

ATTACHMENT 72
CONTACT GUIDE
FOR
HOSPITAL PROVIDERS

REFERENCE YEAR **2017**

[MR_A]CALL PROVIDER:

MR_A1. Hello, have I reached [PROVIDER]?

PHONE NUMBER: [PROVIDER TELEPHONE NUMBER]

YES.....= 1
NO, BUT CAN RECORD A NEW NUMBER.....= 2
NO, NEED TO TRACE THE CASE.....= 3

[IF MR_A1 = 1 GO TO MR_A2,
IF MR_A1 = 2 GO TO CONTACT BLOCK,
IF MR_A1 = 3 GO TO EXIT SCREEN]

MR_A2. I have [an] authorization form[s] for the release of **medical records** and would like to speak to the person who can help me with that process.

- IF RECORDS ARE KEPT BY A MEDICAL RECORDS SERVICE, ASK TO SPEAK WITH THE PERSON IN THE OFFICE WHO DEALS WITH THE MEDICAL RECORDS SERVICE.

CONTINUE, THIS PERSON CAN HELP = 1
COLLECT CONTACT INFORMATION FOR SOMEONE ELSE = 2
NO MEDICAL RECORDS DEPARTMENT; UNCLEAR WHO HANDLES RECORDS = 3

[IF MR_A2= 1 GO TO MR_B1,
IF MR_A2=2 GO TO CONTACT BLOCK,
IF MR_A2=3 GO TO EXIT SCREEN]

[MR_B]IDENTIFY DC POC

MR_B1. My name is (YOUR NAME). 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. For quality assurance and training purposes, this call may be monitored.

POC: [POC NAME]

READ IF NECESSARY: I have [an] authorization form[s] for the release of medical records and would like to speak to the person that can help me with that process.

- IF THIS PERSON CANNOT HELP, ASK TO BE TRANSFERRED TO SOMEONE WHO CAN.

CONTINUE, THIS PERSON CAN HELP.....= 1
COLLECT CONTACT INFORMATION FOR SOMEONE ELSE.....= 2

[IF MR_B1=1, GO TO MR_B2,

IF MR_B1=2, GO TO CONTACT BLOCK]

MR_B2. Thank you. First, can you confirm that this is a hospital, hospital outpatient department, hospital satellite clinic, surgi-center, or a skilled nursing facility?

- YES, THIS IS A HOSPITAL, HOSP OUTPATIENT DEPT, HOSP SATELLITE CLINIC, SURGI-CENTER, OR SKILLED NURSING FACILITY.....1
- NO, THIS IS NOT A HOSPITAL, HOSP OUTPATIENT DEPT, HOSP SATELLITE CLINIC, SURGI-CENTER, OR SKILLED NURSING FACILITY.....2

[IF MR_B2=1 GO TO MR_B4;
IF MR_B2=2 GO TO MR_B3a.]

MR_B3a. How would you describe this facility? Is this:

- A doctor's office.....1
- A publicly-funded clinic.....2
- An urgent care center.....3
- A home care provider.....4
- A long term care facility, such as a nursing home, or.....5
- Something else (SPECIFY)?.....6

(READ ONLY IF NECESSARY:

A hospital outpatient department, hospital satellite clinic, surgi-center, or skilled nursing facility?)

IF RESPONDENT REPORTS HOSPITAL OUTPATIENT DEPARTMENT, HOSPITAL SATELLITE CLINIC, SURGI-CENTER, OR SKILLED NURSING FACILITY GO BACK TO **ITEM MR_B2 - ELIGIBILITY- VERIFY HOSPITAL AND CODE ACCORDINGLY.**

[IF MR_B3a=1,2,3,4,5 GO TO MR_B4]

MR_B4. At this time, [NUMBER FROM PATIENT LIST] patient[s] identified [PROVIDER] as a source of health care during [FILL_YR]. [The/Each] patient signed an authorization form allowing us to contact you for information about the care they received from [PROVIDER] in [FILL_YR]. Much of the information we need is within the medical records. Are the medical records maintained in your office, or is a medical records service used?

- OFFICE MAINTAINS THE INFORMATION = 1
- OFFICE USES A MEDICAL RECORDS SERVICE = 2

[IF MR_B4 = 1 GO TO MR_B4B,
IF MR_B4 = 2 GO TO MR_B4_1]

MR_B4_1. Are you the person who deals with the medical records service?

- YES.....= 1
- NO.....= 2

[IF MR_B4_1 = 1, GO TO MR_C2,
IF MR_B4_1 = 2, GO TO MR_B4A]

MR_B4a. I'll need to collect the name and telephone number for the person in your office who deals with the medical records service.

MR_B4b. I would like to send the authorization form[s] to you, along with additional information explaining the study. I need to be sure I have the correct information for the packet. Should I direct it to you?

- **READ IF THE PERSON ON THE PHONE 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.

YES.....= 1
NO.....= 2

[GO TO CONTACT BLOCK]

MR_B5. Can you please provide the name and number for the person who (needs to receive the courtesy packet/needs to receive the forms) to approve the release of data?

YES.....= 1
NO.....= 2

[IF MR_B5 = 1 GO TO CONTACT BLOCK,
IF MR_B5 = 2 GO TO EXIT SCREEN.]

[MR_C]IDENTIFY MR SERVICE

MR_C1. Hello, my name is (YOUR NAME).

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.
For quality assurance and training purposes, this call may be monitored.

POC: [POC NAME]

READ IF NECESSARY: I have [an] authorization form[s] for the release of medical records and would like to speak to the person that can help me get in touch with the medical records service that maintains your records.

- IF THIS PERSON CANNOT HELP, ASK TO BE TRANSFERRED TO SOMEONE WHO CAN.

CONTINUE, THIS PERSON CAN HELP.....= 1
COLLECT CONTACT INFORMATION FOR SOMEONE ELSE.....= 2

[IF MR_C1=1, GO TO MR_C2,
IF MR_C1=2, GO TO CONTACT BLOCK]

MR_C2. READ IF NECESSARY: At this time, [NUMBER FROM PATIENT LIST] patient[s] identified [PROVIDER] as a source of health care during [FILL_YR]. [The/Each] patient signed an authorization form allowing us to contact you for information about the care they received from [PROVIDER] in [FILL_YR].

We should be able to get all of the information we need from the medical records service.
We can also send you a copy of the authorization form[s] for your files.

I need to be sure I have the correct information for the packet. Should I direct it to you?

- READ IF THE PERSON ON THE PHONE 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.

YES.....= 1
NO.....= 2

[GO TO CONTACT BLOCK]

MR_C3. Can you please provide the name of the medical records service, the name of a contact person, their telephone number and title?

- IF THIS PERSON CANNOT HELP, ASK TO BE TRANSFERRED TO SOMEONE WHO CAN AND RESTART THIS SECTION.

YES.....= 1
NO.....= 2

[IF MR_C3 = 1 GO TO CONTACT BLOCK,
IF MR_C2 = 2 GO TO EXIT SCREEN.]

[MR_D]CALL MR SERVICE

MR_D1. Have I reached [MEDICAL RECORDS SERVICE]?

PHONE NUMBER: [MEDICAL RECORDS SERVICE TELEPHONE NUMBER]

- IF THE PERSON ON THE PHONE SAYS NO, VERIFY THAT YOU DIALED THE CORRECT NUMBER
- IF THE NUMBER IS CORRECT, ASK IF THE PERSON ON THE PHONE KNOWS OF ANOTHER NUMBER FOR THE MEDICAL RECORDS SERVICE. IF THEY DO, GO TO THE CONTACT BLOCK AND EDIT THE INFORMATION FOR THE MEDICAL RECORDS SERVICE.
- IF NO BETTER NUMBER IS AVAILABLE, SELECT "NO" BELOW.

