

## **Instructions for Completing the Initial System Assessment for Upcoming HIPAA Changes**

**Due Date: (specify date)**

Some major changes to the HIPAA federally mandated regulations are forthcoming. Therefore, it is essential for this local agency to update information about locally operated information systems. The Division of Public Health has conducted a similar assessment of state-operated systems (e.g., HIS, Immunization Registry) and will be responsible for implementing any changes to those systems. Once the local agency systems with potential HIPAA impacts are identified, a more in depth assessment will be conducted for those systems. In addition to system changes, the new HIPAA regulations will also require business process changes. A separate assessment will be conducted to identify those potential impacts within this agency at a later time. The HIPAA changes to be assessed are as follows:

**Transition from ICD-9-CM to ICD-10-CM on October 1, 2014:** ICD-10-CM diagnosis codes must be used on all HIPAA transactions, including outpatient claims with dates of service on and after October 1, 2014. Otherwise, claims and other transactions may be rejected resulting in delays and reimbursement impacts. This change does not affect CPT or HCPCS coding for outpatient procedures.

**Transition from Version 4010 to Version 5010 Electronic Health Care Transactions on January 1, 2012:** On January 1, 2012, standards for electronic health care transactions change from Version 4010/4010A1 to Version 5010. These electronic health care transactions include functions like claims, eligibility inquiries, and remittance advices. Unlike the current Version 4010/4010A1, Version 5010 accommodates the ICD-10-CM codes, and must be in place first before the changeover to ICD-10-CM. The Version 5010 change occurs well before the ICD-10-CM implementation date to allow adequate Version 5010 testing and implementation time. If providers do not conduct electronic health transactions using Version 5010 as of January 1, 2012, delays in claim reimbursement may result.

### **Initial System Assessment for Upcoming HIPAA Changes:**

Every effort has been made to try and identify all systems owned and operated by this local agency and the department and/or contact responsible for the system. If you have received this assessment form in error, please contact \_\_\_\_\_ immediately. For any pre-filled information on the assessment form prior to the “Questions” and “Responses” section, the responsible person within the department will need to update any of the pre-filled information that is inaccurate and any incomplete information. Then they will need to answer the questions on the assessment form.

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

For each assessment form, complete information in the columns as follows:

NOTE: To respond to the ‘Yes’ and ‘No’ questions, click on the appropriate ‘Yes’ or ‘No’ box.

Column Heading	Instructions
1. Is this system still in use?	If any local agency staff are using the system, answer ‘yes’. If there are plans to retire or replace the system, please explain in the Responses section including the timeline for replacement. If the answer is ‘yes’, go to Question 3. If the answer is ‘no’, go to Question 2.
2. If Question 2 is ‘no’, was the system replaced?	If ‘yes’, specify the system name and contact person for the replacement system. If you are the contact person for the replacement system, save the assessment form as a second file, then complete the assessment for the replacement system.  If ‘no, the remainder of the questionnaire does not need to be completed. Return the completed form to <i>(insert name and contact information)</i>
3. Does this system store, process, or generate ICD-9-CM (Volumes 1 & 2) diagnosis codes and/or descriptions?	ICD-9-CM (Volumes 1 & 2) is the current, federally mandated diagnostic coding system that includes codes and descriptions. Answer ‘yes’ if the system contains any diagnostic information.
4. Does this system store, process, or generate ICD-9-CM (Volume 3) procedure codes and/or descriptions?	ICD-9-CM (Volume 3) is the current, federally mandated procedure coding system <b>for inpatient procedures</b> that includes codes and descriptions. It is doubtful that any DPH systems use Volume 3 but verification is requested. Answer ‘yes’ if the system contains ICD-9-CM procedure information. Answer ‘no’ if the system does not contain any ICD-9-CM procedure information or contains CPT/HCPCS procedure codes and/or descriptions only.
5. Does this system store, process, or generate dental procedure codes and/or descriptions (CDT)?	The HIPAA mandates code set for dental procedures is the Code on Dental Procedures and Nomenclature (CDT). Answer ‘yes’ if the system contains CDT procedure information. Answer ‘no’ if the system does not contain any CDT procedure information.

