Certified Healthcare Collector

Study Guide

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1. Introduction to Healthcare Collections

Your decision to pursue a career in healthcare collections is extremely timely. With the "baby boomers" constituting a significant portion of today's population, healthcare providers are treating more consumers than ever before. Yet, with reduced fees from capitation, HMO's, PPO's and with a growing number of consumers covered by Medicare and Medicaid, revenues have fallen precipitously. Such financial constraints make it necessary to recover healthcare fees faster and more efficiently.

Also, as the cost of our medical care continues to increase and deductible, co pays, and co-insurance rising comes the potential for staggering losses of revenue that could hamper and debilitate our healthcare system. Left unchecked such losses could force hospitals, private practices and other healthcare providers to close their doors – thus depriving communities of medical attention that is now convenient and readily accessible. Without medical collectors, many bills would remain unpaid, and the financial integrity of our healthcare facilities would be severely jeopardized. You and other recovery specialists are therefore intrinsically vital to our community. Through your efforts and those of other medical collection specialists, billions of dollars are recovered and funneled back to the medical community. This recovered revenue guarantees continued medical care for the elderly, for our children, and for all those that need medical attention.

Collectors have a very important task to fulfill in a field that is growing and providing more opportunities for advancement than ever before. You have joined an industry that allows you to make a positive difference in the lives of others. We welcome you to the ever-growing numbers of healthcare collection specialists.

2. The Characteristics of an Effective Telephone Collector

The personalities of collectors vary greatly, at least on the surface level. Some are charismatic, others quiet, some humorous, and others no-nonsense. Every collector has his or her style, talents, and gifts that help them collect, but beyond the personalities, there are some characteristics common to all effective collectors. They are:

a. **Being a good listener.** Aggressive personality, fast-talker, and insensitivity are all common negatives wrongly associated with being an effective collector. In actuality an effective collector is an exceptionally good listener. Listening imparts respect to the consumer, eases the consumer's defensiveness about the call, and reduces his resistance to pay. Through listening the collector may be able to arrive at different possibilities on how the bill can be paid. Also, through careful listening the collector may discern whether a bill is likely to be paid or not, regardless how adamantly the consumer asserts he will or will not pay. This is called listening with the "third ear."

b. Asking questions. Asking questions, particularly open-ended questions, also reflects the skill level of an effective collector. Open-ended questions, unlike close-ended questions, are questions that cannot be answered with a "yes" or "no." A close-ended question is, "Are you going to pay or not?" An open-ended question is quite different. "How would you like to pay this today?" Asking open-ended questions encourages the consumer to do the thinking, instead of you. Using canned talk-offs or talking quickly just creates more separation between you and the consumer, while asking questions builds trust and creates possibilities for clearing the debt or discerning the consumer's capability to pay.

c. Asking for Payment in Full (PIF). An effective collector consistently asks for payment in full from the consumer: "How would you like to pay this today?" This technique creates a sense of urgency for the consumer to pay now, instead of procrastinating. If the consumer is unable to pay in full, the collector has now created leverage to negotiate for a series of quick payments. Above all, skillful collectors know that to collect efficiently, they need to use their time wisely and collect as much as they can on each call. Collectors know that the older an account becomes, the harder it is to collect; so, it needs to be collected now. A hospital or physician does not have to accept partial payments for services rendered.

d. Familiarity with legitimate sources of payment. An effective collector is aware of a variety of payment sources that are available to the consumers that may be unknown to the consumer himself. For instance, looking at the consumer information sheet will inform the collector about sources of payment: the spouse, the employer, the spouse's employer, and any insurance coverage available. Other sources of monies may be found elsewhere: bank accounts, credit cards, home mortgages, temporary extra employment, tax refunds, and etc. Knowing these sources helps recover money.

See A-Z Money Sources in the back of the study guide

e. Diligently following-up on broken promises. An effective collector will immediately contact a consumer when the consumer fails to fulfill his promise to pay. Why an immediate follow-up? It reinforces a sense of urgency. It maintains the collector's credibility. It may help the collector keep account information current if it has changed. All these facets encourage the consumer to pay.

f. Striving toward goals. In life, setting the right goal is the key to happiness. In collections, setting goals will help you prioritize your time and energy. Skillful collectors will have daily, weekly, monthly, and/or yearly goals that they are pursuing. Human energy, when brought into focus by goals, is very powerful, much like when light becomes focused into a laser beam. That tiny beam can cut through just about anything! You can accomplish much through goal setting. Possible goals may be: setting a monetary amount to collect by the end of the month; increasing your number of daily calls; or decreasing consumers' broken

promises. If you have a high rate of broken promises you may be setting up unrealistic payment plans, closing the sale too early and not repeating the arrangement back to the consumer

g. Maintaining a state of non-attachment. Having a state of non-attachment to your results may sound strange, but it actually helps a collector. Not being attached to your goals does not mean you are indifferent to them. On the contrary, it simply means that your peace of mind will not be affected if you fail to get what you want. Instead of becoming annoyed, agitated, and angered when a consumer fails to comply with your wishes, you will find yourself calm, tactful, and businesslike. You will then convey a positive attitude that allows you to be persistent without being offensive.

h. Managing work queue. Successful collectors are very conscious of what needs to be done to produce the maximum amount of recovery possible while minimizing the effort necessary to do so. They are acutely aware that timely follow-up is crucial to a successful collection effort and make every effort to properly status, document, and schedule accounts, especially those such as paying and payment pending accounts, broken promises, pending insurance, or those with highly specific follow-up requirements.

The law of diminishing return explains that:
With each unsuccessful contact, the probability of collecting the account decreases and expenses increase.

i. Knowing and abiding by state and federals laws. Abiding by the state and federal laws that govern collections is imperative for any collector. Your adherence to the law reflects an abiding respect for the consumer's dignity. It also safeguards your company from unnecessary lawsuits – be they legitimate or frivolous. The most common set of laws governing collections will be found in the Fair Debt Collection Practices Act (FDCPA). Many states have their own laws governing debt collection. Often, these laws are more restrictive than the FDCPA. The effective collector is well versed on the FDCPA and applicable state laws, confident in knowing what they can and cannot do.

3. Consumer Types and Traits

Consumer Types

Discerning quickly which category a consumer falls into. Not everyone, even if they have money, pay their bills. There are different kinds of consumers. Some are far more likely to pay than others. The reasons for not paying will vary. Either way, an effective collector is adept at discerning which category a consumer falls into so as not to squander time. There are essentially seven categories or types.

