CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1421	**Date: August 15, 2014**
	Change Request 8853

SUBJECT: Revised Modification to the Medically Unlikely Edit (MUE) Program

I. SUMMARY OF CHANGES: Additional modifications are being updated in the MUE Program. The updates include clarifications, general processing instructions and detailed explanations of the MAI 2 and MAI 3, ASC, Method 2 CAHs.

EFFECTIVE DATE: January 1, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 5, 2015

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 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

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 1421	Date: August 15, 2014	Change Request: 8853

SUBJECT: Revised Modification to the Medically Unlikely Edit (MUE) Program

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I. GENERAL INFORMATION

A. Background: The Centers for Medicare and Medicaid Services (CMS) implemented the Medically Unlikely Edit (MUE) program on January 1, 2007 to reduce the Medicare Part B paid claims error rate. At the onset or implementation of the MUE Program, regarding the adjudication process, the MUE value for a Healthcare Common Procedural Coding System (HCPCS) code was only adjudicated against the units of service (UOS) reported on each line of a claim. On April 1, 2013, CMS modified the MUE program so that some MUE values would be date of service edits rather than claim line edits. Therefore, at that time, CMS is introduced a new data field to the MUE edit table termed "MUE adjudication indicator" or "MAI". CMS is currently assigning a MAI to each HCPCS code. The following is the current and updated backgound information for this modification CR, including general processing instructions :

1. **MUEs for HCPCS codes with a MAI of "1"** will continue to be adjudicated as a claim line edit.

2. **MUEs for HCPCS codes with a MAI of "2"** will be absolute date of service edit. **These are "per day edits based on policy".** HCPCS codes with an MAI of "2" have been rigorously reviewed and vetted within CMS and obtain this MAI designation because UOS on the same date of service (DOS) in excess of the MUE value would be considered impossible because it was contrary to statute, regulation or subregulatory guidance. This subregulatory guidance includes clear correct coding policy that is binding on both providers and CMS claims processing contractors. Limitations created by anatomical or coding limitations are incorporated in correct coding policy, both in the Health Insurance Portability and Accountability Act (HIPAA) mandated coding descriptors and CMS approved coding guidance as well as specific guidance in CMS and NCCI manuals. For example, it would be contrary to correct coding policy to report more than 1 unit of service for CPT 94002 "ventilation assist and management . . . initial day" because such usage could not accurately describe two initial days of management occurring on the same date of service as would be required by the code descriptor. As a result, claims processing contractors are instructed that an MAI of "2" denotes a claims processing restriction for which override during processing, reopening, or redetermination would be contrary to CMS policy. Although the redetermination is a new look at the claim that is not dependent on the original determination, Medicare Administrative Contractors (MACs) are still bound by all levels of CMS policy. While Qualified Independent Contractors (QICs) are not bound by subregulatory guidance, they should understand the policy nature of the MAI "2" indicator when considering whether to pay UOS in excess of the MUE value if claim denials based on these edits are appealed. The contractor may bypass the MUE for a HCPCS code with an MAI of "2" in response to effectuation instructions from a reconsideration or higher level appeal.

NOTE: Although the Qualified Independent Contractors (QICs) and the Administrative Law Judges (ALJs) are not bound by sub-regulatory guidance, they do give deference to it and should therefore be aware that CMS considers all edits with an MAI of 2 to be firm limits based on sub-regulatory guidance, while some MUE edits with an MAI "2" may be based directly on regulation or statute.

Claims processing contractors will be required to sum all UOS for the code for the same date of service, for the same Health Insurance Claim Number (HICN), and for the same provider on:

a. All claim lines of the current claim

b. Paid claim lines of prior finalized claims

This number should be compared to the MUE value. If the sum of all UOS for the same date of service on all specified claims exceeds the MUE value for the code, contractors shall deny all claim lines for the code for the same date of service on the current claim. Paid claim lines from prior finalized claims shall not be adjusted. All claim lines for HCPCS codes with an MAI of “2” on suspended claims shall be subjected to this claim adjudication process during final processing after release from suspended status. For MCS processed claims, the “same provider” is the rendering provider identified by NPI. For VMS processed claims, the “same provider” is based on the supplier number. For FISS processed claims, the "same provider" is the rendering provider.

