

**A11.** [A10] Can you please provide the name of the billing service, the name of a contact person, their telephone number and title?

NAME OF BILLING SERVICE:_____

CONTACT NAME: _____

TELEPHONE NUMBER: (_____)_____ EXT:____

TITLE: _____

Thank you for that information.

**A12.** [A11] We would like to fax you a copy of the authorization form(s) for your files.

FAX AUTHORIZATION FORM(S)..... 1 (GO TO A12a)
MAIL AUTHORIZATION FORM(S)..... 2 (GO TO A12b)

**A12a.** [A11] I need to be sure I have the correct information for the fax cover page. Should I address this fax to you?

YES → What is the fax number I can use to send you the authorization form(s)?

FAX NUMBER: (_____)_____

Can I also have your title and department?

TITLE: _____
DEPARTMENT:_____

NO → Please tell me to whom I should fax this information.

NAME:_____
TITLE:_____
DEPARTMENT:_____
FAX NUMBER: (_____)_____

TELEPHONE NUMBER: (_____)_____ EXT: _____

Thank you very much for your help. We may call again if other patients identify this practice as a source of medical services. END CONTACT AND CALL BILLING SERVICE NAMED IN A11.
[CONTINUE WITH A13]

**A12b.** [A11] I need to make sure that I have the correct mailing information. Should I address the package to you?

YES → What is the mailing address that I can use to send you the authorization form(s)?

TITLE:_____
DEPARTMENT:_____
ADDRESS: _____
_____

CITY: _____ STATE: _____ ZIP: _____

NO→ Can I have that person's information to mail the authorization form(s)?

NAME:_____
TITLE:_____
DEPARTMENT:_____
ADDRESS: _____
_____
CITY: _____ STATE: _____ ZIP: _____

TELEPHONE NUMBER: (_____)_____ EXT: _____

Thank you very much for your help. We may call again if other patients identify this practice as a source of medical services. END CONTACT AND CALL BILLING SERVICE NAMED IN A11.
[CONTINUE WITH A13]

**BILLING SERVICE**

**A13.** [N/A] (ASK IF NOT OBVIOUS) Have I reached (BILLING SERVICE)?

☐ YES → CONTINUE WITH A14

☐ NO → VERIFY TELEPHONE NUMBER, ADDRESS, AND NAME OF BILLING SERVICE. IF BILLING SERVICE IS DIFFERENT, RECORD PROBLEM AND TERMINATE CALL. CONTACT DIRECTORY ASSISTANCE. IF NO BETTER TELEPHONE NUMBER CAN BE FOUND, GO TO "RECONTACT PROVIDER OFFICE"

**A14.** [N/A] May I please speak to the person who did the billing for (PROVIDER(S)) in **2009**?

☐ SPEAKING TO PERSON WHO DID THE BILLING IN 2009 → RECORD NAME AND VERIFY TELEPHONE NUMBER

(May I please have your name?) (IF ONLY FIRST NAME GIVEN PROBE FOR FULL NAME)

NAME:_____

The telephone number that I dialed is (FILL TELEPHONE NUMBER). Is that the best number at which to reach you?

TELEPHONE NUMBER: (_____)_____ EXT:_____

YES → CONTINUE WITH A15
NO → MAKE CORRECTIONS AS NECESSARY, THEN CONTINUE WITH A15

☐ POC PROVIDED

May I please have the (name and) telephone number of the person who did the billing for (PROVIDER(S)) in 2009? → RECORD NAME AND TELEPHONE NUMBER

NAME:_____

TELEPHONE NUMBER: (_____)_____ EXT:_____

Will you please transfer me to them?

YES → CONTINUE WITH A15

NO → TERMINATE CALL, CONTACT PERSON WHO DEALS WITH BILLING FOR PROVIDER(S), AND CONTINUE WITH A15

☐ BILLING SERVICE DID NOT MAINTAIN RECORDS FOR (PROVIDER(S)) IN 2009 → TERMINATE CALL; GO TO "RECONTACT PROVIDER OFFICE"

**A15.** [A12] (Hello,) my name is (YOUR NAME) and I am calling on behalf of the U.S. Department of Health and Human Services. We are conducting MEPS which is a study about how people in the United States use and pay for health care. We were referred to you by (PROVIDER) for information about [NUMBER FROM PATIENT LIST] of (his/her/their) patients. (The/Each) patient signed an authorization form allowing us to contact you for information about the cost of the care they received from (PROVIDER) in 2009. I would like to fax the authorization form(s) to you along with additional information explaining the study.