- **Represented by Attorney**.
    - There are several reasons a consumer may be represented by an attorney and knowing how to handle these situations will aid you to resolving the situation quickly.
    - Bankruptcy
    - Workman's Compensation Appeals
    - Personal Injury Cases
        - If asked to wait for payment because of a lawsuit or other type of litigation, ask the following questions:
        - Who is the attorney
        - Find out the financial capabilities of the consumer
- **Consumers who fail to fully understand the limits of their insurance policy**. A collector typically wears many hats. Sometimes in our many roles we have to be the educator and inform the consumer of his insurance limits and or policies. The hospital or doctor does not have to accept as settlement in full any amounts paid by the insurance company, when the amount is paid and defined as "reasonable and customary".
- **Professional credit criminals** that never have any intention of paying. A credit criminal may give false information to the facility such as Social Security Number, Date of Birth or Address.
- **Consumers with unresolved disputes**. Collectors may get confused with the difference between a stall and a dispute. A dispute is a reason the consumer feels that they do not owe the debt A stall is a reason the consumer does not want to pay the bill.
- **Irresponsible consumers who cannot effectively control their spending**. This type of consumer may also be considered the staller. Always giving excuses why they haven't paid the bill. A common stall is I never got the bill or the check is in the mail. If a consumer states that the check is in the mail get the details of the payment such as: how much, how it was tendered, check number and where it was mailed.
- **Adverse Circumstances**. Consumers who typically pay their bills on time but are hit with an adverse circumstance, such as: loss of a job, divorce, death in family, or illness. These consumers will typically pay in full once they are back on their feet.
- **The poor and disadvantaged**. Knowing your clients' charity programs and discounts available is important when dealing with the poor and disadvantaged.

The common misperception is that collectors typically contact the poor and disadvantaged. In actuality, a majority of calls are directed toward other types of consumers. Knowing these types will help you move quickly toward resolution.

Consumer Traits
There are consumer types and also consumer traits. Understanding consumer traits will also help us understand our consumer and not squander time.

- **On the Move.** Many consumers become skips. A skip is a consumer who has mail return or disconnected phone numbers. They will require skip tracing to locate them before you can proceed with your collection activity.
- **Seeks Immediate Gratification.** These consumers basically have champagne taste on a beer budget. They over spend and do not manage their finances well. They have a mentality of keeping up with the Jones.
- **More Sophisticated.** Technology and education have changed the world of collections in many ways. Consumers today have access to various forms of media that will aid them in understanding their rights and the laws. Sometimes they receive misleading information, which can also be harmful for them.
- **Credit report more necessary.** A credit report is necessary in today's world. New or existing opportunities may depend on a favorable credit report such as new employers, landlords, banks and lenders.
- **Bankruptcy Option.** There are many types of Bankruptcies. It is very important to understand the basics of bankruptcy and obtain the necessary information from the consumer or consumer's attorney. The following should be obtained when consumer's claim they filed bankruptcy:
    1. Type and chapter
    2. Attorney name and phone number
    3. Who filed (individual or joint filing)
    4. Filing date—all debts incurred prior to the filing date will be included. Any debts incurred after the filing date are due and owing.

See Bankruptcy Handout in the back of the Study Guide.

4. Effective Collection Techniques

If applicable, before you make the call:

1. Have the information in front of you
2. Review Consumer history
3. Know whom you are calling
4. Know how much is owed
5. Know what happened on previous call
6. Anticipate what you will say and how they will respond
7. PMA=PIF (A POSITIVE MENTAL ATTTUDE = PAYMENT IN FULL)

Eight Steps to the Collection Call

The eight steps to the collection call is a great tool to keep you on track and aid you in collection of your account in a professional and ethical manner. The eight steps are a road map or instructions to make a collection call.

1. Identify the Consumer
2. Identify yourself
3. Ask for payment in full
4. Psychological pause (gives the consumer a chance to explain why the bill was not paid) – update demographic and contact information
5. Learn the objection
6. Find the solution
7. Close the deal
8. Confirm the arrangement and update account with call results

Dealing with the Difficult Consumer

Having the tools to help you deal with the difficult consumer will also aid you in the collection of your account. We never want to add fuel to the fire. The following tips will help you gain the consumer's confidence and cooperation.

1. Tone of your voice (lower yours if they raise theirs)
2. Let the consumer speak his/her mind
3. Quit Taking It Personally (Q-Tip) it is a business transaction. Do not take it personally.

5. Laws Governing Collections

The Fair Debt Collection Practices Act (FDCPA), The Fair Credit Reporting Act (FCRA), and the Health Insurance Portability and Accountability Act (HIPAA) all relate to healthcare collections. Being familiar with all these Acts is essential, but it is the FDCPA that is most important to the collection industry, and where this manual predominantly focuses.

The Consumer Financial Protection Bureau (CFPB) was established by the Dodd-Frank Wall Street Reforms and Consumer Protection Act of 2010. Congress established the CFPB to protect consumers by carrying out federal consumer financial laws. The CFPB website lists the following among the duties of the CFPB:

- Write rules, supervise companies, and enforce federal consumer financial protection laws
- Restrict unfair, deceptive, or abusive acts or practices
- Take consumer complaints
- Promote financial education
- Research consumer behavior
- Monitor financial markets for new risks to consumers
- Enforce laws that outlaw discrimination and other unfair treatment in consumer finance

The CFPB has enforcement and regulatory authority under a host of statutes and regulations, including, the FDPCA, FCRA, GLB and EFTA among others. Creditors and collection agencies who must comply with any of these statutes are subject to the CFPB's jurisdiction.

On July 10, 2013, the CFPB announced actions regarding debt collection practices, including opening its consumer complaint resolution process, issuing two bulletins on illegal conduct and publishing action letters for consumers.

The first bulletin clarifies that any company under the CFPB's jurisdiction, including both third-party collectors and creditors collecting their own debts, can be held accountable for any unfair, deceptive, or abusive acts or practices (UDAAPs) in collecting a consumer's debts. The bulletin provides a list of acts or practices related to the collection of consumer debt that could constitute UDAAPs. Some of the practices included in the list are:

- Collecting or assessing a debt and/or any additional amounts in connection with a debt (including interest, fees and charges) **not expressly authorized by the agreement creating the debt** or permitted by law.
- Falsely representing the character, amount or legal status of the debt.
- Threatening any action that is not intended or the covered person or service provider does not have the authorization to pursue, including false threats or lawsuits, arrest, prosecution, or imprisonment for non-payment of a debt.
- Failing to post payment timely or properly or to credit a consumer's account with payments that the consumer submitted on time and then charging late fees to that consumer.
- Misrepresenting whether information about a payment or non-payment would be furnished to a credit reporting agency.

The second bulletin warns companies to avoid deceptive statements concerning the impact that payments may have on a consumer's credit score, credit report or credit worthiness.