YES.....= 1
NO.....= 2

[IF MR_D1 = 1 GO TO MR_D2,
IF MR_D1 = 2 GO TO EXIT]

MR_D2. We were referred to you by [PROVIDER] about [NUMBER FROM PATIENT LIST] of their patients who received medical service in [FILL_YR]. I have [an] authorization form[s] for the release of medical records and would like to speak to the person that can help me with that process.

IF THE PERSON YOU NEED TO TALK TO IS UNAVAILABLE ATTEMPT TO GET THEIR CONTACT INFORMATION VIA THE CONTACT BLOCK AND SET AN APPOINTMENT IF POSSIBLE.

CONTINUE = 1
SERVICE DOES NOT MAINTAIN 2017 RECORDS FOR PROVIDER =2
NOT CLEAR WHO TO SPEAK TO; WRONG NUMBER = 3

[IF MR_D2= 1 GO TO MR_E1,
IF MR_D2=2 OR 3 GO TO EXIT SCREEN]

[MR_E]MR SERVICE: IDENTIFY POC

MR_E1. Hello, my name is (YOUR NAME).

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.
For quality assurance and training purposes, this call may be monitored.

POC: [POC NAME]

READ IF NECESSARY: I have [an] authorization form[s] for the release of medical records and would like to speak to the person that can help me with that process.

- IF THIS PERSON CANNOT HELP, ASK TO BE TRANSFERRED TO SOMEONE WHO CAN.

CONTINUE, THIS PERSON CAN HELP.....= 1
COLLECT CONTACT INFORMATION FOR SOMEONE ELSE.....= 2

[IF MR_E1=1, GO TO MR_E2,
IF MR_E1=2, GO TO CONTACT BLOCK;]

MR_E2. We were referred to you by [PROVIDER] for information about one or more of (his/her/their) patients. At this time, [NUMBER FROM PATIENT LIST] patient[s] signed an authorization form allowing us to contact you for information about the care they received from [PROVIDER] in [FILL_YR].

I would like to send the authorization form[s] to you, along with additional information explaining the study.

I need to be sure I have the correct information for the packet. Should I direct it to you?

- READ IF THE PERSON ON THE PHONE 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.

YES.....= 1
NO.....= 2

[GO TO CONTACT BLOCK]

MR_E3. Can you please provide the name and number for the person who (needs to receive the courtesy packet/needs to receive the forms) to approve the release of data?

YES.....= 1
NO.....= 2

[IF MR_E3 = 1 GO TO CONTACT BLOCK,
IF MR_E3 = 2 GO TO EXIT SCREEN]

[MR_F]DC: EXPLAIN NEXT STEPS

MR_F1. Once you have received the authorization form[s] you can send us the medical records by either fax or mail. For each date of service in [FILL_YR], we are requesting information about the diagnoses and services, and the names of the physicians who treated each patient in [FILL_YR].

IF POC REQUESTS ELECTRONIC TRANSFER, DISCUSS WITH YOUR SUPERVISOR BEFORE SELECTING THIS OPTION.

PROVIDER WILL RESPOND:

.....
.....BY FAX 2
.....BY MAIL 3
. ONLY USE OPTION 4 IF APPROVED BY SUPERVISOR
.....BY ELECTRONIC PORTAL 4

GO TO MR_F2

MR_F2. Within the next [30 minutes / 24 hours] we will [fax/mail/electronically upload] the authorization form[s] and provide instructions for sending the records. If you have any questions about what to send us, please call our toll-free number on the instruction sheet. We will call to verify that you received the authorization forms.

We may call again if other patients identify your practice as a source of medical services.

[IF CB3=1 OR 2 GO TO MR_F4; IF CB3=4, GO TO MR_F3.]

MR_F3.

When the authorization form packet is ready, you will receive an email with your unique username to access the electronic portal. The portal password is the part of your email address before the @ sign and the number 1234. Your password is <fill portal password> all in lower case. It is highly recommended that you change your password after your first log-in.

Each authorization form packet will be encrypted with a password also. Your password for the packet is <fill AF password>. This password is also in lower case.

[GO TO MR_F4]

MR_F4. We are also interested in the charges and the summary of payments for each date of service in [FILL_YR]. Can you provide this information?

YES.....1
NO.....2

[IF MR_F4=1 GO TO CONTACT BLOCK AND THEN MR_F5;
IF MR_F4=2 GO TO MR_F4a.]

MR_F4a. Can you please provide the name and number for whom we should contact to obtain this information?

YES.....1
NO.....2

[IF MR_F4a=1 GO TO CONTACT BLOCK ;
IF MR_F4a=2 GO TO MR_F5].

MR_F5. Lastly, we are interested in collecting the names and locating information for the providers who treated each patient while they received services in this facility during [FILL_YR]. Can you provide this information as well?

YES.....1
NO.....2

[IF MR_F5=1 GO TO CONTACT BLOCK
IF MR_F5=2 GO TO MR_F5a.]

MR_F5a. Can you please provide the name and number for whom we should contact to obtain this information?

YES.....1
NO.....2

[IF MR_F5a=1 GO TO CONTACT BLOCK
IF MR_F5a=2, GO TO EXIT SCREEN;

[MR_G]VERIFY RECEIPT OF AFS

MR_G_Intro. May I please speak to [POC NAME]?

PERSON IS ON THE PHONE.....= 1
PERSON IS NOT AVAILABLE.....= 2

[POC NAME] should fill with the name flagged as primary from CONTACT BLOCK;
IF MR_G_Intro=1, GO TO MR_G1;
IF MR_G_Intro =2, GO TO APPOINTMENT SCREEN]

MR_G1. Hello, my name is (YOUR NAME). I am calling on behalf of the U.S. Department of Health and Human Services. For quality assurance and training purposes, this call may be monitored. We previously spoke about the MEPS study.

Did you receive the authorization form[s] we sent to you?

YES, RECEIVED ALL = 1

YES, BUT PROBLEM REPORTED/NEEDS A RE-SEND = 2

NO = 3

[IF MR_G1=1 and MR_F1 = 1 (FAX) OR 2 (MAIL) GO TO MR_G4;
IF MR_G1=2 OR 3, GO TO MR_G5]

MR_G4.

Our records indicate that you will [fax/mail/electronically upload] the records to us.

IF MR ONLY:

Please send in the complete medical records for all [FILL_YR] dates of service for each patient listed. The information we are attempting to collect from these records includes diagnosis and the names of providers who may have billed the patient separately from the hospital.

IF MR & PA:

Please send in the complete medical records and final billing records for all [FILL_YR] dates of service for each patient listed. The information we are attempting to collect from these medical records includes diagnosis and the names of providers who may have billed the patient separately from the hospital. Information we are attempting to collect for billing includes, charges, payments, and adjustments for each date of service.

[IF THE POC MENTIONS UB04 OR CMS 1500, SAY:] We need a final itemized statement that includes payments and adjustments so that we do not have to call back to obtain this information, but we can use UB04/CMS 1500 forms to accompany these final itemized statements..

When will you send us these records?

DATE: _____

IF DATE IS SELECTED REPEAT THE DATE AND THE DAY OF THE WEEK

OR

1 DAYS

2 WEEKS

NUMBER OF DAYS/WEEKS:

MR_G4_1: Thank you. We will call you back if we do not receive the records by [FILL DATE FROM MR_G4 (CALCULATE DATE IF DAYS/WEEKS ENTERED)].

YOUR NEXT STEPS WILL BE TO EXIT THE CONTACT GUIDE AND CODE THE CASE AS "AFs RECEIVED. WAITING FOR RECORDS TO BE SENT". THEN SET A CALL BACK AFTER THE RECORDS ARE EXPECTED SO WE CAN PROMPT AGAIN IF THEY STILL HAVE NOT BEEN RECEIVED.