IF ASKED READ PATIENT NAMES AND OTHER IDENTIFYING INFORMATION FROM THE PATIENT DATA FORM

[READ IF THE RESPONDENT WOULD LIKE TO PROVIDE THE DATA PRIOR TO RECEIVING AUTHORIZATION FORM(S)]: In order to remain HIPAA compliant, I need to send you the authorization form(s) first. Once you have received the form(s), then we can arrange for the collection of the data.

| | |
|---|---|
| FAX AUTHORIZATION FORM(S)..... | 1 (GO TO A16) |
| MAIL AUTHORIZATION FORM(S)..... | 2 (GO TO A17) |
| OFFICE DOES NOT MAINTAIN THE INFORMATION..... | 3 (TERMINATE AND MARK FOR SUPERVISOR REVIEW) |

**A16.** [A13] I need to be sure I have the correct information for the fax cover page.
Should I address this fax to you?

YES → What is the fax number I can use to send you the authorization form(s)?

FAX NUMBER: (_____)_____

Can I also have your title and department?

TITLE: _____
DEPARTMENT:_____

GO TO A18

NO → Please tell me to whom I should fax this information.

NAME:_____
TITLE:_____
DEPARTMENT:_____
FAX NUMBER: (_____)_____

TELEPHONE NUMBER: (_____)_____ EXT: _____

GO TO A18

**A17.** [A14] I need to make sure that I have the correct mailing information.
Should I address the package to you?

YES → What is the mailing address that I can use to send you the authorization form(s)?

TITLE:_____
DEPARTMENT:_____
ADDRESS: _____
_____
CITY: _____ STATE: _____ ZIP: _____

NO→ Can I have that person's information to mail the authorization form(s)?

NAME:_____
TITLE:_____
DEPARTMENT:_____
ADDRESS: _____
_____
CITY: _____ STATE: _____ ZIP: _____

TELEPHONE NUMBER: (_____)_____ EXT: _____

**A18.** [A15] Once you have received the authorization form(s), we will call back to collect the data over the phone. For each date of service in 2009, we are requesting information about charges, payments, diagnoses, and services provided.

What would be the best day and time to call back to collect this information by phone?

DAY:_____ DATE:_____ R's TIME:_____ AM/PM

IF BILLING SERVICE DOESN'T WANT TO PROVIDE DATA OVER THE PHONE, OFFER FAX OR MAIL

You can send us the medical records by either fax or mail.

PROVIDER WILL RESPOND:

BY PHONE..... 1
BY FAX..... 2
BY MAIL..... 3

IF POC WILL RESPOND BY PHONE READ:
Thank you very much. We will allow time for you to receive and review the authorization form(s), and then we will call you back to collect the data.

IF POC WILL RESPOND BY FAX OR MAIL READ:
We hope you can send the records to our office within two weeks. We will include an instruction sheet when we (fax/mail) the authorization form(s). If you have any questions about what to send us, please call our toll-free number on the instruction sheet. We may call again if other patients identify a practice associated with this billing service as a source of medical services. Thank you very much for your help.

**CALL BACK TO CONFIRM AUTHORIZATION FORM(S) RECEIPT**

**A19.** [A16] May I please speak to (POC)?

Hello, my name is (YOUR NAME) and I am calling on behalf of the U.S. Department of Health and Human Services. We previously spoke about the MEPS study. Did you receive the authorization form(s) we (faxed/sent)?

YES ..... (GO TO A20 IF MODE = PHONE; GO TO A22 IF MODE = FAX OR MAIL)
NO ..... (GO TO A23)

IF MODE = PHONE, ASK A20

**A20.** [A21] If it is convenient for you, we can just go ahead and complete the data forms together over the phone right now. I'd be happy to hold on while you get the information you need from your records.

WILL COMPLETE BY PHONE NOW..... 1 (GO TO EVENT FORM)
WILL COMPLETE BY PHONE IN THE FUTURE..... 2 (GO TO A21)

**A21.** [A23] What would be the best day and time to call you back?

DAY:_____ DATE:_____ R's TIME:_____ AM/PM

Thank you very much for your help.

IF MODE = FAX or MAIL, ASK A22

**A22**. [N/A] Our records indicate that you will (fax/mail) the records to us. We hope you can do so within two weeks. Thank you very much for your help.

