CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1310	**Date: November 6, 2013**
	Change Request 8451

SUBJECT: HCPCS Analysis CR for Conversion of Old HCPCS Code to New

I. SUMMARY OF CHANGES: As part of this CR, CMS requests that CWF identify how to prevent sending data for discontinued HCPCS codes to MBD. The solution should address the elimination of obsolete historical HCPCS data, the handling of any HCPCS codes that may be discontinued in the future, and the need to have all active preventive services HCPCS codes passed down to MBD for every beneficiary record in CWF

EFFECTIVE DATE: April 1, 2014
IMPLEMENTATION DATE: April 7, 2014

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
Not Applicable

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One-Time Notification

**Unless otherwise specified, the effective date is the date of service.*

One-Time Notification

Pub. 100-20	Transmittal: 1310	Date: November 6, 2013	Change Request: 8451

SUBJECT: HCPCS Analysis CR for Conversion of Old HCPCS Code to New

EFFECTIVE DATE: April 1, 2014
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I. GENERAL INFORMATION

A. Background: The HIPAA Eligibility Transaction System (HETS) is the CMS system that receives and processes Eligibility requests and returns Eligibility and Benefit details to users within the Provider community. The HETS system retrieves the data it returns from the IUI database, which is fed with data which is initially sourced from CWF, EDB, and MARX. Preventive Services Healthcare Common Procedure Code System (HCPCS) codes, and the date which the beneficiary is next eligible for each procedure, are passed down on the CWF to MBD extract file. Each quarter, it is possible for HCPCS code values to be discontinued and, in some cases, replaced by a new code value. Since the inception of HETS in 2005, eight Preventive HCPCS codes that are returned by HETS have been discontinued.

The HETS application has a need to return only the HCPCS codes which are effective as of the current system date. For a beneficiary that has not had a claim submitted for a Preventive Service since the HCPCS code value was changed, CWF stores their next eligible date associated with the old, terminated HCPCS code and passes it down to MBD. HETS has a need for CWF to crosswalk these to the current HCPCS code value before passing them down to MBD, so that HETS will be able to return accurate information on the 271 Eligibility response.

The only HCPCS codes that will be loaded to both the midtier databases as well as passed down to the IUI database will be codes that are effective as of the current date. Beneficiaries who have not had a particular preventive service since the code was changed will still be passed down with their next eligible date for that procedure associated with the current HCPCS code.

CWF will continue to store HCPCS data as it does today. This CR only represents a change to the data that is passed on the CWF to MBD Extract File.

B. Policy: The HETS Business Owner requires that only HCPCS codes that are effective as of the current system date are returned by HETS.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
8451.1	CWF shall convert all legacy HCPCS codes to their current HCPCS value.											X	

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
8451.1.1	CWF shall no longer send terminated HCPCS to HETS. If the HCPCS was terminated and replaced by a new value, then that data should be sent down, but CWF should pass it down with the valid HCPCS code.											X	
8451.2	CWF shall pass the MBD the next eligible date for every applicable (based on gender) current Preventive Service for every beneficiary, regardless of when they last had a claim submission on record for a similar procedure.											X	

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility							
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Other
		A	B	HHH					
	None								

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Pat Ruther, 410-786-0182 or patricia.ruther@cms.hhs.gov (Shelia Dickerson 410-786-2887)

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:
Not Applicable

Section B: For Medicare Administrative Contractors (MACs):
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