Refer to the CFPB website (http://www.consumerfinance.gov/) or your Compliance Officer for additional information and guidance on how the CFPB's oversight and jurisdiction impacts your office.

A. FDCPA

The Fair Debt Collections Practices Act (FDCPA) is where a majority of laws applying to collections are found. This manual addresses these laws in the next section. However, there are other laws outside of the FDCPA (and for that matter outside of the FCRA and HIPPA, too) that you as a collector need to know.

- Once a collector has received notice that a consumer has filed bankruptcy, he should not contact the consumer for any reason.

- After the receipt and acceptance of three regular monthly payments of the same amount, an implied contract may be created. There is no actual law referable to this, but in a Court of Law the judge may side with the consumer, allowing him/her to continue with like payments.

The FDCPA provides that a collector can contact a consumer whom is represented by an attorney if the attorney does not respond to the collector's calls and/or written communication within a reasonable amount of time. But what should you do when you are initially asked to wait for payment because of a lawsuit or other type of litigation?

Seek to obtain the following information:

1. Name and contact information for the attorney
2. Type of case (worker's compensation, personal injury, etc.)
3. If the debt has a letter of protection
4. The financial capabilities of the consumer

The FDCPA is a federal law that specifically regulates collection agencies, instructing them on what is and is not permissible when collecting past due accounts. Memorizing every facet of it would be laborious and impractical because it is comprehensive and regulates many functions beyond your own as a collector. With that said, however, there are certain aspects of the FDCPA that are absolutely mandatory for you to know and abide by. This study guide presents ten fundamental rules that for all intents and purposes keep you safe within the bounds of the FDCPA as you collect. But these rules should not be construed as a substitute for a more substantial review of the FDCPA. Please consult your company for such a review and, as with all aspects of collection law, speak with your manager whenever you are uncertain as to whether a particular activity violates the FDCPA.

FDCPA 10 Golden Rules

1. **Never misrepresent yourself or the debt**

   You are a collector. You are not a lawyer, attorney or anything other than a collector. Therefore, never portray or insinuate that you are what you are not. This same rule applies to the accounts you are working. Always represent the bill accurately. Do not inflate the balance in order to "discount" the amount for prompt payment. Never claim the bill constitutes a criminal offense unless your client can pursue valid criminal charges. Never falsely claim that nonpayment of the debt will result in termination of employment. You are allowed to use an "alias" if you use it consistently.

2. **Never discuss the debt with third parties unless you have the consumer's express permission to do so.**

   Do not discuss the bill to ANY extent with anyone that is a third party unless you have the consumer's permission. This includes leaving messages in person or on a

recording device. Parties that call in response to a bill sent to the consumer or claiming to "handle" the affairs of the consumer still are considered third parties, and we cannot divulge any information to them, with the exception of spouses and parents of minor children. Remember that when we are attempting to verify the consumer's employment, a collector must never state that the employee (consumer) owes a debt. According to the FDCPA you may speak with: the consumer, the consumer's spouse (if permitted by state law), the creditor, parents of minor children, a consumer reporting agency, the consumer's attorney, guardian, executor or administrator.

3. **Never threaten any action that you do not intend to take.**

   The FDCPA makes it very clear that we are prohibited from telling the consumer that certain action will be taken if your client or company does not customarily take such action. Unless your client sues, reports to the credit bureau, refuses future services etc. you cannot threaten any of these activities. This rule also applies to telling a consumer that garnishment of wages will be started if payment is not received immediately. Wages cannot be garnished without a judgment.

4. **Never make repeated phone calls meant to harass the consumer.**

   Remember that harassment is NOT defined by the FDCPA. Basically, any act considered to be harassing to the consumer is harassment. One form of harassment is making repeated phone calls to irritate or intimidate the consumer. There are many other forms of harassment that collectors need to avoid. If you treat the consumer the way you wish to be treated, you will never be intentionally harassing in your communications. Remember that if a consumer (and/or spouse, guardian, executor, or administrator) notifies you in writing to cease all communication, you must comply with their request. The collector may only then contact the consumer once more to notify the consumer of what action(s) your client may pursue. Be sure your account is marked "disputed" and the credit bureau is so notified. There is no limit in the number of calls a collector may call a consumer in any given day. But you must not cause the telephone to ring repeatedly or continuously with the intent to annoy, abuse, or harass the consumer.

5. **Never make calls before 8 a.m. or after 9 p.m. unless the consumer has requested such contact.**

   Remember that the time specified by the FDCPA is the consumer's local time, NOT your local time. Be aware of the time zone the consumer falls into and then plan your call so that it does not violate the time constraints imposed by the FDCPA. Additionally, you may not attempt to contact the consumer at their place of employment at any time if you are aware that the employer prohibits the consumer from receiving this type of communication, or the consumer has asked you not to contact him/her at work.

6. **Never curse or use vulgarity.**

   This rule speaks for itself. Even if the consumer is abusive towards you, this does not give you the right to respond in a like manner. You are a professional and, as such, you are in control of your actions. Your job is to collect the outstanding account; arguments do not collect bills.

7. **Never refuse to identify yourself or your company when the consumer requests such information.**

   The FDCPA makes it very clear that you are to identify yourself and your company when you establish contact with the consumer. Furthermore, you must make it clear that you are attempting to collect a debt.

8. **Never refuse to transfer complaint calls to your supervisor if asked to do so.**

   When asked by the consumer, consumer's legal guardian or attorney to provide your supervisor's name and / or contact number, provide the information immediately. Collectors who refuse to provide this information will generally escalate the perceived problem to your client's office. It is far better to have a complaint handled within your company

9. **Never make promises or commitments you cannot honor.**

   In your dealings with the consumer you should never claim that you can take any action that you have no authority to take. This includes reduction of the debt's amount, deleting credit bureau information, or providing inaccurate information to your company or client, etc.

10. **Always treat the consumer the way you would wish to be treated.**

    This is possibly the most important rule of all. If you treat others as you wish to be treated the other nine rules will be followed. As you know, you are far more likely to deal with someone who has treated you with respect and understanding than someone who has been demeaning and disrespectful.

*** Additional notes regarding the FDCPA**

- If accepting a post-dated check or instrument by more than 5 days, the collector must send a written notice to the consumer 3 to 10 days before depositing the check or instrument.
- You cannot demand payment from the consumer during the validation period.
- If a consumer notifies the collector in writing to cease further communication with the consumer, the debt collector shall not initiate further communication with the consumer concerning the debt unless the collector is making a final call to advise the consumer on what collection activities the client may pursue.

