CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 11897	**Date: March 10, 2023**
	Change Request 13136

SUBJECT: April 2023 Update of the Hospital Outpatient Prospective Payment System (OPPS)

I. SUMMARY OF CHANGES: The purpose of this Recurring Update Notification (RUN) Change Request (CR) is to describe changes to and billing instructions for various payment policies implemented in the April 2023 Outpatient Prospective Payment System (OPPS) update. The April 2023 Integrated Outpatient Code Editor (I/OCE) will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in this Change Request (CR). This RUN applies to Chapter 4, section 50.8 (Annual Updates to the OPPS Pricer for Calendar Year (CY) 2007 and Later).

EFFECTIVE DATE: April 1, 2023
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 3, 2023

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	4/Table of Contents
R	4/10.2.3/Comprehensive APCs
R	4/20.6/Use of Modifiers
R	4/20.6.1/Where to Report Modifiers on the Hospital Part B Claim
R	4/20.6.2/Modifier 50
R	4/20.6.3/Modifiers LT and RT
R	4/20.6.4/Modifiers 73 and 74
R	4/20.6.5/Modifiers 76 and 77
R	4/20.6.6/Modifiers for Radiology Services
R	4/20.6.7/Modifier CA
D	4/20.6.8/HCPCS Level II Modifiers
R	4/20.6.9/Modifier FB
R	4/20.6.10/Modifier FC
R	4/20.6.11/Modifier PO
R	4/20.6.12/Modifier PN
R	4/20.6.13/Modifier CT
R	4/20.6.14/Modifier FX
R	4/20.6.15/Modifier FY
R	4/20.6.16/Modifier JG
R	4/20.6.17/Modifier TB
R	4/20.6.18/Modifier ER
R	4/20.6.19/Modifier CG
R	4/60.4.2/Complete List of Device Pass-through Category Codes
R	4/170/Hospital and CMHC Reporting Requirements for Services Performed on the Same Day

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 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:

Recurring Update Notification

Attachment - Recurring Update Notification

Pub. 100-04	Transmittal: 11897	Date: March 10, 2023	Change Request: 13136

SUBJECT: April 2023 Update of the Hospital Outpatient Prospective Payment System (OPPS)

EFFECTIVE DATE: April 1, 2023
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 3, 2023

I. GENERAL INFORMATION

A. Background: This Recurring Update Notification (RUN) provides instructions on coding changes and policy updates that are effective April 1, 2023 for the Hospital Outpatient Prospective Payment System (OPPS). The updates include coding and policy changes for new services, pass-through drug and devices, Covid-19 treatments, PLA codes and other items and services. The April 2023 revisions to I/OCE data files, instructions, and specifications are provided in the forthcoming April 2023 I/OCE CR.

B. Policy: 1. New Covid-19 CPT Vaccines and Administration Codes

American Medical Association (AMA) has been issuing unique Current Procedural Terminology (CPT) Category I codes which are developed based on collaboration with Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) for each coronavirus vaccine as well as administration codes unique to each such vaccine and dose. These codes are effective upon receiving Emergency Use Authorization (EUA) or approval from the Food and Drug Administration (FDA).

The Current Procedural Terminology (CPT) Editorial Panel has recently approved:

- A new CPT code (91316) describing the "Moderna COVID-19 Vaccine, Bivalent" for use as a booster for ages 6 months through 5 years.
- A new CPT code (0164A) describing the service to administer the "Moderna COVID-19 Vaccine, Bivalent" (91316).
- A new CPT code (91317) describing the "Pfizer-BioNTech COVID-19 Vaccine, Bivalent" for use as a third primary series dose for ages 6 months through 4 years.
- A new CPT code (0173A) describing the service to administer the "Pfizer-BioNtech COVID-19 Vaccine, Bivalent" (91317).