3. **MUEs for HCPCS codes with a MAI of “3”** will be date of service edits. **These are “per day edits based on clinical benchmarks”.** If claim denials based on these edits are appealed, contractors may pay UOS in excess of the MUE value if there is adequate documentation of medical necessity of correctly reported units. If contractors have pre-payment evidence (e.g. medical review) that UOS in excess of the MUE value were actually provided, were correctly coded and were medically necessary, the contractor may bypass the MUE for a HCPCS code with an MAI of “3” during claim processing, reopening or redetermination, or in response to effectuation instructions from a reconsideration or higher level appeal.

Claims processing contractors will be required to sum all UOS for the code for the same date of service, for the same HICN, and for the same provider on:

a. All claim lines of the current claim

b. Paid claim lines of prior finalized claims

This number should be compared to the MUE value. If the sum of all UOS for the same date of service on all specified claims exceeds the MUE value for the code, claims processing contractors shall deny all claim lines for the code for the same date of service on the current claim. Paid claim lines from prior finalized claims shall not be adjusted. Contractors may pay UOS in excess of the MUE value if there is pre-payment adequate documentation of medical necessity or on appeal of the denied claim(s). All claim lines for HCPCS codes with an MAI of “3” on suspended claims shall be subjected to this claim adjudication process during final processing after release from suspended status. For MCS processed claims, the same provider is the rendering provider identified by NPI. For VMS processed claims, the same provider is the based on the supplier number. For FISS processed claims, the same provider is the rendering provider.

4. **General Processing Instructions.**

Since ASC providers (specialty code 49) cannot report modifier 50, the MUE value used for editing should be doubled for HCPCS codes with an MAI of “2” or “3” if the bilateral surgery indicator for the HCPCS code is “1”.

Contractors shall sum the units of service for multiple identical line items without any HCPCS/CPT modifier. Contractors shall deny all claim lines on current claims if the total UOS for multiple identical line items without any HCPCS/CPT modifier exceeds the MUE value for the HCPCS code.

However, for those situations in which the total UOS for multiple identical claim line items without any HCPCS/CPT modifier do not exceed the MUE value, current duplicate review policy remains in effect. That is, when potential duplicate line items are present on the same claim, contractors shall perform an automated or manual review of those line items to ensure they are processed (paid or denied) according to current system edit logic. Since MUEs are the last automated edits applied before CWF, the sequential position in the automated claims processing procedure of current duplicate review policy should not be altered.

Carriers/FIs/Part A/B MACs shall remind providers to report bilateral surgical procedures on a single claim line with modifier 50 and one (1) UOS. When modifier -50 is required by manual or coding instructions, claims submitted with two lines or two units and anatomic modifiers will be denied for incorrect coding. Contractors may reopen or allow resubmission of those claims in accordance with their policies and with Pub 100-04, Claims Processing Manual, Chapter 34 Section 10.1, “Clerical errors (which includes minor errors and omissions) shall be treated as reopenings” Providers should be encouraged to change and resubmit their own claims where possible and to change their coding practices, but during reopening contractors may when necessary correct the claim to modifier -50 from an equivalent 2 units of bilateral anatomic modifiers. The original submitted version of the claim is retained in the Medicare IDR. Those claims processing contractors shall also remind providers to use anatomic modifiers (e.g. RT, LT, FA, F1-F9, TA, T1-T9, E1-E4) and report procedures with differing modifiers on individual claim lines when appropriate. Many MUEs are based on the assumption that correct modifiers are used.

B. Policy:

The NCCI contractor produces a table of MUEs. The table contains ASCII text and consists of seven columns. Contractors shall continue to use the Tabular Presentation Format for the MUE Transmission). There are three format charts, one for contractors using the Medicare Carrier System (MCS), one for contractors using the Fiscal Intermediary Shared System (FISS), and one for contractors using VIPS Medicare System (VMS) system. CMS has updated the table with a new column or data field which indicates the three levels of the MUE adjudication indicator (MAI).

Contractors shall apply MUEs to either claim lines or date of service, based on the MUE adjudication indicator (MAI) for that particular code, on or after the beginning effective date of an edit and before or on the ending effective date.

For HCPCS codes with a MAI of “1”, MUEs are set to auto-deny the claim line item if units of service on the claim line exceed the value in column 2 of the MUE table. For HCPCS codes with a MAI of “2” or “3”, all UOS for the same date of service on the current claim and prior finalized claims are summed, and if that sum exceeds the value in column 2 of the MUE table, all claim lines with that HCPCS code for that date of service are denied on the current claim. Paid claim lines from prior finalized claims shall not be adjusted. Pub. 100-08, PIM, chapter 3, section 3.5.1, indicates that automated review is acceptable for medically unlikely cases and apparent typographical errors.