MR_G4_2:

INTERVIEWER: USE THIS SCREEN WHEN PROMPTING FOR RECORDS

We were anticipating receiving (medical records/ medical and billing records) from you by [DATE/CALCULATED DATE FROM MR_G4], but my records show we have not received them. Have you sent the records to us?

- YES.....1
- NO.....2

IF MR_G4_2 = 2 GO TO MR_G4_5

MR_G4_3: How did you send the records? Did you fax, mail hardcopies via express or regular mail, mail CDs via express or regular mail, or use a record service's portal?

- FAX.....1
- MAIL HARDCOPIES VIA EXPRESS MAIL...2
- MAIL HARDCOPIES VIA REGULAR MAIL...3
- MAIL CDs VIA EXPRESS MAIL.....4
- MAIL CDs VIA REGULAR MAIL.....5
- RECORD SERVICE'S ELECTRONIC PORTAL.....6
- ELECTRONIC PORTAL.....8
- OTHER (Specify: _____).....7

IF POC IS SENDING CD: Was the password provided or did you send it separately?

- Provided
- Emailed separately
- Mailed separately

MR_G4_4: What date did you send them?

DATE: _____

Thank you for sending them. The records are received in a separate department and it can take a few days to upload the documents into our system. We will investigate and call you back if we have further questions. We apologize for any inconvenience.

INTERVIEWER:

- DISPOSITION THE CASE AT CATEGORY: REFUSALS/PROBLEMS/OTHER WITH EVENT CODE 675-CASE REQUIRES SUPERVISOR REVIEW
- LEAVE A DETAILED CALL HISTORY COMMENT AFTER ENDING THE CALL

- USE "DIFFICULT CASE" SHEET TO CAPTURE CASE ID AND DETAILS AND HAVE A TEAM LEAD OR SUPERVISOR FOLLOW UP AND RESOLVE WITHIN 24 HOURS

MR_G4_5

We need to obtain these records for the study as soon as possible. Is there something that can be done to speed up (or expedite) the process?

INTERVIEWER: LISTEN TO POC TO DETERMINE IF THERE IS ANYTHING WE CAN DO TO HELP FACILITATE THEM SENDING IN RECORDS. OFFER:

- FTP AND SECURE E-MAIL
- A FEDEX PICKUP FOR CASES THAT ARE ABOVE 15 PAIRS

When will you send us these records?

DATE: _____

IF DATE IS SELECTED REPEAT THE DATE AND DAY OF THE WEEK

OR

 DAYS

NUMBER OF DAYS/WEEKS:  WEEKS

IF MR ONLY:

Please send in the complete medical records for all [FILL_YR] dates of service for each patient listed. The information we are attempting to collect from these records includes diagnosis and the names of providers who may have billed the patient separately from the hospital.

IF MR & PA:

Please send in the complete medical records and final billing records for all [FILL_YR] dates of service for each patient listed. The information we are attempting to collect from these medical records includes diagnosis and the names of providers who may have billed the patient separately from the hospital. Information we are attempting to collect for billing includes, charges, payments, and adjustments for each date of service.

[IF THE POC MENTIONS UB04 OR CMS 1500, SAY:] We need a final itemized statement that includes payments and adjustments so that we do not have to call back to obtain this information, but we can use UB04/CMS 1500 forms to accompany these final itemized statements.

MR_G4_6: Thank you. We will call you back if we do not receive the records by [FILL DATE FROM MR_G4_5 (CALCULATE DATE IF DAYS/WEEKS ENTERED)].

INTERVIEWER: SET A CALL BACK AFTER THE RECORDS ARE EXPECTED SO WE CAN PROMPT AGAIN IF THEY STILL HAVE NOT BEEN RECEIVED.

[GO TO EXIT SCREEN]

MR_G5. I'm sorry. Let me re-send the authorization form[s] to you.

I need to be sure I have the correct information for the packet. Should I direct it to you?

YES = 1
NO = 2

- **IF PERSON ON PHONE WANTS TO PROVIDE DATA BEFORE RECEIVING AUTHORIZATION FORMS:** 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.

[GO TO CONTACT BLOCK]

MR_G6.

Once we verify that you have received the authorization forms, you will receive an email with your unique username to access the electronic portal. The portal password is the part of your email address before the @ sign and the number 1234. Your password is <fill portal password> all in lower case. It is highly recommended that you change your password after your first log-in.

[GO TO EXIT]

[MR_H]BAD MR SERVICE INFO.

MR_H1. ASK (BY NAME) TO SPEAK WITH THE POC WHO DEALS WITH THE EXTERNAL BILLING SERVICE

This is (YOUR NAME) calling on behalf of the U.S. Department of Health and Human Services. For quality assurance and training purposes, this call may be monitored.

We previously spoke about the MEPS study. Thank you for providing the contact information for [MEDICAL RECORDS SERVICE NAME]. Unfortunately we were unable to locate [MEDICAL RECORDS SERVICE NAME] with the contact information you provided. Could you please verify the contact information we currently have for [MEDICAL RECORDS SERVICE NAME]?

[PRESENT MEDICAL RECORDS SERVICE CONTACT INFO HERE]

MEDICAL RECORDS SERVICE CONTACT INFO IS CORRECT=1

MEDICAL RECORDS SERVICE CONTACT INFO IS NOT CORRECT=2

[IF MR_H1=1, GO TO MR_H2;
IF MR_H1=2, GO TO CONTACT BLOCK]

MR_H2. That is currently the information we have on file. Do you know of any other way we can get in touch with [MEDICAL RECORDS SERVICE NAME]?

YES = 1
NO = 2

[IF MR_H2 = 1 GO TO CONTACT BLOCK, ;

[IF MR_H2=2 GO TO EXIT SCREEN]

[MR_I]ANY OTHER MR SERVICE?

MR_I1. ASK (BY NAME) TO SPEAK WITH THE POC WHO DEALS WITH THE EXTERNAL BILLING SERVICE

This is (YOUR NAME) calling on behalf of the U.S. Department of Health and Human Services.
For quality assurance and training purposes, this call may be monitored.

We previously spoke about the MEPS study. Thank you for providing the contact information for [MEDICAL RECORDS SERVICE NAME]. We were able to locate [MEDICAL RECORDS SERVICE NAME] with the information you provided. However, they reported that they did not maintain the medical records for [PROVIDER(S)] in [FILL_YR]. Could you please check to see if another medical records service maintained medical records for [PROVIDER(S)] in [FILL_YR]?

OTHER MEDICAL RECORDS SERVICE MAINTAINED RECORDS	=1
NO OTHER MEDICAL RECORDS SERVICE MAINTAINED RECORDS	=2

[IF MR_I1=1, GO TO CONTACT BLOCK,;
IF MR_I1=2, GO TO EXIT SCREEN]

[PA_A]CALL PROVIDER

PA_A1. Hello, have I reached [PROVIDER]?

PHONE NUMBER: [PROVIDER TELEPHONE NUMBER]

YES.....= 1
NO, BUT CAN RECORD A NEW NUMBER.....= 2
NO, NEED TO TRACE THE CASE.....= 3

[IF PA_A1 = 1 GO TO PA_A2,
IF PA_A1 = 2 GO TO CONTACT BLOCK,
IF PA_A1 = 3 GO TO EXIT]

PA_A2. I have [an] authorization form[s] for the release of **billing and payment records** and would like to speak to the person that can help me with that process.

- IF RECORDS ARE KEPT BY AN EXTERNAL BILLING SERVICE, ASK TO SPEAK WITH THE PERSON IN THE OFFICE WHO DEALS WITH THE EXTERNAL BILLING SERVICE.

