Department of Health & Human Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-17
Baltimore, Maryland 21244-1850

Notice of Assessment

Date of Notice: FULL DATE

CONTACT NAME:
JOB TITLE:
NAME OF ENTITY:
ADDRESS 1:
ADDRESS 2:
CITY, STATE and ZIP:

Re: Assessment Number **XXXXX**

Dear TITLE LAST NAME:

The purpose of this letter is to inform you that the Department of Health and Human Services (HHS), National Standards Group (NSG) within the Centers for Medicare & Medicaid Services' (CMS), has randomly selected **<Covered Entity Name>** to be the subject of a Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Affordable Care Act (ACA) Operating Rules provisions assessment. This assessment is set to begin on (month, day, year) and is scheduled to take approximately 30 days.

NSG is responsible for promoting compliance of the HIPAA Administrative Simplification requirements in 45 CFR Part 162, specifically as it relates to transactions, code sets, unique identifiers, and operating rules. As part of this promotion, and in support of the health care industry, assessments are conducted as a compliance review activity, and is part of the compliance review process in 45 CFR Part 160.308. Additional information pertaining to compliance can be found at: CMS Regulations and Guidance.

Further in this letter, there are additional components detailing specific information to be provided by you (see Parts B, C, and D) and the steps you must take in order to facilitate the assessment process. Information requested within this letter must be received by this office no later than (month, day, year (within 10 business days)). We will review the information you provide, and will notify you if it is satisfactory, or if we need additional information. Please be assured that we will protect sensitive and/or confidential information received to the full extent required by federal law.

Using the previously provided login information, please upload all requested artifacts in this letter to your secure portal site.

Transactions should be in a text format (TXT), and all other documentation should be in Microsoft Word, Excel or in a PDF format.

If at any time you are unable to serve as the designated contact person for the <**Covered Entity Name**> assessment, please notify us immediately, in writing, and provide a replacement contact name, address, telephone number, and email address.

When corresponding with this office, please include the assessment number located at the top of this letter.

Sincerely,
Michael Cimmino, Director
National Standards Group
Office of Burden Reduction and Health Informatics

Enclosures – Parts A, B, C, D

Part A -Assessment Objectives, Scope, and Review Process

Assessment Objectives

The objective of the HIPAA Administrative Simplification Optimization program is to conduct assessments and identify whether a covered entity is compliant with the HIPAA - adopted standards, and administrative simplification. In addition, the objectives include the opportunity for a covered entity to correct noted deficiencies, allowing the covered entity to address compliance issues before they result in a complaint.

Assessment Scope

The scope of the assessment consists of the following actions:

- Random selection of a covered entity
- Notification to the covered entity
- Artifact request from the covered entity
- Artifacts provided by the covered entity
- Assessment review conducted
- Assessment outcome reported to covered entity
- Covered entity reviews assessment outcome
- Covered entity responds to assessment outcome
- Assessment finalized
- If necessary, covered entity referred for a corrective action

Assessment Review Process

The assessment review is conducted to determine if the selected covered entity is compliant with electronic standards, including HIPAA transactions, unique identifiers, code sets, and operating rules, hereinafter referred to as standards. The determination is made by reviewing the following:

- HIPAA mandated electronic transactions
- EDIFECS XEngine validation tool results, which is accessed through the Administrative Simplification Enforcement and Testing Tool (ASETT)
- Implementation guides (TR3s)
- Applicable code sets
- Applicable operating rules and attestations, and
- Applicable companion guides

Part B - Entity Information

This section is intended to collect organization and contact information. It must be completed by a qualified member of the organization. Complete all applicable sections.

Section 1. Organization and Point of Contact Information

Organization Information

Organization Name:		DBA[1]:			
Contact Name:		Title:			
Telephone:		E-mail:			
Business Address:		City:			
State/Province:		Country:		Zip:	
URL:					

Assessment Point of Contact Information

Organization Name:					
Assessment Contact Name:		Title:			
Telephone:		E-mail:			
Business Address:		City:			
State/Province:		Country:		Zip:	
URL:					

Section 2. Type of Covered Entity (check all that apply)

☐ Large Health Plan[2]	☐ Large Provider[3]	☐ Large Institution
☐ Small Health Plan[4]	☐ Small Provider[5]	☐ Small Institution
☐ Clearinghouse	☐ Business Associate	☐ Other (please specify):

1 DBA (Doing Business As…)
2 annual receipts >$5 million
3 provider with more 25 or more full-time employees, or a physician, practitioner, facility, or supplier with 10 or more full-time equivalent employees
4 annual receipts ≤ $5 million
5 provider with less than 25 full time employees, or a physician, practitioner, facility, or supplier with less than 10 full time equivalent employees

Section 3. Operating Rule Certification

Has your organization obtained a voluntary Operating Rule seal from CORE? If so, when was it obtained? (To answer yes, certificate status must be current and not revoked.)