- If a consumer owes multiple debts, but makes a single payment and one of the debts is disputed, the collector **may not** apply the payment to the disputed debt.
- A collector has 5 days after the initial communication with a consumer concerning an account to send a 30-day validation notice unless it is done in the original communication, or payment is made within five days.

FOTI

In general leaving a voice message on a consumer's answering machine for the purpose of attempting to collect a debt is a "communication" under the FDCPA. FDCPA defines "communication" as "the conveying of information regarding a debt directly or indirectly to any person through any medium." Most of the debate about the issue of leaving messages on consumers' answering machines relates to an inherent contradiction in the FDCPA. The FDCPA requires debt collectors to disclose certain information in any communication with a consumer in an attempt to collect a debt. This is generally referred to as "Meaningful Disclosure" and prohibits debt collectors from disclosing information regarding a debt to third parties. This is generally referred to as "third party disclosure."

Sections 806(6) and 807(11) of the FDCPA tells us that we must provide meaningful disclosure of a debt collectors identity and leave the mini-Miranda disclosure in a voice mail/answering machine message left for a consumer. However, 805(b) tells us that we may be in violation of third party disclosure if someone other than the consumer listens to the voice mail/answering machine message. This obviously creates confusion as to what is the proper course of action. Does a debt collector leave a message or does a debt collector leave messages in some instances and not others or does a debt collector never leave a message.

This study guide will not instruct a debt collector on a course of action. For that, a debt collector should follow the instructions given to them by their employer. There is no clear course of action in relation to this issue and different debt collection agencies will be dealing with this issue in a multitude of ways.

It is generally accepted that adhering to sections 806 and 807 of the FDCPA is less risky as a third party must overhear the message in order for a violation to occur. While adhering to section 805 could be a violation for every message left, as the debt collector is not leaving "meaningful disclosure" in their message. The other prevailing thought here is that if it is possible for all the messages in this instance to be a violation then it is possible for a class action law suit could be brought against the agency.

Courts all over the country have ruled on cases concerning the above issues in a variety of ways. There is no conclusive action in regards to leaving messages that has been found to keep a debt collection agency out of court. Even the non-action of not leaving a message has been met with a court action. In response to numerous court cases and to try and mitigate risk, some agencies took the position of not leaving a message when calling a consumer and reaching an answering machine. One court case did rule that a debt collector did not have to leave a message when calling a consumer. But be aware that

there is conflict regarding this. The question basically is, if a debt collector hangs up without leaving a message, is that still considered a communication under FDCPA if the debt collector's phone number appears on the caller ID?

A debt collection agency should consult with independent council to determine how best to proceed with leaving voice mail messages.

B. State Laws

Many states have specific laws that are more restrictive than the FDCPA. It is important to check info the State Laws that govern Medical collections in your area.

C. FCRA

The Fair Credit Reporting Act (FCRA) was created by Congress to insure the accuracy and fairness of credit reporting. Many collection agencies credit report consumers in their system as a leverage tool to recover monies owed to their clients. Since collection agencies work with consumer reporting agencies, they have "responsibilities with fairness, impartiality, and a respect for the consumer's right to privacy."

> The term "consumer report" means any written, oral, or other communication of any information by a consumer reporting agency bearing on a consumer's credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living.

It is essential, when providing information to a consumer-reporting agency, that the collection agency provide:

- Accurate information concerning the account status, paid or current balance
- Account delinquency date*
- A notice of the account being disputed by the consumer
- A notice of a canceled account (i.e. the collection agency has canceled and returned the account to the client)

***** The **date of delinquency** is defined as "the month and year of the commencement of the delinquency on the account that immediately preceded collection activity, charge to profit or loss, or similar action." The three options for determining the date of delinquency provided for in the FCRA are:

1) Reporting the date of delinquency as provided by the original creditor
2) Establishing a reasonable procedure to obtain the date of delinquency from the creditor
3) Establishes and follows reasonable procedures to ensure the date reported as the date of delinquency precedes the date on which the account is placed for collection.

Consult with your supervisor to determine the method used by your employer.

Pulling Consumer Credit Reports under the FCRA

Pintos v. Pacific Creditors Association:

Prior to Pintos v. Pacific Creditors, it was generally accepted that a debt collector had a permissible purpose to pull a consumers credit report for the purposes of collecting a debt. FCRA 604 (a) states that a debt collector can pull a consumers credit report if the debt collector "intends to use the information in connection with a credit transaction involving the consumer…" In Pintos, the Ninth circuit found to qualify under 604(a) a credit transaction must satisfy two conditions. The first is that the credit transaction must be voluntary and the second is that it must involve the extension of credit. Since Pintos was not involved in the credit transaction and it was not done voluntarily, there was no permissible purpose to obtain a credit report. It is important to understand that Pintos only applies to debts that do not involve an extension of credit to which the consumer voluntarily assented. It is not a given that a debt collector cannot pull a consumers credit report. Examples of debts that might have a permissible purpose under 604(a) could be; student loans, credit cards and utilities. Examples of debts that might not have a permissible purpose under 604(a) might be; subrogation claims, bad checks and emergency room visits.

D. HIPAA

HIPAA is the acronym for the Health Insurance Portability and Accountability Act of 1996. It was created for the purposes of

- Standardizing how health insurance information is transmitted electronically.
- Standardizing how health insurance information is secured.
- Protecting a consumer's right to determine who has access to their health insurance information.

PHI is the acronym for Protected Health Information. Issues about disclosing a consumer's PHI applies to "covered entities" like hospitals, but also applies to "business associates" like collection agencies.

The three standards covered by HIPAA are electronic transactions, the privacy rule and the security rule. A covered entity's contract with its business associate is called a Business Associate Agreement. This contract must:

1. Describe the permitted and required uses of PHI by the Business Associate.
2. Provide that the business associate will not use or further disclose the PHI other than as permitted or required by the contract or as required by law.

3. Require the business associate to use appropriate safeguards to prevent the use or disclosure of the PHI other than as provided for by the contract.
4. Contain security breach notification requirements.

HIPAA has had profound consequences on the privacy and security rights regarding the accessibility and transmission of health insurance information. Some of its ramifications on collection agencies have been anticipated, but it will take time to see how all this plays out for the industry.

Understanding HIPPA

Privacy vs. Security
Privacy—Regulation designed to protect the PHI maintained by Covered Entities.
Security—Security addresses how the PHI is kept confidential and private.

Use vs. Disclosure
Use—How PHI can be used for treatment or for payment activities, such as collecting.
Disclosure—Regulation designed to monitor how PHI is shared.