CONTINUE, THIS PERSON CAN HELP = 1
COLLECT CONTACT INFORMATION FOR SOMEONE ELSE = 2
NO BILLING DEPARTMENT; UNCLER WHO HANDLES BILLING = 3

[IF PA_A2= 1 GO TO PA_B1,
IF PA_A2=2, GO TO CONTACT BLOCK
IF PA_A2=3 GO TO EXIT SCREEN]

[PA_B]IDENTIFY DC POC

PA_B1. My name is (YOUR NAME).

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.
For quality assurance and training purposes, this call may be monitored.

POC: [POC NAME]

READ IF NECESSARY: I have [an] authorization form[s] for the release of billing and payment records and would like to speak to the person that can help me with that process.

- IF THIS PERSON CANNOT HELP, ASK TO BE TRANSFERRED TO SOMEONE WHO CAN.

CONTINUE, THIS PERSON CAN HELP.....= 1
COLLECT CONTACT INFORMATION FOR SOMEONE ELSE.....= 2

[IF PA_B1=1, GO TO PA_B2,
IF PA_B1=2, GO TO CONTACT BLOCK;]

PA_B2 At this time, [NUMBER FROM PATIENT LIST] patient[s] identified [PROVIDER] as a source of health care during [FILL_YR]. [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 [FILL_YR]. Much of the information we need is within the billing and payment records. Are the billing and payment records maintained in your office, or is an external billing service used?

OFFICE MAINTAINS THE INFORMATION = 1
OFFICE USES AN EXTERNAL BILLING SERVICE = 2

[IF PA_B2 = 1 GO TO PA_B2b,
IF PA_B2 = 2 GO TO PA_B2_1]

PA_B2_1. Are you the person who deals with the external billing service?

YES = 1
NO = 2

[IF PA_B2_1 = 1, GO TO PA_C2,
IF PA_B2_1 = 2, GO TO PA_B2a]

PA_B2a. I'll need to collect the name and telephone number for the person in your office who deals with the external billing service.

NEXT BUTTON TAKES USER TO CONTACT_BLOCK

PA_B2b. DID THIS PERSON ON THE PHONE WITH YOU NOW MENTION THAT HE/SHE DOES NOT NEED AUTHORIZATION FORMS BECAUSE WE ALREADY PROVIDED THESE TO THE MEDICAL RECORDS DEPARTMENT?

NO, WE SHOULD SEND AUTHORIZATION FORMS TO THIS PERSON.....1

YES, WE CAN SKIP SENDING AUTHORIZATION FORMS TO THIS PERSON.....2

IF PA_B2b = 1 GO TO PA_B2c;
IF PA_B2b = 2 GO TO PA_B2c]

PA_B2c. [IF PA_B2b=1 FILL "I would like to send the authorization form[s] to you, along with additional information explaining the study. I need to be sure I have the correct information for the packet. Should I direct it to you?"
[IF PA_b2b=2 FILL "I'll need to send you some basic information about the study. Should I direct it to you?"

- READ IF THE PERSON ON THE PHONE 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.

YES.....= 1
NO.....= 2

[GO TO CONTACT BLOCK]

PA_B3. Can you please provide the name and number for the person who (needs to receive the courtesy packet/needs to receive the forms) to approve the release of data?

YES.....= 1
NO.....= 2

[IF PA_B3 = 1 GO TO CONTACT BLOCK,
IF PA_B3 = 2 GO TO EXIT SCREEN.]

[PA_C]IDENTIFY BILLING SERVICE

PA_C1. Hello, my name is (YOUR NAME). 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. For quality assurance and training purposes, this call may be monitored.

POC: [POC NAME]

READ IF NECESSARY: I have [an] authorization form[s] for the release of billing and payment records and would like to speak to the person that can help me get in touch with the external billing service that maintains your billing and payment records.

- IF THIS PERSON CANNOT HELP, ASK TO BE TRANSFERRED TO SOMEONE WHO CAN.

CONTINUE, THIS PERSON CAN HELP.....= 1
COLLECT CONTACT INFORMATION FOR SOMEONE ELSE.....= 2

[IF PA_C1=1, GO TO PA_C2,
IF PA_C1=2, GO TO CONTACT BLOCK]

PA_C2. READ IF NECESSARY: At this time, [NUMBER FROM PATIENT LIST] patient[s] identified [PROVIDER] as a source of health care during [FILL_YR]. [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 [FILL_YR].

We should be able to get all of the information we need from the billing service.
We can also send you a copy of the authorization form[s] for your files.

I need to be sure I have the correct information for the packet. Should I direct it to you?

- READ IF THE PERSON ON THE PHONE 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.

YES.....= 1
NO.....= 2

[GO TO CONTACT BLOCK]

PA_C3. Can you please provide the name of the billing service, the name of a contact person, their telephone number and title?

YES.....= 1
NO.....= 2

- IF THIS PERSON CANNOT HELP, ASK TO BE TRANSFERRED TO SOMEONE WHO CAN AND RESTART THIS SECTION.

[IF PA_C3 = 1 GO TO CONTACT BLOCK,
IF PA_C3 = 2 GO TO EXIT SCREEN.]

[PA _D]CALL BILLING SERVICE

PA_D1. Have I reached [BILLING SERVICE]?

PHONE NUMBER: [BILLING SERVICE TELEPHONE NUMBER]

- IF THE PERSON ON THE PHONE SAYS NO, VERIFY THAT YOU DIALED THE CORRECT NUMBER.
- IF THE NUMBER IS CORRECT, ASK IF THE PERSON ON THE PHONE KNOWS OF ANOTHER NUMBER FOR THE BILLING SERVICE. IF THEY DO, GO TO THE CONTACT BLOCK AND EDIT THE INFORMATION FOR THE BILLING SERVICE.
- IF NO BETTER NUMBER IS AVAILABLE, SELECT “NO” BELOW.

YES.....= 1
NO.....= 2

[IF PA_D1 = 1 GO TO PA_D2,
IF PA_D1 = 2 GO TO EXIT SCREEN]

PA_D2. We were referred to you by [PROVIDER] about [NUMBER FROM PATIENT LIST] of their patients who received medical service in [FILL_YR]. I have [an] authorization form[s] for the release of billing and payment records and would like to speak to the person that can help me with that process.

IF THE PERSON YOU NEED TO TALK TO IS UNAVAILABLE ATTEMPT TO GET THEIR CONTACT INFORMATION VIA THE CONTACT BLOCK AND SET AN APPOINTMENT IF POSSIBLE.

CONTINUE = 1
SERVICE DOES NOT MAINTAIN [FILL_YR] RECORDS FOR PROVIDER =2
NOT CLEAR WHO TO SPEAK TO; WRONG NUMBER = 3

[IF PA_D2= 1 GO TO PA_E1, ,
IF PA_D2=2 OR 3, GO TO EXIT SCREEN]

[PA_E]BILLING SVC.: IDENTIFY POC

PA_E1Hello, my name is (YOUR NAME).

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.
For quality assurance and training purposes, this call may be monitored.

POC: [POC NAME]

READ IF NECESSARY: I have [an] authorization form[s] for the release of billing and payment records and would like to speak to the person that can help me with that process.

- IF THIS PERSON CANNOT HELP, ASK TO BE TRANSFERRED TO SOMEONE WHO CAN.

CONTINUE, THIS PERSON CAN HELP.....= 1
COLLECT CONTACT INFORMATION FOR SOMEONE ELSE.....= 2

[IF PA_E1=1, GO TO PA_E2,
IF PA_E1=2, GO TO CONTACT BLOCK;]

PA_E2. We were referred to you by [PROVIDER] for information about one or more of (his/her/their) patients. At this time, [NUMBER FROM PATIENT LIST] patient[s] signed an authorization form allowing us to contact you for information about the care they received from [PROVIDER] in [FILL_YR]. For each date of service in [FILL_YR] we are asking for the charges and the summary of payments.