The Centers for Medicare & Medicaid Services (CMS) identifies an effective date of 12/08/2022 for both of the Moderna and Pfizer-BioNTech "COVID-19 Vaccine, Bivalent" administration CPT codes, 0164A and 0173A, respectively, which describe the service to administer the bivalent formulations of the vaccines. This effective date corresponds with Food and Drug Administration (FDA) Emergency Use Authorizations (EUA) and/or approvals for both the "Moderna COVID-19 Vaccine, Bivalent" and the "Pfizer-BioNTech COVID-19 Vaccine, Bivalent," described by CPT codes 91316 and 91317, effective 12/08/2022.

Effective December 8, 2022, CPT codes 91316 and 91317 are assigned to status indicator "L" (Not paid under OPPS. Paid at reasonable cost; not subject to deductible or coinsurance) in the April 2023 I/OCE update.

Effective December 8, 2022, CPT codes 0164A and 0173A are assigned to status indicator "S" (Procedure or Service, Not Discounted When Multiple, separate APC assignment) and APC 9398 (Covid-19 Vaccine Admin

Dose 2 of 2, Single Dose Product or Additional Dose) in the April 2023 I/OCE update.

Beneficiary cost sharing shall not be applied to the new vaccine product codes or the new administration codes.

CMS will provide future direction to the contractors as EUAs and/or approvals become available.

Table 1, attachment A, lists the long descriptors for the codes. These codes, along with their short descriptors, status indicators, and payment rates (where applicable) are also listed in the April 2023 OPPS Addendum B that is posted on the CMS website. For information on the OPPS status indicators, refer to OPPS Addendum D1 of the CY 2023 Outpatient Prospective Payment System (OPPS)/Ambulatory Surgical Center (ASC) final rule for the latest definitions.

2.OPPS Payment for COVID–19 Treatments after the Public Health Emergency (PHE)

After the PHE, payment for COVID-19 treatments will be packaged into the payment for a comprehensive APC (C-APC) when these services are billed on the same outpatient claim, subject to standard exclusions under the C-APC policy. Please see the updated CMS internet only manual language in the Medicare Claims Processing Manual, Pub.100-04, Chapter 4, Section 10.2.3 – Comprehensive APCs.

3. CPT Proprietary Laboratory Analyses (PLA) Coding Changes Effective April 1, 2023

The AMA CPT Editorial Panel established 23 new PLA codes, specifically, CPT codes 0364U through 0386U, effective April 1, 2023.

Table 2, attachment A, lists the long descriptors and status indicators for the codes. The codes have been added to the April 2023 I/OCE with an effective date of April 1, 2023. In addition, the codes, along with their short descriptors and status indicators, are listed in the April 2023 OPPS Addendum B that is posted on the CMS website. For more information on OPPS status indicators, refer to OPPS Addendum D1 of the Calendar Year 2023 OPPS/ASC final rule for the latest definitions.

4. a. New Device Pass-Through Category Effective January 1, 2023

Section 1833(t)(6)(B) of the Social Security Act requires that, under the OPPS, categories of devices be eligible for transitional pass-through payments for at least two (2), but not more than three (3) years. In addition, section 1833(t)(6)(B)(ii)(IV) of the Act requires that we create additional categories for transitional pass-through payment of new medical devices not described by existing or previously existing categories of devices.

As discussed in section IV.A.2. (New Device Pass-Through Applications for CY 2023), of the CY 2023 OPPS/ASC final rule with comment period, for the January 2023 update, we approved three (3) new devices for pass-through status under the OPPS, specifically, HCPCS codes C1747, C1826, and C1827. For the full discussion on the criteria used to evaluate device pass-through applications, refer to the CY 2023 OPPS/ASC final rule with comment period, which was published in the **Federal Register** in November of CY 2022. Refer to Table 3A, attachment A, for the long descriptor, status indicator, APC, and offset amount for these three (3) HCPCS codes.