**A23.** [A17] I'm sorry. Let me (re-fax/re-send) the authorization form(s) to you.

FAX AUTHORIZATION FORM(S)..... 1 (GO TO A24)
MAIL AUTHORIZATION FORM(S)..... 2 (GO TO A25)

IF ASKED READ PATIENT NAMES AND OTHER IDENTIFYING INFORMATION FROM THE PATIENT DATA FORM

[READ IF THE RESPONDENT WOULD LIKE TO PROVIDE THE DATA PRIOR TO RECEIVING AUTHORIZATION FORM(S)]: In order to remain HIPAA compliant, I need to send you the authorization form(s) first. Once you have received the form(s), then we can arrange for the collection of the data.

**A24.** [A18] IF FAXED PREVIOUSLY: Before I send the authorization form(s) again, I would like to verify the information to include on the fax cover page.

CONFIRM PRELOAD INFORMATION

FAX NUMBER: (_____)_____
NAME:_____
TITLE:_____
DEPARTMENT:_____

We will call again to ensure that you received the authorization form(s). Thank you for your help.

IF MAILED PREVIOUSLY: I need to be sure I have the correct information for the fax cover page. Should I address this fax to you?

YES → What is the fax number I can use to send you the authorization form(s)?

FAX NUMBER: (_____)_____

Can I also have your title and department?

TITLE: _____
DEPARTMENT:_____

NO → Please tell me to whom I should fax this information.

NAME:_____
TITLE:_____
DEPARTMENT:_____
FAX NUMBER: (_____)_____
TELEPHONE NUMBER: (_____)_____ EXT: _____

We will call again to ensure that you received the authorization form(s). Thank you for your help.

**A25.** [A19] IF MAILED PREVIOUSLY: Before I send the authorization form(s) again, I would like to verify the information on the mailing label.

CONFIRM PRELOAD INFORMATION

NAME:_____
TITLE:_____
DEPARTMENT:_____
ADDRESS:_____
_____
CITY: _____ STATE: _____ ZIP: _____
TELEPHONE NUMBER: (_____)_____ EXT: _____

We will call again to ensure that you received the authorization form(s). Thank you for your help.

IF FAXED PREVIOUSLY: I need to make sure that I have the correct mailing information. Should I address the package to you?

YES → What is the mailing address that I can use to send you the authorization form(s)?

TITLE:_____
DEPARTMENT:_____
ADDRESS: _____
_____
CITY: _____ STATE: _____ ZIP: _____

NO→ Can I have that person's information to mail the authorization form(s)?

NAME:_____
TITLE:_____
DEPARTMENT:_____
ADDRESS: _____
_____
CITY: _____ STATE: _____ ZIP: _____
TELEPHONE NUMBER: (_____)_____ EXT: _____

We will call again to ensure that you received the authorization form(s). Thank you for your help.

**RECONTACT PROVIDER OFFICE [N/A]**

**INCORRECT BILLING SERVICE**

Hello may I speak to (POC)? This is (YOUR NAME) calling on behalf of the U.S. Department of Health and Human Services. We previously spoke about the MEPS study. Thank you for providing the contact information for (BILLING SERVICE). Unfortunately we were unable to locate (BILLING SERVICE) with the information you provided. Could you please verify the contact information we currently have for (BILLING SERVICE)?

NAME OF BILLING SERVICE:_____

CONTACT NAME:_____

TELEPHONE NUMBER: (_____)_____ EXT: _____

TITLE: _____

SAME INFORMATION CONFIRMED – That is currently the information we have on file. Do you know of any other way we can get in touch with (BILLING SERVICE)?

YES → COLLECT OTHER CONTACT INFORMATION

NAME OF BILLING SERVICE:_____

CONTACT NAME:_____

TELEPHONE NUMBER: (_____)_____ EXT: _____

TITLE: _____

NO → END CONTACT AND MARK FOR SUPERVISOR REVIEW

Thank you very much for your help.

**DID NOT MAINTAIN RECORDS**

Hello may I speak to (POC)? This is (YOUR NAME) calling on behalf of the U.S. Department of Health and Human Services. We previously spoke about the MEPS study. Thank you for providing the contact information for (BILLING SERVICE). We were able to locate (BILLING SERVICE) with the information you provided. However, they reported that they did not maintain the billing records for (PROVIDER(S)) in 2009. Could you please check to see if another billing service provided billing records for (PROVIDER(S)) in 2009?

**OTHER BILLING SERVICE PROVIDED →**

What is the name of the billing service, the name of a contact person, their telephone number and title?

NAME OF BILLING SERVICE:_____

CONTACT NAME:_____

TELEPHONE NUMBER: (_____)_____ EXT: _____

TITLE: _____

Thank you very much for your help.

**NO OTHER BILLING SERVICE PROVIDED →** END CONTACT AND MARK FOR SUPERVISOR REVIEW