I would like to send the authorization form[s] to you, along with additional information explaining the study.
I need to be sure I have the correct information for the packet. Should I direct it to you?

- READ IF THE PERSON ON THE PHONE 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.
YES.....= 1
NO.....= 2

[GO TO CONTACT BLOCK]

PA_E3. Can you please provide the name and number for the person who (needs to receive the courtesy packet/needs to receive the forms) to approve the release of data?

YES.....= 1
NO.....= 2

[IF PA_E3 = 1 GO TO CONTACT BLOCK,
IF PA_E3 = 2 GO TO EXIT SCREEN]

[PA _F]DC: EXPLAIN NEXT STEPS

PA_F1. Once you have received the [authorization form[s]/information explaining the study] you can send us the billing and payment records by either fax or mail. For each date of service in [FILL_YR], we are collecting the amounts charged for services before any adjustments or discounts, and the sources and amounts of payment.

IF POC REQUESTS ELECTRONIC TRANSFER, DISCUSS WITH YOUR SUPERVISOR BEFORE SELECTING THIS OPTION.

PROVIDER WILL RESPOND:

.....BY FAX 2
BY MAIL 3
 . . . ONLY USE OPTION 4 IF APPROVED BY SUPERVISOR
BY ELECTRONIC PORTAL 4

PA_F2. Within the next [30 minutes / 24 hours] we will [fax/mail/electronically upload] the [authorization form[s]/information explaining the study] and provide instructions for sending the records. If you have any questions about what to send us, please call our toll-free number on the instruction sheet. We will call to verify that you received the authorization forms.

We may call again if other patients identify your practice as a source of medical services.]

PA_F3.

When the authorization form packet is ready, you will receive an email with your unique username to access the electronic portal. The portal password is the part of your email address before the @ sign and the number 1234. Your password is <fill portal password> all in lower case. It is highly recommended that you change your password after your first log-in.

Each authorization form packet will be encrypted with a password also. Your password for the packet is <fill AF password>. This password is also in lower case.

PA_F4. We are also interested in collecting the names and locating information for the providers who treated each patient while they received services in this facility in [FILL_YR]. Can you provide this information as well?

YES.....1
 NO.....2

[IF PA_F4=1 GO TO CONTACT BLOCK,;
 IF PA_F4=2 GO TO PA_F4a.]

PA_F4a. Can you please provide the name and number for whom we should contact to obtain this information?

YES.....1
 NO.....2

[IF PA_F4a=1 GO TO CONTACT BLOCK,;
 IF PA_F4a=2 GO TO EXIT].

[PA _G]VERIFY RECEIPT OF AFs

PA_G_Intro. May I please speak to [POC NAME]?

PERSON IS ON THE PHONE.....= 1
 PERSON IS NOT AVAILABLE.....= 2

[IF PA_G_Intro=1, GO TO PA_G1;
IF PA_G_Intro =2, GO TO APPOINTMENT SCREEN]

PA_G1. Hello, my name is (YOUR NAME). I am calling on behalf of the U.S. Department of Health and Human Services. For quality assurance and training purposes, this call may be monitored. We previously spoke about the MEPS study.

Did you receive the [authorization form[s]/information explaining the study] we sent to you?

YES, RECEIVED ALL = 1
YES, BUT PROBLEM REPORTED/NEEDS A RE-SEND = 2
NO = 3

[IF PA_G1=1 and PA_F1 = 1 (FAX) OR 2 (MAIL) OR 3 (ELECTRONIC PORTAL) GO TO PA_G4;
IF PA_G1=2 OR 3, GO TO PA_G5]

PA_G4.

Our records indicate that you will [fax/mail/electronically upload] the records to us.

IF PA ONLY: Please send in the final billing records for all [FILL_YR] dates of service for each patient listed. The information we are attempting to collect from these billing records includes charges, payments, and adjustments for each date of service.

IF MR & PA:

Please send in the complete medical records and final billing records for all [FILL_YR] dates of service for each patient listed. The information we are attempting to collect from these medical records includes diagnosis and the names of providers who may have billed the patient separately from the hospital. Information we are attempting to collect for billing includes, charges, payments, and adjustments for each date of service.

[IF THE POC MENTIONS UB04 OR CMS 1500, SAY:] We need a final itemized statement that includes payments and adjustments so that we do not have to call back to obtain this information, but we can use UB04/CMS 1500 forms to accompany these final itemized statements.

When will you send us these records?

DATE: _____

IF DATE IS SELECTED REPEAT THE DATE AND DAY OF THE WEEK

OR

1 DAYS

NUMBER OF DAYS/WEEKS 2 WEEKS

PA_G4_1. Thank you. We will call you back if we do not receive the records by [FILL DATE FROM PA_G4 (CALCULATE DATE IF DAYS/WEEKS ENTERED)].

YOUR NEXT STEPS WILL BE TO EXIT THE CONTACT GUIDE AND CODE THE CASE AS “AFs RECEIVED. WAITING FOR RECORDS TO BE SENT”. THEN SET A CALL BACK AFTER THE RECORDS ARE EXPECTED SO WE CAN PROMPT AGAIN IF THEY STILL HAVE NOT BEEN RECEIVED.

PA_G4_2

INTERVIEWER: USE THIS SCREEN WHEN PROMPTING FOR RECORDS

We were anticipating receiving (IF PA ONLY: billing and payment records / IF MR & PA: medical records and billing and payment records) from you by [DATE/CALCULATED DATE FROM PA_G4], but my records show we have not received them. Have you sent the records to us?

- YES.....1
- NO.....2

IF PA_G4_2 = 2 GO TO PA_G4_5

PA_G4_3:

How did you send the records? Did you fax, mail hardcopies via express or regular mail, mail CDs via express or regular mail, or use a record service’s portal?

- FAX.....1
- MAIL HARDCOPIES VIA EXPRESS MAIL...2
- MAIL HARDCOPIES VIA REGULAR MAIL...3
- MAIL CDs VIA EXPRESS MAIL.....4
- MAIL CDs VIA REGULAR MAIL.....5
- RECORD SERVICE’S ELECTRONIC PORTAL.....6
- ELECTRONIC PORTAL.....8
- OTHER (Specify: _____).....7

IF POC IS SENDING CD: Was the password provided or did you send it separately?

- Provided
- Emailed separately
- Mailed separately

PA_G4_4: What date did you send them?

DATE: _____

Thank you for sending them. The records are received in a separate department and it can take a few days to upload the documents into our system. We will investigate and call you back if we have further questions. We apologize for any inconvenience.

INTERVIEWER:

- DISPOSITION THE CASE AT CATEGORY: REFUSALS/PROBLEMS/OTHER WITH EVENT CODE 675-CASE REQUIRES SUPERVISOR REVIEW
- LEAVE A DETAILED CALL HISTORY COMMENT AFTER ENDING THE CALL
- USE "DIFFICULT CASE" SHEET TO CAPTURE CASE ID AND DETAILS AND HAVE A TEAM LEAD OR SUPERVISOR FOLLOW UP AND RESOLVE WITHIN 24 HOURS

[NEXT WILL ROUTE TO EXIT SCREEN]

PA_G4_5

We need to obtain these records for the study as soon as possible. Is there something that can be done to speed up (or expedite) the process?

INTERVIEWER: LISTEN TO POC TO DETERMINE IF THERE IS ANYTHING WE CAN DO TO HELP FACILITATE THEM SENDING IN RECORDS. OFFER:

- FTP AND SECURE E-MAIL
- A FEDEX PICKUP FOR CASES THAT ARE ABOVE 15 PAIRS

When will you send us these records?

