Achievable

CCMA DUMP SHEET

HIPAA, insurance and the law

HIPAA

Standard	Covers
Transactions and code sets	CPT for procedures, ICD for diagnoses
Privacy Rule	Written, electronic and **oral** PHI
Security Rule	Electronically stored and transmitted PHI (ePHI)
Unique identifiers	**NPI** (provider, 10-digit), HPI (health plan), EIN (employer)

- **Enforced by the HHS Office for Civil Rights**
- **Covered entity:** providers, health plans and clearinghouses that transmit PHI electronically
- **No written authorization needed** for treatment, payment and operations (TPO); an opportunity to agree or object; incidental disclosure; public-interest activities; a limited data set; or disclosure to the patient
- **Written authorization is required for one thing:** disclosure to a **third party**, such as an employer, life insurer, lawyer, or another facility
- **If the caller is not named on the authorization**, you may not release information *or confirm the person is a patient*
- **Extra protection:** psychotherapy notes (stored separately), substance abuse information, HIV information
- **Security Rule safeguards:** administrative, physical, technical
- **HITECH (2009):** penalties from $100 per unknowing violation to **$1.5 million per calendar year**. Over **500** people affected means notifying the media and the OCR secretary

The law

- **ADA:** a minimum **30 × 48 inches** of clear floor space beside the exam table
- **Good Samaritan laws** protect a responder who is unpaid, acts reasonably within their training and the limits of the emergency, and is not negligent or reckless
- **Mandatory reporting:** immediately by phone or fax for hepatitis A, outbreaks, pertussis, measles, plague, TB; up to 3 days for STIs, hepatitis B—E, Lyme, mumps, meningitis, tetanus, varicella; by mail for HIV and AIDS
- **Vaccine adverse events go to VAERS**, co-sponsored by CDC and FDA
- **Incident reports:** facts only, completed **by the end of the day**, and **never referenced inside the patient's health record**

Medicare and Medicaid

Part	Covers	Premium
A	Inpatient hospital	**None**: payroll funded
B	Ambulatory care and professional services	Monthly. Pays **80%** of the allowed amount after the deductible
C	Managed-care version of A + B, possibly more	Varies
D	Prescription drugs	Additional monthly

- **Medigap** covers Part B's remaining 20%
- **Medicaid is always the payer of last resort**
- **Accepting Medicaid** means accepting the allowed amount as payment in full; you may collect the copayment but never bill above it
- **CHIP** covers children over the Medicaid income limit and, unlike Medicaid, **carries a premium**
- **TRICARE:** uniformed service members and families. **CHAMPVA:** families of veterans permanently disabled or killed in the line of duty

Term	Meaning
Deductible	Paid before the insurer pays. $100—$5,000
Coinsurance	The split after the deductible, typically 80/20
Copayment	Fixed dollar amount per visit
Out-of-pocket maximum	The most the policyholder pays in a plan year; deductible, coinsurance and copays count, premiums do not. Then the insurer pays 100%
Assignment of benefits	Payment goes directly to the provider
Birthday rule	The parent whose **month and day** falls first in the year is primary for a child
PAR provider	Contracted; accepts the fee schedule as payment in full

- **HMO:** lowest premium, **no deductible or coinsurance**, PCP gatekeeper, referrals and preauthorization always required, 100% patient liability out of network
- **PPO:** no PCP, no referral to see a specialist; pays out of network, at a higher deductible or coinsurance. Premiums higher than an HMO's
- **EPO:** usually no referral, but pays only in network except in a true emergency. Premiums between HMO and PPO
- **POS:** a PCP and referrals, as in an HMO; pays out of network, at a lower rate. Premiums between HMO and PPO