

Initial System Assessment for Upcoming HIPAA Changes

Local Agency Dept: _____
Contact Name: _____
Email: _____ **Phone:** _____ **Date:** _____
System Name: _____

System Functionality <i>Please describe the purpose of the system and any other information about the system that will aid in understanding the system.</i>	
Business Processes Supported <i>(Describe the major business processes, programs, or services this system supports)</i>	
Who provides system support? <i>(e.g., Local IT staff, Vendor – specify)</i>	
Results of prior System Impact Assessments <i>(if applicable)</i>	

Questions	Y	N	Responses
1. Is this system still in use? If Question 1 is 'yes', skip to Question 3.	<input type="checkbox"/>	<input type="checkbox"/>	
2. If Question 2 is 'no', was the system replaced? If yes , specify system name and contact person for system. Then complete questionnaire based on replacement system. If no , the remainder of the questionnaire does not need to be completed)	<input type="checkbox"/>	<input type="checkbox"/>	
3. Does this system store, process, or generate ICD-9-CM (Volumes 1 & 2) diagnosis codes and/or descriptions?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Does this system store, process, or generate ICD-9-CM (Volume 3) procedure codes and/or descriptions?	<input type="checkbox"/>	<input type="checkbox"/>	
5. Does this system store, process, or generate dental procedure codes and/or descriptions (CDT)?	<input type="checkbox"/>	<input type="checkbox"/>	
6. Does this system store, process, or generate pharmacy codes (e.g., NDC)?	<input type="checkbox"/>	<input type="checkbox"/>	
7. Does this system store, process, or generate prescription information that may be sent electronically to a Pharmacy (e.g., NCPDP)?	<input type="checkbox"/>	<input type="checkbox"/>	

Questions	Y	N	Responses
8. Does this system store, process, or generate:	<input type="checkbox"/>	<input type="checkbox"/>	Provider Identifier (Provider ID, Tax ID, EIN, Internal Number)
	<input type="checkbox"/>	<input type="checkbox"/>	Provider Address
9. Does this system store, process, or generate any of the following by: electronic, telephone, fax, email, paper, etc...	<input type="checkbox"/>	<input type="checkbox"/>	Medical Claims (837)
	<input type="checkbox"/>	<input type="checkbox"/>	Medical Claims Payment (835)
	<input type="checkbox"/>	<input type="checkbox"/>	Enrollment in a Health Plan (834)
	<input type="checkbox"/>	<input type="checkbox"/>	Premium Payment for Health Care Coverage (820)
	<input type="checkbox"/>	<input type="checkbox"/>	Eligibility Request (270)
	<input type="checkbox"/>	<input type="checkbox"/>	Eligibility Response (271)
	<input type="checkbox"/>	<input type="checkbox"/>	Authorizations (278)
	<input type="checkbox"/>	<input type="checkbox"/>	Claim Status Request (276)
	<input type="checkbox"/>	<input type="checkbox"/>	Claim Status Response (277)

Is additional information or assistance needed to determine impact? Yes No

Send your completed system assessment to *(insert name and contact information)* by *(specify date)*. If you have any questions related to the system assessment, email or call *(insert name)*.