DATE: _____

IF DATE IS SELECTED REPEAT THE DATE AND DAY OF THE WEEK

OR

 **1** DAYS

NUMBER OF DAYS/WEEKS:  **2** WEEKS

IF PA ONLY: Please send in the final billing records for all [FILL_YR] dates of service for each patient listed. The information we are attempting to collect from these billing records includes charges, payments, and adjustments for each date of service.

IF MR & PA:

Please send in the complete medical records and final billing records for all [FILL_YR] dates of service for each patient listed. The information we are attempting to collect from these medical records includes diagnosis and the names of providers who may have billed the patient separately from the hospital. Information we are attempting to collect for billing includes, charges, payments, and adjustments for each date of service.

[IF THE POC MENTIONS UB04 OR CMS 1500, SAY:] We need a final itemized statement that includes payments and adjustments so that we do not have to call back to obtain this information, but we can use UB04/CMS 1500 forms to accompany these final itemized statements.

PA_G4_6: Thank you. We will call you back if we do not receive the records by [FILL DATE FROM PA_G4_5 (CALCULATE DATE IF DAYS/WEEKS ENTERED)].

INTERVIEWER: SET A CALL BACK AFTER THE RECORDS ARE EXPECTED SO WE CAN PROMPT AGAIN IF THEY STILLHAVE NOT BEEN RECEIVED.

[GO TO EXIT SCREEN]

PA_G5. I'm sorry. Let me re-send the [authorization form[s]/information explaining the study] to you.

I need to be sure I have the correct information for the packet. Should I direct it to you?

YES = 1

NO = 2

- IF PERSON ON PHONE WANTS TO PROVIDE DATA BEFORE RECEIVING AUTHORIZATION FORMS: 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.

[GO TO CONTACT BLOCK]

PA_G6.

Once we verify that you have received the authorization forms, you will receive an email with your unique username to access the electronic portal. The portal password is the part of your email address before the @ sign and the number 1234. Your password is <fill portal password> all in lower case. It is highly recommended that you change your password after your first log-in.

[GO TO EXIT]

[PA_H]BAD BILLING SERVICE INFO.

PA_H1. ASK (BY NAME) TO SPEAK WITH THE POC WHO DEALS WITH THE EXTERNAL BILLING SERVICE

This is (YOUR NAME) calling on behalf of the U.S. Department of Health and Human Services. For quality assurance and training purposes, this call may be monitored.

We previously spoke about the MEPS study. Thank you for providing the contact information for [BILLING SERVICE NAME]. Unfortunately we were unable to locate [BILLING SERVICE NAME] with the contact information you provided. Could you please verify the contact information we currently have for [BILLING SERVICE NAME]?

[PRESENT BILLING SERVICE CONTACT INFO HERE]

BILLING SERVICE CONTACT INFO IS CORRECT =1

BILLING SERVICE CONTACT INFO IS NOT CORRECT =2

[IF PA_H1=1, GO TO PA_H2;
IF PA_H1=2, GO TO CONTACT BLOCK]

PA_H2. That is currently the information we have on file. Do you know of any other way we can get in touch with [BILLING SERVICE NAME]?

YES = 1
NO = 2

[IF PA_H2 = 1 GO TO CONTACT BLOCK,
IF PA_H2=2 GO TO EXIT SCREEN.]

[PA _I]ANY OTHER BILLING SERVICE?

PA_I1. ASK (BY NAME) TO SPEAK WITH THE POC WHO DEALS WITH THE EXTERNAL BILLING SERVICE

This is (YOUR NAME) calling on behalf of the U.S. Department of Health and Human Services. For quality assurance and training purposes, this call may be monitored.

We previously spoke about the MEPS study. Thank you for providing the contact information for [BILLING SERVICE NAME]. We were able to locate [BILLING SERVICE NAME] with the information you provided. However, they reported that they did not maintain the billing and payment records for [PROVIDER(S)] in [FILL_YR]. Could you please check to see if another billing service maintained billing and payment records for [PROVIDER(S)] in [FILL_YR]?

OTHER BILLING SERVICE MAINTAINED RECORDS..... 1
NO OTHER BILLING SERVICE MAINTAINED RECORDS..... 2

[IF PA_I1=1, GO TO CONTACT BLOCK;
IF PA_I1=2, GO TO EXIT SCREEN]

[AO_A]PROVIDER/AO CONTACT

AO_A1READ IF NOT OBVIOUS: Have I reached [POC NAME]?

YES.....= 1
NO.....= 2

PHONE NUMBER: [POC TELEPHONE NUMBER]

YES.....= 1
NO, BUT CAN RECORD A NEW NUMBER.....= 2
NO, NEED TO TRACE THE CASE.....= 3

[IF AO_A1 = 1 GO TO AO_A2,
IF AO_A1 = 2 GO TO CONTACT BLOCK,
IF AO_A1 = 3 GO TO AO EXIT]

AO_A2.

IF AO POC WAS PROVIDED BY MEDICAL RECORDS OR PATIENT ACCOUNTS:

May I please speak to [POC NAME]?

IF NO AO POC WAS PROVIDED BY MEDICAL RECORDS OR PATIENT ACCOUNTS::

“Can I please speak to someone in the administrative office who can help me with contacting/locating information for providers?”

- IF THE PERSON YOU NEED TO TALK TO IS UNAVAILABLE ATTEMPT TO GET THEIR CONTACT INFORMATION VIA THE CONTACT BLOCK AND SET AN APPOINTMENT IF POSSIBLE.

CONTINUE, THIS PERSON CAN HELP = 1
COLLECT CONTACT INFORMATION FOR SOMEONE ELSE = 2
UNCLEAR WHO TO SPEAK TO = 3

[IF AO_A2= 1 GO TO AO_A3,
IF AO_A2=2, GO TO CONTACT BLOCK,
IF AO_A2=3, GO TO EXIT SCREEN]

AO_A3. READ IF NECESSARY: (Hello,) my name is (YOUR NAME).

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.

POC: [POC NAME]

Earlier, your medical records department gave us information about the care that some of our study participants received at your facility and the names of the providers of that care. Now we need locating information for those providers and whether the charges for their services would be included in the hospital's bill or billed separately by the provider. Can you provide this information?

- IF THIS PERSON CANNOT HELP, ASK TO BE TRANSFERRED TO SOMEONE WHO CAN.

CONTINUE, THIS PERSON CAN HELP.....= 1
COLLECT CONTACT INFORMATION FOR SOMEONE ELSE.....= 2

[IF AO_A3=1, GO TO AO_A4,
IF AO_A3=2, GO TO CONTACT BLOCK;]

AO_A4. For quality assurance and training purposes, this call may be monitored. If it is convenient for you, I can collect this locating information 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
WILL COMPLETE BY PHONE IN THE FUTURE = 2

[IF AO_A4=1 GO TO AO_A5;
IF AO_A4=2 GO TO AO_A4a]

AO_4a. I understand. What would be the best day and time to call you back to collect this information?

- o EARLY MORNING = 9AM
- o LATE MORNING = 11AM
- o EARLY AFTERNOON = 2PM
- o LATE AFTERNOON = 4PM

DATE: _____

R's TIME: _____ AM/PM

TIMEZONE:

[IF COMPLETE, GO TO EXIT SCREEN]

AO_A5. NEED THE ABILITY TO PULL UP THE LIST OF PROVIDERS THAT WAS COLLECTED IN MR SECTION

GO TO SBD SUBROUTINE [SBD_CGINTRO]

SBD SUB ROUTINE

New York General ()

Administrative Offices/A0_SBD

[OPEN PATIENT LIST](#)

COLLECT INFORMATION FOR SBDs BY CLICKING "SELECT" NEXT TO EACH SBD

NOTE: You must finalize each SBD after you are done collecting contact information. To do this, click on "Finalize" in the table and answer TRACE1.