HIPAA Security Requirements

The HIPAA securities regulations require us to safeguard the security of the electronic information that we collect, transmit, and store. There are four requirements of security:

- Ensuring confidentiality, integrity, and availability of electronic protected health information (PHI)
- Protect against threats or hazards
- Protect against unauthorized uses of disclosures
- Ensuring compliance by workforce

Security is everybody's business: Medical professionals, clerical and billing staff, managers and supervisors, information systems managers and staff, including consultants and contractors. Security is the responsibility of every person who comes into contact with protected health information. All employees are required to receive HIPAA awareness training and each employee will also sign a security agreement before being authorized to access PHI.

HIPAA Privacy Requirements

The HIPAA privacy regulations require us to: protect information from being used or disclosed inappropriately; to give consumers greater control over sharing of information; and to increase consumer access to information.

Healthcare professionals, Business Associate (BA), and their employees must prevent improper or unauthorized disclosure of information by remaining alert and aware of their responsibilities and using common sense in their everyday work to avoid:

Intentional, but unauthorized, disclosures:

- Failure to check credentials of requestor.
- Failure to check consumer authorization.

Unintentional disclosures:

- Breakdown of security during natural or man-made disasters.

Accidental Disclosures:

- Overheard conversations among staff or between staff and consumers.
- Information left in public view, such as on computer screens, papers left on desks, or files accessible to view by public/passers-by.

To prevent breaches of security, follow your company's guidelines for computer use.

- Log on and log off the network; minimizing your screen does not meet security standards except if you have a password protected screensaver on your computer.
- Never let others use your user ID.
- Choose a secure password and regularly update your password.
- Never share your password or write your password down.
- Secure your workstation.

"Minimum Necessary" means to give only the minimum of information necessary to complete the request of use or disclosure of PHI.

Privacy and Security Policy Compliance

HIPAA requires notification to the Covered Entity of any violation of the privacy and/or security policies. HIPAA also requires organizations to have sanction policies in place, to apply against a member of the workforce who fails to comply with privacy and security policies. The U.S. Department of Health and Human Services Office of Civil Rights is the federal department responsible for reviewing violations of HIPAA. Non-compliance with HIPAA could result in civil and criminal penalties. Fines can range up to $250,000.00 and 10 years of prison for knowingly misusing a patient's non-public personal information.

Under the MDHBA Certification standards, all Certified Healthcare Business Associates must carry an errors and omissions insurance policy. MDHBA certified agencies must have a HIPAA compliance officer to review and implement updated HIPAA requirements pertaining to business associates.

HIPAA Use and Disclosure

Sharing Information With Family Members or Consumer Personal Representatives: The HIPAA privacy rule allows for sharing information with members of a consumer's family and close personal friends. Disclosure is permitted to spouses; to parents and legal guardians; and to others who are involved in the consumer's care. A formal authorization is not necessary, but the consumer should give his or her consent when they are alert and able to object or not object. If the consumer is present when the healthcare information is disclosed and does not speak up to object, consent is implied to

share the information. HIPAA requirements are a "baseline" requirement for consumer privacy. HIPAA defers to state laws that prohibit disclosures without consumer consent.

Privacy Requirements for Authorization of Use and Disclosure: Authorization is not needed for the use and disclosure of healthcare information when used for **treatment**. Authorization is not needed for the use and disclosure of healthcare information when **pursuing the collection of payment** for services provided for consumer care. Authorization is not needed for the use and disclosure of healthcare information used for **healthcare operations**. Healthcare operations are defined as the maintenance of medical records; maintenance of accounting records; quality assurance activities; supporting legal activities; investigating complaints; resolving grievances and general business management. Authorization is not needed for **legally mandated disclosures**. The definition of legally mandated disclosures would include police and law enforcement; public health reporting agencies for reportable infectious diseases and vital events, such as birth and death, abuse and neglect reporting, and licensing and regulatory oversight.

Consumer Access to Information: HIPAA gives consumers the right to review and copy their records; to request changes in their records; to request corrections of information in their records; and to have changes communicated to others. HIPAA gives providers certain rights as well. Providers have the right to charge for copies of health information and to deny requested changes in consumer records. MDHBA Certified Healthcare Business Associates will defer to their company policy on how to provide a consumer with requested access to their information.

E. HITECH

On Feb 17, 2009 ARRA American Recovery and Reinvestment Act 2009, Public Law 111-5 (ARRA) and HITECH Health Information Technology for Economic and Clinical Health Act, Title XIII of ARRA (HITECH ACT) was enacted.

Intent and Purpose:

- Adoption of electronic health records and development of a National network
- Medicare and Medicaid incentives programs to begin 2011 that will produce significant money $21 billion

Impact on Health Care Industry:

- Specific fines and Penalties for Violations of HIPAA for Business Associates
- Specific fines and Penalties for Violations of HIPAA for individual employees
- Updates to Business Associate Agreements and 2nd tier Business Associates
    - (Business Associates now have the same basic security responsibilities as covered entities).
- State Attorney Generals have enforcement authority
- Breach notification requirements
- Prohibit the sale of electronic health records or PHI
- Transition to electronic health records

Covered entities and or business associates are obligated to notify consumers of a breach of their unsecured PHI.

The Department of Health and Human Services, the Office for Civil Rights, the Federal Trade Commission, the Consumer Financial Protection Bureau and State Attorney Generals all have enforcement authority for HIPAA and HITECH.

F. PPACA

The Patient Protection an Affordable Care Act (PPACA), signed by President Obama March 23, 2010. This act and the Health Care and Education Reconciliation Act of 2010 (signed into law on March 30, 2010) made up the health care reform of 2010.

Also known as: Affordable Care Act, Healthcare Insurance Reform, Obamacare, and Healthcare Reform.

The laws focus on reform of the private health insurance market, providing better coverage for those with pre-existing conditions, improving prescription drug coverage in Medicare and extending the life of the Medicare trust fund by at least 12 years.

The law includes numerous health-related provisions to take effect over a four-year period beginning in 2010. In order of their assessed impact the primary provisions are as follows:

- Guaranteed issue and community rating will be implemented nationally so that insurers must offer the same premium to all applicants of the same age, sex, and geographical location regardless of pre-existing conditions.
- Medicaid eligibility is expanded to include all individuals and families with incomes up to 133% of the poverty level.
- Health insurance exchanges will commence operation in each state, offering a marketplace where individuals and small businesses can compare policies and premiums, and buy insurance (with a government subsidy if eligible).
- Firms employing 50 or more people but not offering health insurance will pay a "shared responsibility payment" if the government has had to subsidize an employee's health care
- Non exempt persons not securing minimum essential health insurance coverage are also fined under the shared responsibility rules. This requirement to maintain insurance or pay a fine is often referred to as the individual mandate, though being insured is not actually mandated by law. Not being insured will not be a crime and no criminal penalty can attach to non payment of the fine. The fine serves to encourage most people into an insurance pool and to deter healthy individuals from buying insurance only when they become ill.
- Improved benefits for Medicare prescription drug coverage are to be implemented.
- Changes are enacted which allow a restructuring of Medicare reimbursement from "fee-for-service" to "bundled payments".