☐ **YES** ☐ **NO**

Date of Certificate:

Section 4. Business Relationships

Does your organization have a relationship with one or more third-party agents (clearinghouses, vendors, etc.) that conduct transactions or operating rules (ORs) on your behalf? ☐ Yes ☐ No

Please provide company name(s) and points of contact for each third-party relationship:

Company Name	Contact Name	Transaction/OR

Section 5. Acknowledgments

By signing below, I attest that the information provided as part of this questionnaire is true and accurate to the best of my knowledge.

Please manually sign or double click the "X" to e-sign.

x	***Date:*** Click to enter a date.
Contact Person Name:	***Title:***

Part C - Artifact Request

Entity Type: Choose an item.

DUE DATE: Click or tap to enter a date.

Please provide the artifacts selected below by using one of the methods in the above cover letter:

Documentation

☐ Completed Assessment Package Form (this form, Parts B and D)

☐ Companion Guides for transactions marked below

☐ Completed Operating Rule Attestation for the following transaction(s): 270, 271, 276, 277, 835, EFT

☐ Other: _____

Transactions

☐ 270 Health Care Eligibility Verification Request
- Starting with the __ day of month, provide first XX requests. This may consist of one file or multiple files.

☐ 271 Health Care Eligibility Verification Response
- Starting with the __ day of month, provide first XX responses. This may consist of one file or multiple files.

☐ 276 Health Care Claim Status
- Starting with the __ day of month, provide first XX requests. This may consist of one file or multiple files.

☐ 277 Health Care Claim Status Response
- Starting with the __ day of month, provide first XX responses. This may consist of one file or multiple files.

☐ 278 Health Care Services Review - Request
- Starting with the __ day of month, provide first XX requests. This may consist of one file or multiple files.

☐ 278 Health Care Services Review - Response
- Starting with the __ day of month, provide first XX responses. This may consist of one file or multiple files.

☐ 835 Health Care Claim Payment/Advice Transactions
- Starting with the __ day of month, provide first XX remitted claims. This may consist of one file or multiple files.

☐ 837 Health Care Claim- Institutional
- Starting with the __ day of month, provide first XX claims. This may consist of one file or multiple files.

☐ 837 Health Care Claim- Professional

- Starting with the __ day of month, provide first XX claims. This may consist of one file or multiple files.

☐ 837 Health Care Claim- Dental
- Starting with the __ day of month, provide first XX claims. This may consist of one file or multiple files.

☐ 820 Premium Payment
- Starting with the __ day of month, provide first XX premium payments. This may consist of one file or multiple files.

☐ 834 Benefit Enrollment
- Starting with the __ day of month, provide first XX enrollments. This may consist of one file or multiple files.

☐ NCPDP D.0 Pharmacy Claim
- Starting with the __ day of month, provide first XX remitted claims. This may consist of one file or multiple files.

Part D - Trading Partner Identification

In the table below, provide the requested information to identify your organization's most frequent trading partners, not to exceed 25. The list should account for 50% of your transactions for the past 90 days. As part of our assessment initiative, we reserve the right to select entities at random to contact and confirm the information provided.

	Company Name	**Contact Person/Role**	**Phone**	**Email**	**Transaction Volume (%)**
Ex.	*ABC Health Plan*	*John Doe/Director*	*(999)999-9999*	*john@abc.com*	*10%*
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
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21					
22					
23					
24					
25					

In accordance with the Paperwork Reduction Act (1995), no persons are required to respond to a collection of information, unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is **0938-XXXX (Expires XX/XX/XXXX)**. The time required to complete this information collection is estimated to average **[10 hours]** per response (4 forms x 60 minutes/form), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to:

Centers for Medicare & Medicaid Services
Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact: Kevin Stewart at kevin.stewart@cms.hhs.gov .