SBDs currently listed:

Edit	Updated	Name	Provider Phone	Address	Speciality	Finalize	BillEx
Select	12/30/2016	Alex Bell	323-222-2222:	--	Adolescent Medicine Internal Medicine	Finalize ()	1
Select	12/30/2016	Dr. Rosa Parks	--:	--	Anesthesiology - General	Finalize ()	2
Select		Dr. Kevin Smith			Radiology - Diagnostic	Finalize ()	
Select		Dr. Martin King Jr.			Surgery - Cardiothoracic	Finalize ()	

YOU ARE EDITING A PREVIOUSLY ENTERED SBD RECORD

I want to ask about **Dr. Kevin Smith**, whose specialty is Radiology - Diagnostic. This doctor was reported as someone who bills separately for services.

SBD_CGINTRO. I want to ask about [PHYSICIAN NAME], whose specialty is [SPECIALTY]. This doctor was reported as someone who bills separately for services.

COLLECT INFORMATION FOR SBDs BY CLICKING "SELECT" NEXT TO EACH SBD

NOTE: You must finalize each SBD after you are done collecting contact information. To do this, click on "Finalize" in the table and answer TRACE1.

SBDs currently listed:

Edit	Updated	Name	Provider Phone	Address	Speciality	Finalize	BillEx
Select	12/30/2016	Alex Bell	323-222-2222:	--	Adolescent Medicine Internal Medicine	Finalize ()	1
Select	12/30/2016	Dr. Rosa Parks	--:	--	Anesthesiology - General	Finalize ()	2
Select		Dr. Kevin Smith			Radiology - Diagnostic	Finalize ()	
Select		Dr. Martin King Jr.			Surgery - Cardiothoracic	Finalize ()	

YOU ARE EDITING A PREVIOUSLY ENTERED SBD RECORD

I want to ask about **Dr. Kevin Smith**, whose specialty is Radiology - Diagnostic. This doctor was reported as someone who bills separately for services.

1. Can you tell whether this physician bills separately or has charges included in your facility's bill? **Required**

- SBD_CG8a.** Can you tell whether this physician bills separately or has charges included in your facility's bill?
- BILLS SEPARATELY = 1
 - CHARGES INCLUDED IN FACILITY BILL = 2
 - BILLING ARRANGEMENT VARIES (SPECIFY) = 3
 - DON'T KNOW = 4

2. What is the business practice phone number and location for Dr. Martin King Jr.?

NAME OF GROUP Practice (IF APPLICABLE):

PHONE: Format: xxx-xxx-xxxx

PHONE EXTENSION:

NATIONAL PROVIDER ID:

Group NPI:

STREET:

CITY:

STATE:

ZIP: Format: xxxxx or xxxxx-xxxx

What is the business practice phone number and location for [FILL]?

Name of Group Practice (If applicable):

PHONE:

PHONE EXTENSION

NATIONAL PROVIDER ID

GROUP NPI:

STREET:

CITY

STATE:

ZIP:

3. Does this physician use a billing service or have billing contact information that is different than his or her business practice location?

SBD_CG8b.

Does this physician use a billing service or have billing contact information that is different than his or her business practice location?

- YES 1
- NO 2

4. What is the billing contact information?

Use previously entered billing services for this Contact Group

NAME OF BILLING SERVICE: _____

PHONE of billing service: _____ **Format: xxx-xxx-xxxx**

PHONE EXTENSION: _____

Address of billing service:

STREET: _____

CITY: _____

STATE:

ZIP: _____ **Format: xxxxx or xxxxx-xxxx**

SBD_CG9

What is the billing contact information?

Name of Billing Service:

PHONE of billing service

Address of billing service:

STREET

CITY

STATE

ZIP

SBD_CG10. RECORD ANY NOTES AO GIVES ABOUT [PHYSICIAN NAME]

How are you finalizing this SBD? SELECT ONE.

1. Done with this SBD- contacting information collected or confirmed does not bill separately
2. Done with this SBD – unable to collect contacting information
3. Still working to obtain contact information for this SBD

Updated screenshot:

COLLECT INFORMATION FOR SBDs BY CLICKING "SELECT" NEXT TO EACH SBD

NOTE: You must finalize each SBD after you are done collecting contact information. To do this, click on "Finalize" in the table and answer TRACE1.

SBDs currently listed:

Edit	Updated	Name	Provider Phone	Address	Speciality	Finalize	BillEx
Select	12/30/2016	Alex Bell	323-222-2222:	--	Adolescent Medicine Internal Medicine	Finalize ()	1
Select	12/30/2016	Dr. Rosa Parks	--:	--	Anesthesiology - General	Finalize ()	2
Select		Dr. Kevin Smith			Radiology - Diagnostic	Finalize ()	
Select		Dr. Martin King Jr.			Surgery - Cardiothoracic	Finalize ()	

You are Finalizing an SBD

[Finalize this SBD](#)

SBDID: 10403

SBD Name: Dr. Rosa Parks

TRACE1. How are you finalizing this SBD? SELECT ONE

- 1. Done with this SBD - contacting information collected or confirmed does not bill separately
- 2. Done with this SBD - unable to collect contacting information
- Still working to obtain contact information for this SBD

[Finalize this SBD](#)

SBD_CG11. HAVE YOU OBTAINED CONTACT INFORMATION FOR ALL PROVIDERS/SBDs IN THE LIST?

- 1** YES, OBTAINED ALL AVAILABLE CONTACT INFORMATION FOR ALL SBDs LISTED
- 2** NO, STILL WORKING ON GETTING CONTACT INFORMATION.

« Previous

Next »

Breakoff »

SBD_CG12. Who would be able to help me with the information for the remaining providers?

ADDITIONAL AO POC PROVIDED = 1

DK; NO ADDITIONAL AO POC PROVIDED = 2

SECTION J: GAINING PERMISSION: TALKING POINTS

INTRODUCTION:

May I please speak to [POC NAME]?

Hello, my name is (YOUR NAME).

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. For quality assurance and training purposes, this call may be monitored.

I recently spoke with {POC YOU ARE WORKING WITH FOR DATA COLLECTION} about the study. I explained that at this time, [NUMBER FROM PATIENT LIST] patient[s] identified [PROVIDER] as a source of health care during [FILL_YR]. [The/Each] patient signed an authorization form allowing us to contact you for information about the diagnoses and services provided by [PROVIDER] in [FILL_YR]. Much of the information we need is within the (billing and payment records/medical records).

{POC YOU ARE WORKING WITH FOR DATA COLLECTION} has agreed to participate and provide us with the information we are looking for, but has requested that we first send you a copy of the authorization form[s] in order to receive permission to release the data to us.

I'm calling to confirm that you are in fact the best person to receive the forms[s] and information about the study by fax and confirm your contact information so that I can address the information to you.

VERIFY PERMISSION PACKET RECEIPT:

May I please speak to [POC NAME]?

(Hello, my name is (YOUR NAME).) I am calling on behalf of the U.S. Department of Health and Human Services. We previously spoke about the MEPS study. For quality assurance and training purposes, this call may be monitored. Did you receive the authorization form[s] we sent to you?