- Establishment of a national voluntary insurance program for purchasing community living assistance services and support.
- Low income persons and families above the Medicaid level and up to 400% of the poverty level will receive subsidies on a sliding scale if they choose to purchase insurance via an exchange (persons at 150% of the poverty level would be subsidized such that their premium cost would be of 2% of income or $50 a month for a family of 4).
- Very small businesses will be able to get subsidies if they purchase insurance through an exchange.
- Additional support is provided for medical research and the National Institutes of Health.
- Enrollment into CHIP and Medicaid is simplified with improvements to both programs.
- The law will introduce minimum standards for health insurance policies and remove all annual and lifetime coverage caps.
- The law mandates that some health care insurance benefits will be essential coverage for which there will be no co-pays. Policies issued before the law came into effect are grandfathered in and are mostly not affected by the new rules.
- Coverage for young adults-an Insurer that provides dependent coverage of children must continue to make such coverage available for an adult child until the child turns 26.

  Source:
  http://en.wikipedia.org/wiki/Patient_Protection_and_Affordable_Care_Act

G. TCPA

The **Telephone Consumer Protection Act of 1991** (TCPA) was passed by the United States Congress in 1991 and signed into law by President George H. W. Bush as Public Law 102-243.

The TCPA impacts auto-dialed calls to cellular phones and pre-recorded messages.

Healthcare providers should update their application forms to include appropriate disclosure and consent provisions regarding their right, and right of their agents to communicate with the consumer on their cell phone.

Below are strategies for collectors to help be compliant with the TCPA:

- **Include prior express consent in consumer contracts that provide consent to call using an automated telephone dialing system or a pre-recorded voice.**
- **Use technology to identify cell phone numbers**
- **Train collectors to seek proper consent**
- **Document proper consent**

H. Doctrine of Necessities

The Doctrine of Necessities is a common law doctrine used to determine if both spouses are liable for the debts of the other spouse, when debts are incurred to provide necessaries such as medical treatment. It is based upon the laws of the state where the consumer resides. State law should be reviewed for definition and interpretation of pre/post marriage liability, same sex marriage and common law marriage liabilities.

6. Insurance Plans

A. Medicare

Medicare is the federal health insurance program for people who are 65 or older, certain younger people with disabilities and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD). Medicare is part of the Social Security Act.

1. Medicare Part A – covers inpatient hospital stays, care in a skilled nursing facility, hospice care and some home health care.
2. Medicare Part B – covers certain doctors' services (lab tests, doctor visits and surgeries), outpatient care, medical supplies (wheelchairs and walkers if they are considered medically necessary) and preventive services.
3. Medicare Part C – Also known as Medicare Advantage Plus – Type of Medicare health plan offered by a private company that contracts with Medicare to provide all of a consumer's Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO), Private Fee-for-Service Plans, etc.
4. Medicare Part D – Adds prescription drug coverage to Original Medicare Plans or a Medicare Advantage Plan.

B. Medicaid

Provides health coverage for some low-income people, families and children, pregnant women, the elderly, and people with disabilities. In some states, the program covers all low-income adults below a certain income level. Medicaid programs must follow federal guidelines, but vary somewhat from state to state. These programs are administered at the state level.

C. COBRA

Consolidated Omnibus Budget Reconciliation Act (COBRA) requires continuation of group health insurance coverage to be offered to covered employees, their spouses, former spouses, and dependent children when coverage might otherwise be terminated due to specific events. Examples of qualifying events are:

1. Termination of employment (voluntary or involuntary)
2. Reduction in hours of employment
3. Death of the covered employee
4. Divorce

D. TRICARE(formerly CHAMPUS)

Health program for Uniformed Service members and their families; National Guard/Reserve members and their families; Survivors of deceased military members; Former spouses; Medal of Honor recipients and their families.

D. CHAMPVA - Civilian Health and Medical Program of the Department of Veterans Affairs

Health benefits program in which the Department of Veterans Affairs shares the cost of certain health care services and supplies with eligible beneficiaries. Provides coverage to the spouse or widow(er) and to the children of a veteran who: 1) is permanently and totally disabled due to a service-connected disability; or 2) was permanently or totally disabled due to a service-connected condition at the time of death; or 3) died of a service-connected disability; or 4) died on active duty and the dependents are not otherwise eligible for TRICARE benefits.

E. Coordination of Benefits

This occurs when a patient uses 2 or more types of insurance to pay for medical services. The process can be complex as each policy must be billed in the proper order. The patient could still incur out of pocket expenses when seeking treatment outside of the insurance provider's networks.

7. Medical Collections Glossary

All vocations come with their unique vocabularies. For example, flying a plane requires knowledge of aeronautical terms like *thrust*, *pitch*, and *yaw*. Though these words may sound like gibberish to most of us, they are indispensable for piloting a plane. Likewise, as a medical collector you have your language to learn, too. Knowing the common "medical collection" terms listed below will help you navigate through your tasks with greater ease and joy.

Acute care: A term used to describe treatment of an episodic or short-term problem.

Administrative adjustment: A bookkeeping adjustment to reflect services provided but not billed to consumer because costs of billing and collections would exceed charges; or, to reflect partial adjustment of charges in special circumstances.

All payer systems: Pricing systems in which all hospital payers, from both private and federal programs, participate.

Ambulatory surgery: Surgery performed on a non-hospitalized consumer; consumer goes home on the same day of surgery.

Ambulatory visit group (AVG): Similar to DRG's, except outconsumer rather than inconsumer care.

Ancillary Services: Services other than room, board and medical and nursing services, i.e., laboratory and radiology.

Approved charge: The maximum fee a managed care plan will pay a provider in a given geographical area for covered service(s).

Assignment: Practice of accepting as payment in full the amount approved by Medicare or other payers. Regarding Medicare; physicians accepting assignment receive 80% of the approved amount from Medicare and bill consumers for the remaining amount, once the consumers' deductible is meet.

B

Basic Benefits: "basic health services" as specified in a member's insurance benefits certificate. Services required under applicable federal and state laws and regulations.

Balance Billing: Billing of a person for charges outstanding and above the amount paid by the health plan -- the difference between billed charges and the amount paid by insurance.