When summing Units of Service, contractors shall apply MUEs to all lines with the same HCPCS code, regardless of modifiers (for the exception of modifier 55) or revenue codes. (Modifier 55 is exempt from MUE editing for all 3 MAI levels.) However, in applying MUEs to Critical Access Hospital claims (TOB 85X), contractors shall apply the Outpatient Hospital MUE once to UOS reported with any non-excluded revenue codes except 096X, 097X and 098X (i.e. Method 2 physician services), once to UOS reported with revenue codes 096X, 097X and 098X but without modifier AS, 80, 81 or 82 (i.e. primary surgeon), and once to UOS reported with revenue codes 096X, 097X and 098X and with modifier AS, 80, 81 or 82 (i.e. assistant surgeon). This applies the MUE separately to facility services, to physician/surgeon services and to assistant surgeon services.

For HCPCS codes with confidential MUEs (i.e., Publication Indicator = 0), the MAI levels may not be published or shared with anyone outside of your organization. All other MAIs for non-confidential MUEs can be published or shared.

The CMS will continue to set the units of service for each MUE high enough to allow for medically likely daily frequencies of services provided in most settings. Because MUEs are based on current coding instructions and practices, MUEs are prospective edits applicable to the time period for which the edit is effective. A change in an MUE is not retroactive and has no bearing on prior services unless specifically updated with a retroactive effective date. In the unusual case of a retroactive MUE change, contractors are not expected to identify claims but should reopen impacted claims that are brought to their attention. Since MUEs are auto-deny edits, denials may be appealed. Appeals shall be submitted to local contractors not the NCCI/MUE contractor, Correct Coding Solutions, LLC. Contractors adjudicating an appeal for a claim

denial for a HCPCS code with an MAI of “1” or “3” may pay medically necessary UOS in excess of the MUE value. As detailed in the Background, above, during processing, reopening, or redetermination claims processing contractors are not expected to pay UOS in excess of the MUE for a HCPCS code with an MAI of “2” because these edits are based on CMS sub-regulatory guidance. QICs and ALJs adjudicating an appeal for a claims denial for a HCPCS code with a MAI of “2,” are reminded that these edits are based in policy rather than clinical considerations so they may want to consider all evidence or documentation in that light prior to paying UOS in excess of the MUE value.

NOTE: Quarterly, the NCCI/MUE contractor will provide files to CMS with a revised table of MUEs and contractors will download via the Network Data Mover.

Furthermore, if Medicare contractors identify questions or concerns regarding the MUEs, they shall bring those concerns to the attention of the NCCI/MUE contractor. The NCCI/MUE contractor may refer those concerns to CMS and the CMS MUE Workgroup, and CMS may change the MUE limits after reviewing the issues and/or upon reviewing data and information concerning MUE claim appeals.

Finally, a denial of services due to an MUE is a coding denial, not a medical necessity denial. The presence of an ABN shall not shift liability to the beneficiary for UOS denied based on an MUE. If during reopening or redetermination medical records are provided with respect to an MUE denial for an edit with an MAI of “3”, contractors should review the records to determine if the provider actually furnished units in excess of the MUE, if the codes were used correctly, and whether the services were medically reasonable and necessary. If the units were actually provided but one of the other conditions is not met, a change in denial reason is may be warranted (for example, a change from the MUE denial based on incorrect coding to a determination that the item/service is not reasonable and necessary under section 1862(a)(1)) This may also be true for certain edits with an MAI of “1.”CMS interprets the notice delivery requirements under §1879 of the Social Security Act (the Act) as applying to situations in which a provider expects the initial claim determination to be a reasonable and necessary denial. Consistent with NCCI guidance, denials resulting from MUEs are not based on any of the statutory provisions that give liability protection to beneficiaries under section 1879 of the Social Security Act. Thus, ABN issuance based on an MUE is NOT appropriate.

The CMS will distribute the MUEs as a separate file for each shared system when the quarterly MUEs are distributed.