- IF THE PERSON ON THE PHONE **DID** RECEIVE THE FORMS, ASK:
 - Do you have any questions or concerns about the study information or the forms we sent?
 - At this point may I follow-up with {POC YOU ARE WORKING WITH FOR DATA COLLECTION} about the release of data?
 - IF YOU ARE CLEARED TO SPEAK WITH THE POC YOU ARE WORKING WITH FOR DATA COLLECTION,
 - EXIT TO THE CMS, MAKE THE POC YOU ARE WORKING WITH FOR DATA COLLECTION THE PRIMARY POC ON THE POC SCREEN
 - CALL THEM USING
SECTION MR_G: VERIFY RECEIPT OF AFs IF DEALING WITH MEDICAL RECORDS
OR SECTION PA_G: VERIFY RECEIPT OF AFs IF DEALING WITH PATIENT ACCOUNTS.
 - IF THE PERSON ON THE PHONE DOES NOT GIVE YOU PERMISSION
 - EXIT TO THE CMS TO CODE THE CASE AS "CASE REQUIRES SUPERVISOR REVIEW" AND ENTER A PROBLEM REPORT ON THIS CASE WHEN YOU RETURN TO THE CMS
- IF THE PERSON ON THE PHONE **DID NOT** RECEIVE THE FORMS, SAY
 - I'm sorry. Let me re-send the authorization form[s] to you.
 - GO TO THE CONTACT BLOCK BY PRESSING NEXT AND VERIFY THE CONTACT INFORMATION WE HAVE ON FILE, THEN
 - EXIT TO THE CMS AND TRIGGER A RE-SEND OF THE PERMISSION PACKET TO THIS PERSON

CONTACT BLOCK

CB3. Can you provide a fax number to receive the information?

[INTERVIEWER: IF POC ASKS ABOUT MAIL, OFFER THE MAIL OPTION. IF POC REQUESTS ELECTRONIC PORTAL, DISCUSS WITH YOUR SUPERVISOR BEFORE SELECTING THIS OPTION.]

1. FAX
2. MAIL
3. N/A
4. ELECTRONIC PORTAL

 INDIVIDUALIZED PACKETS NEEDED. (COMMONLY USED FOR VA CASES.)

CB3A: COMMENTS

CONTACT FIELDS

PROVIDER NAME:
MEDICAL RECORDS/BILLING SERVICE NAME:
POC FIRST NAME:
POC LAST NAME:
PHONE:
EXT:
TIMEZONE:
FAX:
VERIFY FAX:
E-MAIL:
VERIFY E-MAIL:
TITLE:
DEPARTMENT:
ADDRESS:
CITY:
STATE:
ZIP:

FOLLOW-UP QUESTIONS

CB1. WILL YOU BE CALLING THIS PERSON NEXT?

1. YES
2. NO

CB2a. WHICH SECTIONS OF THE CONTACT GUIDE APPLY TO THIS POC?

1. MEDICAL RECORDS
2. PATIENT ACCOUNTS ***
3. ADMINISTRATIVE OFFICE
4. MEDICAL RECORDS AND PATIENT ACCOUNTS ***
5. MEDICAL RECORDS AND ADMINISTRATIVE OFFICE
6. PATIENT ACCOUNTS AND ADMINISTRATIVE OFFICE ***
7. MEDICAL RECORDS, PATIENT ACCOUNTS AND ADMINISTRATIVE OFFICE POC ***

*****CB2b** Does this office handle records for...

[CHECK ALL THAT APPLY]

CB2_1a Physician billing

CB2_1b Outpatient billing

CB2_1c Inpatient/ER billing

CB2_1d All Facility billing

CB2_1e Billing that includes all professional and facility fees for all types of services: inpatient, ER, outpatient, and office visits, or

CB2_1f_OTH Some other type of billing (Specify:_____)

INTERVIEWER: IF THE MEDICAL RECORDS SECTION APPLIES TO THIS POC (CB2a = 1, 4, 5, or 7) PLEASE ASK CB2c, OTHERWISE GO TO CB2

******CB2c.** Does this office handle medical records for...

[CHECK ALL THAT APPLY]

CB2c_1 Emergency Room

CB2c_2 Inpatient stays

CB2c_3 Outpatient care

CB2c_4 Clinic care

CB2c_5 All Medical Records (including ER, Inpatient and Outpatient care)

CB2c_6 Some other type of medical records

CB2. WHAT TYPE OF POC IS THIS PERSON?

1. PROVIDER LEVEL GATEKEEPER
2. HANDLES RELEASE OF IN-HOUSE RECORDS
3. DEALS WITH IN-HOUSE RECORDS FOR MR
4. DEALS WITH IN-HOUSE RECORDS FOR PA
5. DEALS WITH MEDICAL RECORDS SERVICE
6. DEALS WITH EXTERNAL BILLING SERVICE
7. MEDICAL RECORDS SERVICE GATEKEEPER
8. EXTERNAL BILLING SERVICE GATEKEEPER
9. HANDLES RELEASE OF RECORDS FOR MEDICAL RECORDS SERVICE
10. HANDLES RELEASE OF RECORDS FOR EXTERNAL BILLING SERVICE
11. ADMINISTRATIVE OFFICE POC
12. HANDLES RELEASE OF IN-HOUSE RECORDS & IS ADMINISTRATIVE OFFICE POC
13. COURTESY PACKET RECIPIENT
14. PERMISSION PACKET RECIPIENT
16. NEW/UPDATED NAME FOR PROVIDER
15. POC FOR REMAINING PROVIDERS (SBDs)

CB4. ADD ANOTHER POC?

1. YES
2. NO

BRANCH

TYPICAL CONTACT SEQUENCE BY SECTION:

INTERNAL BILLING: A, B, Contact Block, F, end call

EXTERNAL BILLING SERVICE: Call provider: A, B, C, Contact Block,
end call

Call billing service: D, E, edit Contact Block, end call

VERIFY AFs WERE RECEIVED: Go to G

CLICK ON YOUR NEXT STEP

O₁ MR – IDENTIFY A POC AT THIS PROVIDER’S OFFICE (SECTION MR_B)

O₂ MR – IDENTIFY A POC WHO WORKS WITH EXTERNAL BILLING SERVICE
(SECTION MR_C)

O₃ MR - CALL THE EXTERNAL BILLING SERVICE (SECTION MR_D)

O₄ MR – VERIFY AUTHORIZATION FORMS WERE RECEIVED (SECTION MR_G)

O₅ PA – IDENTIFY A POC AT THIS PROVIDER’S OFFICE (SECTION PA_B)

O₆ PA – IDENTIFY A POC WHO WORKS WITH EXTERNAL BILLING SERVICE
(SECTION PA_C)

O₇ PA – CALL THE EXTERNAL BILLING SERVICE (SECTION PA_D)

O₈ PA – VERIFY AUTHORIZATION FORMS WERE RECEIVED (SECTION PA_G)

CALLBACK/APPOINTMENT SCREEN

Can you please provide me with a better time to call back in order to reach him/her?

- EARLY MORNING = 9AM
- LATE MORNING = 11AM
- EARLY AFTERNOON = 2PM
- LATE AFTERNOON = 4PM

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

EXIT SCREEN

[Instrument logic will be implemented so text only appears on screen when provider verification has not been completed]: Before we send you the form(s). I'll need to determine that all of the providers I have listed were in fact associated with this hospital in [FILL_YR]. I'm going to read you a list of providers; please tell me if each one was associated with this hospital in [FILL_YR].]

PRESS FINISH TO EXIT CONTACT GUIDE AND TO GO TO CASE MANAGEMENT SYSTEM.

DO NOT HANG UP UNTIL YOU GET TO CALL DISPOSITION SCREEN.

IF POC RECEIVED AUTHORIZATION FORMS AND IS SENDING IN RECORDS, ENTER EVENT CODE

443 – MR AFs Received - Waiting for Records to be Sent – Mail/Fax/Web or

445 – PA AFs Received – Waiting for Records to be Sent – Mail/Fax/Web

IF YOU NEED TO SEND A COURTESY OR PERMISSION PACKET:

1. SAVE EVENT CODE FOR FAX/MAIL PACKET TO THIS POC FIRST
2. RE-ENTER CONTACT GUIDE AND CALL THE BILLING SERVICE OR PERMISSION POC
3. SAVE EVENT CODE FOR FAX/MAIL PACKET FOR COURTESY OR PERMISSION PACKET