Blue Cross and Blue Shield: A nationwide federation of local, not-for-profit insurance organizations that contract with hospitals and other healthcare providers to make payment for healthcare services to their subscribers (the hospital and/or provider).

Business Associate: A person or entity that performs certain functions or activities that involve the use or disclosure of protected health information on behalf of, or provides services to, a covered entity.

C

Cafeteria plan: A written plan under which an employer can provide employees with a choice of taxable or nontaxable benefits and employees are taxed only to the extent of the value of the taxable benefit chosen.

Capitation: A method of payment (generally used by HMO's) in which healthcare providers are paid a flat fee for each person services are provided to, regardless of how many services any individual requires. The purpose of this payment schedule is to shift risk of controlling resource utilization to the healthcare provider.

Case management: The process of identifying an individual's specific healthcare needs and a plan to efficiently utilize healthcare resources is defined and implemented. This

process has been established to achieve optimum consumer related services in the most cost-effective manner.

CHAMPVA: Civilian Health and Medical Program of the Department of Veterans Affairs. A health benefits program in which the Department of Veterans Affairs shares the cost of certain health care services and supplies with eligible beneficiaries.

CMS: Centers for Medicaid & Medicare Services. This is the federal agency responsible for administering Medicare and overseeing states' administration of Medicaid. It also manages: HMO qualification, Utilization and Quality Control Peer Review, and various other financing and quality assurance programs. CMS is a division of the U.S. Department of Health and Human Services (HHS).

CMS-1450 (also referred to as UB04): Billing form used for hospital in consumer medical charges.

CMS-1500 (also referred to as HCFA -1500): Billing form used to bill for all out consumer/ancillary charges including physician charges.

COBRA: A federal law that allows people who lose benefit eligibility under a group health plan to continue that coverage without lapse.

Coinsurance: The percentage of medical costs that must be paid by the insured.

Commercial Plan: Refers to the medical benefit package(s) an insurance company/managed care (HMO, PPO, IPA, etc.) offers to employers.

Co-payment: A share of cost arrangement in which the insured pays a specified amount for a specified service, to the provider, out of his/her own pocket at the time services are rendered.

Cost allowable: The amount of the costs incurred by a provider in the course of rendering services that is recognized as payable by a third-party payer.

CPT: Current procedural terminology. A physician services coding system developed by the AMA and updated annually. Medicare (and most health insurers) requires physicians to use CPT codes in filing claims.

Customary charge: A healthcare provider's median (typical) charge for a given service during a specified period (i.e., "reasonable and customary").

D

Deductible: A set amount of medical expenses the insured (consumer) must pay to become eligible for insurance benefits.

Diagnosis (principal or primary): A diagnosis established as being chiefly responsible for the admission of a consumer to the hospital for care.

Diagnosis (secondary): A condition that exists at the time of admission or develops and affects the treatment given and/or length of stay.

Discharge: The formal release by a hospital, upon a physician's direction, of a consumer who no longer requires hospital care.

DME: Durable medical equipment. Equipment that can stand repeated use.

DRG: Diagnosis Related Group. A consumer classification system relating demographic, diagnostic and therapeutic characteristics of consumers to the length of inconsumer stay and the amount of resources consumed. It is a framework for hospital case mix and the identification of classifications of illness and injuries for which Medicare payment is made under the pricing program.

E

Effective date: The date on which one's health plan agreement goes into effect.

Eligibility determination: Verifying a consumer's eligibility for medical services under particular programs or insurance plans.

EMC: Electronic media claim. Claims submitted electronically.

EOB: Explanation of Benefits. It is a statement detailing which billed services are or are not covered by commercial insurance. It includes the amount of the claim submitted, amount paid by the insurance company and the balance of charges owed by the consumer.

EOMB: Explanation of Medicare Benefits. It is a statement detailing which billed services are or are not covered by Medicare and the amount due from Medicare and the consumer.

F

Fee schedule: A listing of fee maximums used to reimburse physicians and/or other providers on a fee-for-service basis.

Fee-for-service reimbursement: Healthcare payment system under which physicians and other providers receive a payment for billed charges for each unit of service provided. The more services provided, the more the provider earns.

G

Group practice: A combined practice of three (3) or more physicians and/or dentists who share an office, equipment, records, staff, expenses and income.

H

HCFA-1500 (also referred to as CMS-1500): Billing form used to bill for all out consumer/ancillary charges including physician charges.

HCPCS: Pronounced "hick-picks". It is a common CMS procedural coding system, listing services, procedures and supplies provided by physicians and other providers. HCPS includes current procedural terminology (CPT) codes, national alphanumeric codes and local alphanumeric codes. The national codes have been developed by CMS to supplement CPT codes. It includes physician services not included in CPT codes as well as non-physician services such as ambulance, physical therapy and durable medical equipment (DME).

HMO: Health Maintenance Organization. An organization that has management responsibility for providing comprehensive healthcare services on a prepayment basis to voluntarily enrolled persons within a designated population.

Health plan: Generic term to refer to a specific benefit package offered by an insurer.

Hill Burton program: A federal program of financial assistance created by the Hospital Survey and Construction act of 1946 for the construction and modernization of healthcare facilities.

Hospice services: Services providing care to the terminally ill.

Hospital day: Any twenty-four (24) hour period commencing at 12:00 am, or 12:00 pm, whichever is used by a hospital to determine a hospital day, during which a consumer receives medical services at the hospital.

I

ICD-10 coding: International Classification of Diseases. A listing of diagnosis and identifying codes for reporting diagnosis of health plan enrollees by physicians.

Individual stop-loss coverage: A practice in experience rating that isolates claim amounts per individual over a defined level. These isolated, or pooled amounts, are charged to a pool funded by the pool charges of all groups who share this same pooling level.

L

Length of stay: Number of calendar days that elapse between an in consumer's admission and discharge.

Limiting charge: Limit set by law on how much non-participating physicians may bill Medicare consumers.

M

Managed care: A system of managing and financing healthcare delivery to ensure that services provided to managed care plan members are medically necessary, efficiently provided and appropriately priced.

Mandated benefits: Medical benefits that health insurance plans are required by state or federal law to provide to policyholders and eligible dependents.

Medicaid: A federal program, administered by states, which provides healthcare benefits to indigent and medically indigent persons.

Medically necessary: A term used to describe the supplies and services provided to diagnose and treat a medical condition in compliance with specific standards of good medical practice.

Medicare: A federal program that provides health insurance benefits primarily to persons over the age of sixty-five (65) and others eligible for social security benefits (i.e., handicapped). If the healthcare provider does not accept Medicare assignment the Medicare reimbursement checks will be mailed to the consumer.