II. BUSINESS REQUIREMENTS TABLE

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

Number	**Requirement**	**Responsibility**								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8853.1	CMS shared system maintainers shall update the data field language for the MUE adjudication indicators (MAIs), if needed, to allow CMS contractors (Carriers/FIs/Part A/B MACs/DME MACs) to adjudicate MUE claims appropriately based on MAI of 1, 2 or 3: MAI 1 - HCPCS codes with an MAI of 1 will continue to be adjudicated as a claim line edit.					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	MAI 2 - HCPCS codes with an MAI of 2 will be date of service edits. **These are “per day edits based on policy”**. MAI 3 - HCPCS codes with an MAI of 3 will be date of service edits. **These are “per day edits based on clinical benchmarks”**.									
8853.2	**CMS shared system maintainers shall have already created edit logic when HCPCS codes are assigned a MAI of “2” or MAI of “3” to indicate that both are date of service edits for the same HCPCS code, same beneficiary, and same provider, as defined in BR # 8853.1. For MCS processed claims, the “same provider” is the rendering provider identified by NPI.For VMS processed claims, the “same provider” is based on the supplier number. For FISS processed claims, the "same provider" is the rendering provider.** **(NOTE: For any HCPCS code assigned a MAI of “1”, the edit logic has also already been established within all shared systems as a claim line edit.)**					X				
8853.3	For MAI 1: CMS shared system maintainers shall continue to adjudicate via claim line.	X	X			X				
8853.4	For MAI 2, CMS claims processing contractors and CMS shared system maintainers shall continue to: Sum all UOS for the code for the same date of service on: a. All claim lines of the current claim b. Paid claim lines of prior finalized claims This number should be compared to the MUE value.If the sum of all specified UOS for the same date of service on all claims exceeds the MUE value for the code, contractors shall deny all claim lines for the code for the same date of service on the current claim.Paid claim lines from prior finalized claims shall not be adjusted.All claim lines for HCPCS codes with an MAI of “2” on suspended claims shall be subjected	X	X		X	X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	to this claim adjudication process during final processing after release from suspended status.									
8853.4.1	Since ASC providers (specialty code 49) cannot report modifier 50, the MUE value used for editing should be doubled for HCPCS codes with an MAI of "2" if the bilateral surgery indicator for the HCPCS code is "1".		X							
8853.4.2	Since Method 2 Critical Access Hospitals may separately report physician services and assistant surgeon services on institutional claims, in applying MUEs to Critical Access Hospital claims (TOB 85X) , contractors shall apply the Outpatient Hospital MUE once to UOS reported with any non-excluded revenue codes except 096X, 097X and 098X (i.e. physician services), once to UOS reported with revenue codes 096X, 097X and 098X but without modifier AS, 80, 81 or 82 (i.e. primary surgeon), and once to UOS reported with revenue codes 096X, 097X and 098X and with modifier AS, 80, 81 or 82 (i.e. assistant surgeon).	X				X				
8853.5	For MAI 3, CMS claims processing contractors and CMS shared system maintainers shall continue to: Sum all UOS for the code for the same date of service on: a. All claim lines of the current claim b. Paid claim lines of the prior finalized claims. This number should be compared to the MUE value. If the sum of all specified UOS for the same date of service on all claims exceeds the MUE value for the code, contractors shall deny all claim lines for the code for the same date of service on the current claim. Paid claim lines from prior finalized claims shall not be adjusted. All claim lines for HCPCS codes with an MAI of 3 on suspended claims shall be subjected to this claim adjudication process during final processing after release from suspended status. If contractors have pre-payment evidence (e,g, medical review) that UOS in excess of the MUE value were provided, were coded correctly and were medically necessary, the contractor may bypass the MUE for a HCPCS code with an MAI of 3.	X	X		X	X				