Column Heading	Instructions
6. Does this system store, process, or generate pharmacy codes (e.g., NDC)?	<p>The Drug Listing Act of 1972 requires registered drug establishments to provide the Food and Drug Administration (FDA) with a current list of all drugs manufactured, prepared, propagated, compounded, or processed by it for commercial distribution. (See Section 510 of the Federal Food, Drug, and Cosmetic Act (Act) (21 U.S.C. § 360)). Drug products are identified and reported using a unique, three-segment number, called the National Drug Code (NDC), which serves as a universal product identifier for human drugs.</p> <p>Answer ‘yes’ if the system contains Pharmacy (NDC) codes. Answer ‘no’ if the system does not contain any pharmacy codes.</p>
7. Does this system store, process, or generate pharmacy codes or prescription information that may be sent electronically to a Pharmacy? (e.g., NCPDP)?	<p>The National Council for Prescription Drug Program (NCPDP) creates and promotes data interchange standards for the pharmacy services sector of the healthcare industry. The Telecommunication Standard Implementation Guide Version D.0 is the next HIPAA-named version for pharmacy claims, effective 1-1-2012. Answer ‘yes’ if the system contains Pharmacy or prescription information. Answer ‘no’ if the system does not contain any pharmacy or prescription information.</p>
8. Does this system store, process, or generate Provider Identifiers (NPI) and/or Provider Addresses?	<p>The Administrative Simplification provisions of HIPAA mandated the adoption of a standard unique identifier for health care providers. The National Plan and Provider Enumeration System (NPPES) collects identifying information on health care providers and assigns each a unique <b>National Provider Identifier (NPI)</b>. One of the changes that will occur with the implementation of 5010 is Provider Zip Code must be the complete Zip Code (i.e., 99999-9999).</p> <p>Answer ‘yes’ if the system contains Provider Identifiers and/or addresses. Answer ‘no’ if the system does not contain Provider Identifiers and/or addresses.</p>
Does this system store, process, or generate any of the following by: electronic, telephone, fax, email, paper, etc.	
TRANSACTIONS – COB (837)	<p>Answer ‘yes’ if the system stores, processes or generates the standard Coordination of Benefits (Dental, Professional, and/or Institutional) ANSI ASC X12N 837 transaction. Answer ‘no’ if the system does not store, process or generate the standard Coordination of Benefits (Dental, Professional, and/or Institutional) ANSI ASC X12N 837 transaction.</p>

<b>Column Heading</b>	<b>Instructions</b>
TRANSACTIONS – Claims & Encounters (837)	Answer ‘yes’ if the system stores, processes or generates the standard Health Care Claims or Equivalent Encounter Information (Dental, Professional, and/or Institutional) ANSI ASC X12N 837 transaction. Answer ‘no’ if the system does not store, process or generate the standard Health Care Claims or Equivalent Encounter Information (Dental, Professional, and/or Institutional) ANSI ASC X12N 837 transaction.
TRANSACTIONS – Remittance Advice – Payment (835)	Answer ‘yes’ if the system stores, processes or generates the standard Health Care Payment and Remittance Advice ANSI ASC X12N 835 transaction. Answer ‘no’ if the system does not store, process or generate the standard Health Care Payment and Remittance Advice ANSI ASC X12N 835 transaction.
TRANSACTIONS – Enrollment & Disenrollment (834)	Answer ‘yes’ if the system stores, processes or generates the standard Enrollment and Dis-enrollment in a Health Plan ANSI ASC X12N 834 transaction. Answer ‘no’ if the system does not store, process or generate the standard Enrollment and Dis-enrollment in a Health Plan ANSI ASC X12N 834 transaction.
TRANSACTIONS – Premium Payment (820)	Answer ‘yes’ if the system stores, processes or generates the standard Health Plan Premium Payment ANSI ASC X12N 820 transaction. Answer ‘no’ if the system does not store, process or generate the standard Health Plan Premium Payment ANSI ASC X12N 820 transaction.
TRANSACTIONS – Eligibility Request (270)	Answer ‘yes’ if the system stores, processes or generates the standard Eligibility for a Health Plan ANSI ASC X12N 270 transaction. Answer ‘no’ if the system does not store, process or generate the standard Eligibility for a Health Plan ANSI ASC X12N 270 transaction.
TRANSACTIONS – Eligibility Response (271)	Answer ‘yes’ if the system stores, processes or generates the standard Eligibility for a Health Plan ANSI ASC X12N 271 transaction. Answer ‘no’ if the system does not store, process or generate the standard Eligibility for a Health Plan ANSI ASC X12N 271 transaction.
TRANSACTIONS – Referral & Authorization (278)	Answer ‘yes’ if the system stores, processes or generates the standard Referral Certification and Authorization ANSI ASC X12N 278 transaction. Answer ‘no’ if the system does not store, process or generate the standard Referral Certification and Authorization ANSI ASC X12N 278 transaction.
TRANSACTIONS – Claim Status Request (276)	Answer ‘yes’ if the system stores, processes or generates the standard Health Care Claim Status ANSI ASC X12N 276 transaction. Answer ‘no’ if the system does not store, process or generate the standard Health Care Claim Status ANSI ASC X12N 276 transaction.

<b>Column Heading</b>	<b>Instructions</b>
TRANSACTIONS – Claim Status Response (277)	Answer ‘yes’ if the system stores, processes or generates the standard Health Care Claim Status ANSI ASC X12N 277 transaction. Answer ‘no’ if the system does not store, process or generate the standard Health Care Claim Status ANSI ASC X12N 277 transaction.
Is additional information or assistance needed to determine impact?	Please indicate if additional information or assistance is needed to complete this initial assessment.