Medicare part A: Supplementary medical insurance program which automatically enrolls all persons aged sixty-five (65) and over entitled to health benefits under old age, survivors, disability and health insurance programs for railroad retirement, persons under sixty-five (65) who have been eligible for disability for more than two (2) years, and insured workers (and dependents) requiring renal dialysis or kidney transplantation.

Medicare part B: Supplementary medical insurance program which includes physician's services and in which all persons entitled to Part A, a Hospital Insurance Program, may enroll on a monthly premium basis.

Medicare part C: Also known as Medicare Advantage Plus – Type of Medicare health plan offered by a private company that contracts with Medicare to provide all of a consumer's Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO), Private Fee-for-Service Plans, etc.

Medicare part D: Adds prescription drug coverage to Original Medicare Plans or a Medicare Advantage Plan.

Medicare beneficiary: A person who has been designated by the Social Security Administration as entitled to receive Medicare benefits.

Medicare payment schedule: The new method (and basis) for setting physician Medicare payments. It is based on the RBRVS developed by the Harvard University of Public Health.

Modified fee-for-schedule: The system in which providers are paid on a fee-for-service basis. Specific fee maximums apply for each procedure.

N

Non-participating physician: A physician who has elected not to sign a Medicare participation agreement. Non-participating physicians must collect from consumers for services, but are free to bill Medicare consumers for more than Medicare approved amounts. However, the amount billed may not exceed the lower of MAAC or limiting charge. Approved amounts for non-participating physicians are set at ninety-five (95) percent of approved amounts for participating physicians in the same locality. Non-participating physicians may elect to accept assignment on a case-by-case basis.

NONPAR: Non-participatory provider. This refers to a provider that has not contracted with an insurance carrier or managed care plan.

O

Open enrollment period: The period during which subscribers (the insured) in a health benefit program have an opportunity to select an alternative health plan being offered to them.

Out-of-area: Treatment given an HMO member outside of the geographical limits of his/her own HMO. This coverage is generally restricted to valid emergency services.

P

Participating physician: A physician who has signed a Medicare participation agreement. Said agreement binds the physician to accept assignment on all Medicare claims within the calendar year.

Per Diem cost: Cost per day – the hospital or other institutional cost for a day of care.

Point-of-service-plan: A type of health insurance plan allowing the covered person to choose to receive a service from a participating or non-participating provider, with different benefit levels associated with the use of participating providers.

PPO: Preferred provider organization. A variety of direct contractual relationships between hospitals, physicians, insurers, employers or third-party administrators in which providers negotiate with group purchasers to provide health services for a defined population.

Premium: A predetermined monthly membership fee that a subscriber or employer pays for insurance coverage.

Professional component: Portion of payment for a service covering physician work, practice costs and professional liability.

Provider: A healthcare professional or hospital, or group of healthcare professionals or hospitals that provide medical care services to consumers.

R

Reasonable and customary charges: A charge for healthcare services that is consistent with the going rate or charge within a certain geographical area for identical or similar services.

Referral authorization: A verbal or written approval of a request for an insured member to receive medical services or supplies outside of the participating medical group.

Referring physician: A physician who sends a consumer to another source for examination, surgery, or to have specific procedures rendered.

Review (claims): Retrospective review of claims by insurers (or others responsible for payment) to determine the financial liability of the payer, eligibility of the insured and the provider, appropriateness of the services rendered and utilization rates for specific plans.

S

Stop-loss reinsurance: A type of reinsurance purchased by primary insurers to protect against excessive claim loses.

Subscriber: The person responsible for payment of medical insurance premiums or whose employment is the basis for eligibility for membership in an insurance health plan.

Supplemental services: Extra or optional services that a health plan may cover or provide in addition to basic health services.

T

TPA: Third party administrator. An independent person or corporate entity that administrates group benefit plans, claims, and administration for a self-insured company/group.

Trauma center: A service providing emergency and specialized intensive care to critical ill and injured consumers.

TRICARE: Formerly known as the **Civilian Health and Medical Program of the Uniformed Services** (**CHAMPUS**), TRICARE is a health care program of the United States Department of Defense Military Health System. TRICARE provides civilian health benefits for military personnel, military retirees, and their dependents, including some members of the Reserve Component.

U

UB04 (also referred to as CMS-1450): Billing form used for hospital in consumer medical charges.

Utilization: Extent to which the members of a group use a service or type of service within a specified time.

UR: Utilization review. It includes the evaluation of the necessity, appropriateness, and efficiency of the use of medical services and facilities to help ensure the proper use of healthcare facilities.

W

Worker's Compensation Insurance: Covers medical expenses for employees who are injured while at work.

MDHBA

A Healthcare Receivables Management Association

CHAPTER 7-

Personal non-repayment Bankruptcy

All non-exempt property (or its value) may have to be given to Chapter 7 Trustee soon after the Trustee's hearing. However, they often do not have to give up anything if they have only a small amount of non-exempt property. Any non-exempt property that is taken by the Trustee is converted to money and paid to creditors.

CHAPTER 13-

Personal/Repayment Plan Bankruptcy

The value of non-exempt property must be paid to the Bankruptcy Trustee as a part of the monthly payments to the Trustee, and the debtor will keep all the non-exempt property.

CHAPTER 11-

Business/non-repayment Bankruptcy

This Bankruptcy is used for Corporations, DBA's, sole proprietorships and commercial businesses.

*CHAPTER 12-*Farm Plan Bankruptcy

This pertains to only businesses whose revenue is 50% or more farming revenue.

EXEMPT PROPERTY

Amounts vary state-by-state for jewelry, clothing, household goods, per person/ per couple, auto, equity exemption, house used as residence, business equipment, etc.

STAY OF BANKRUPTCY

A stay means that all collection efforts must cease immediately.

DISCHARGE/DISMISSAL

Discharge means that the bankruptcy Court has accepted the debtor's motion for bankruptcy for all chapters.

Dismissal means that for some reason the bankruptcy was not allowed. Once you receive a copy of the dismissal you are no longer under a stay of bankruptcy. You may pursue collection efforts once more. If the account is with a collection agency then notify them at once.

DATE FILED vs DATE OF SERVICE-

Remember to check if date of service is prior to bankruptcy file date. If after you may continue collection.

MDHBA
A Healthcare Receivables Management Association

A-Z Money Sources

Autopay
Bank Loan
Credit Card
Debit Card
Equity on Home
Family/Friends
Girlfriend
Home Loan
Insurance
Job
K-401(K)
Loan
Mom
Nest Egg
Overtime
Pawn Shop
Quarter Bonus
Refinance
Savings
Tax Refund
Unemployment Check
Vacation Pay
Work 2nd Job
X-spouse
Yard Sale
Zero Interest Credit Card Loan