CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2464	**Date: May 4, 2012**
	Change Request 7383

NOTE: Transmittal 2299, dated September 8, 2011, is being rescinded and replaced by Transmittal 2464, dated May 4, 2012 to change the effective and implementation dates for VMS. All other information remains the same.

SUBJECT: Enhance the Multi-Carrier System (MCS) and ViPS Medicare System (VMS) to maintain five full years of pricing data and to automatically price claims/adjustments at the rates in effect at the dates of service.

I. SUMMARY OF CHANGES: CMS is requiring claims processors to maintain at least the current and previous four years of fee schedule data (five years total), regardless of the number of updates and/or pricing periods within those five years. MCS and VMS shall continue pricing claims/adjustments from the appropriate schedule for the date(s) of service, or the oldest available schedule if a service was rendered prior to the dates that the oldest available schedule was in effect.

EFFECTIVE DATE: October 1, 2011 (MCS) and October 1, 2012 (VMS)
IMPLEMENTATION DATE: October 3, 2011 (MCS implementation; VMS analysis and design)
October 1, 2012 (VMS implementation)

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
R	12/20.6 Update Factor for Fee Schedule Services
R	20/20.5 Online Pricing Files for DMEPOS

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

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 obligated 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:

Business Requirements

Manual Instruction

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