Number	Requirement	Responsibility: A/B MAC A	A/B MAC B	A/B MAC HHH	DME MAC	Shared-System Maintainers FISS	Shared-System Maintainers MCS	Shared-System Maintainers VMS	Shared-System Maintainers CWF	Other
8853.5.1	Since ASC providers (specialty code 49) cannot report modifier 50, the MUE value used for editing should be doubled for HCPCS codes with an MAI of 3 if the bilateral surgery indicator for the HCPCS code is 1.		X							
8853.5.2	Since Method 2 Critical Access Hospitals may separately report physician services and assistant surgeon services on institutional claims, in applying MUEs to Critical Access Hospital claims (TOB 85X) , contractors shall apply the Outpatient Hospital MUE once to UOS reported with any non-excluded revenue codes except 096X, 097X and 098X (i.e. physician services), once to UOS reported with revenue codes 096X, 097X and 098X but without modifier AS, 80, 81 or 82 (i.e. primary surgeon), and once to UOS reported with revenue codes 096X, 097X and 098X and with modifier AS, 80, 81 or 82 (i.e. assistant surgeon).	X				X				
8853.6	CMS Medicare claims processing contractors and shared system maintainers shall continue to sum the units of service for multiple identical line items without any HCPCS/CPT modifier. Contractors shall deny all claim lines on current claims if the total UOS for multiple identical line items without any HCPCS/CPT modifier exceeds the MUE value for the HCPCS code. However, for those situations in which the total UOS for multiple identical claim line items without any HCPCS/CPT modifier do not exceed the MUE value, current duplicate review policy remains in effect. That is, when potential duplicate line items are present on the same claim, contractors shall perform an automated or manual review of those line items to ensure they are processed (paid or denied) according to current system edit logic. Since MUEs are the last automated edits applied before CWF, the sequential position in the automated claims processing procedure of current duplicate review policy should not be altered. **NOTE**: Special logic for modifiers Q3, TC, and 26 for services with an MAI of 2 and MAI of 3 still apply, as required in CR8402.	X	X		X	X				
8853.7	CMS Medicare claims processing contractors and FISS shall continue to allow claims appended with	X	X			X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	modifier 55 to be exempt from MUE editing for all 3 MAI levels. No other modifier on a claim line shall exempt the claim line from an MUE.									
8853.8	Carriers/FIs/Part A/B MACs shall remind providers to report bilateral surgical procedures on a single claim line with modifier 50 and one (1) UOS.Those claims processing contractors shall also remind providers to use anatomic modifiers (e.g. RT, LT, FA, F1-F9, TA, T1-T9, E1-E4) and report procedures with differing modifiers on individual claim lines when appropriate.Many MUEs are based on the assumption that these modifiers are used.	X	X							
8853.9	CMS Medicare claims processing contractors shall adhere to the following regarding ABNs: A denial of services due to an MUE is a coding denial, not a medical necessity denial. The presence of an ABN shall not shift liability to the beneficiary for UOS denied based on an MUE. CMS interprets the notice delivery requirements under §1879 of the Social Security Act (the Act) as applying to situations in which a provider expects the initial claim determination to be a reasonable and necessary denial. Consistent with NCCI guidance, denials resulting from MUEs are not based on any of the statutory provisions that give liability protection to beneficiaries under section 1879 of the Social Security Act. Thus, ABN issuance based on an MUE is NOT appropriate.	X	X		X					
8853.10	Some MUEs still remain confidential and are for CMS personnel and CMS Medicare Contractor use only. CMS contractors and CMS personnel shall not share the MUE values nor the MAI levels for the remaining codes with confidential MUEs outside of their organization(s).	X	X		X					
8853.11	CMS shared system maintainers shall apply MUEs after all other edits and audits have completed and before the claim is sent to CWF.					X				
8853.12	CMS shared system maintainers and the data centers, Enterprise Data Centers (EDCs) or contractor data centers (CDCs), shall have already installed the date					X				CDC, VDC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	of service edit MAIs in all systems.									
8853.13	CMS Medicare claims processing contractors shall continue to allow physicians, suppliers, facilities and beneficiaries appeal rights under the Medicare claims appeal process (See Pub 100-04, Claims Processing Manual, Chapter 29.) CMS Medicare claims processing contractors processing an appeal of an MUE denial may pay medically necessary UOS in excess of an MUE value when an override is necessary in accordance with the policy described in this CR. FISS shall create a mechanism for bypassing the MUEs for FIs, upon appeal.	X	X		X	X				
8853.14	CMS shared system maintainers shall continue to ensure that MUEs are applied based on same date of service, same provider, same HCPCS/CPT code, same beneficiary HICN. The shared systems maintainers currently provide this capability.					X				
8853.15	CMS Medicare claims processing contractors shall continue to refer any request to modify the MUE value for a specific code to: National Correct Coding Initiative Correct Coding Solutions, LLC P.O. Box 907, Carmel, IN 46082-0907 FAX: 317-571-1745	X	X		X					
8853.16	CMS Medicare claims processing contractors shall continue to assign MSN message 15.6, ANSI reasoncode 151, group code CO (contractual obligation), and remark codes N362 and MA01 to claims that fail the MUEs, when the units of service on the claim are in excess of the MUE value, and deny the entire claim line(s) for the relevant HCPCS code.	X	X		X					
8853.17	CMS claims processing contractors and CMS shared system maintainers shall not allow any payment, if a HCPCS code has an MUE value of 0 (zero). No units of service are eligible for payment for that code.	X	X		X	X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
8853.18	MLN Article : A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X		X	

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Valeria Allen, 410-786-7443 or valeria.allen@cms.hhs.gov

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

VI. FUNDING

Section A: 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.

ATTACHMENTS: 0