Furthermore, we are adding these three (3) new device category codes and their pass-through expiration dates to Table 4, attachment A. We note we are updating the device category long descriptor for device HCPCS code C1831, which was effective October 1, 2021, from "Personalized, anterior and lateral interbody cage (implantable)" to "Interbody cage, anterior, lateral or posterior, personalized (implantable)" effective January 1, 2023. Refer to Table 4 for the complete list of device category HCPCS codes and definitions used for present and previous transitional pass-through payment.

b. Device Offset from Payment for the Following HCPCS Codes

Section 1833(t)(6)(D)(ii) of the Act requires that we deduct from pass-through payments for devices an amount that reflects the device portion of the APC payment amount. This deduction is known as the device offset, or the portion(s) of the APC amount that is associated with the cost of the pass-through device. The device offset from payment represents a deduction from pass-through payments for the applicable pass-through device.

c. Transitional Pass-Through Payments for Designated Devices

Certain designated new devices are assigned to APCs and identified by the I/OCE as eligible for payment based on the reasonable cost of the new device reduced by the amount included in the APC for the procedure that reflects the packaged payment for device(s) used in the procedure. The I/OCE will determine the proper payment amount for these APCs as well as the coinsurance and any applicable deductible. All related payment calculations will be returned on the same APC line and identified as a designated new device. We refer readers to Addendum P (Device-Intensive Procedures for CY 2023) of the CY 2023 OPPS/ASC final rule with comment period for the most current OPPS HCPCS Offset file. Addendum P is available via the Internet on the CMS website, specifically, at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices.

Section 4141 of the Consolidated Appropriations Act of 2023 amended Section 1833(t)(6) of the Social Security Act to extend pass-through status for certain devices for a 1-year period beginning on January 1, 2023. The pass-through devices that received this extension are displayed in Table 3B, attachment A and noted in Table 4. Since the pass-through status for these devices were set to expire on December 31, 2022, the pass-through device costs were packaged into the cost of the associated procedures which determined the procedure's CY 2023 APC assignment. However, the changes to Section 1833(t)(6) as a result of Section 4141 also require that we do not remove the packaged cost of the extended pass-through device from the payment amount for a covered OPD service for which it is packaged. Therefore, we are maintaining the APC assignment for these procedures associated with these pass-through devices for CY 2023. Additionally, we are continuing the CY 2022 device offset amount, the device offset amount prior to packaging the pass-through device costs, for the procedures that are associated with the extended pass-through devices. The CY 2023 device offset amounts are displayed in Table 3B. The device offset amounts for the associated procedures performed with the extended pass-through devices are not reflected in Addendum P of the CY 2023 OPPS/ASC final rule with comment period.

d. Alternative Pathway for Devices That Have a Food and Drug Administration (FDA) Breakthrough Designation

For devices that have received FDA marketing authorization and a Breakthrough Device designation from the FDA, CMS provides an alternative pathway to qualify for device pass-through payment status, under which devices would not be evaluated in terms of the current substantial clinical improvement criterion for the purposes of determining device pass-through payment status. The devices would still need to meet the other criteria for pass-through status. This applies to devices that receive pass-through payment status effective on or after January 1, 2020. For information on the device criteria to qualify for pass-through status under the OPPS, refer to this CMS website, specifically at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/passthrough_payment.

e. Expiring Pass-through Status for Six Device Category HCPCS Codes Effective January 1, 2023

As specified in section 1833(t)(6)(B) of the Social Security Act, under the OPPS, categories of devices are eligible for transitional pass-through payments for at least two (2), but not more than three (3) years. As discussed in section IV.A.1. b. (Expiration of Transitional Pass-Through Payments for Certain Devices) of the CY 2023 OPPS/ASC final rule with comment period, the pass-through period for several device category

HCPCS code will expire on December 31, 2022. These codes are listed below in Table 3C, attachment A. We note that these device category HCPCS codes will remain active, however, their payment will be included in the primary service. As a reminder, for OPPS billing, because charges related to packaged services are used for outlier and future rate setting, hospitals are advised to report the device category HCPCS codes on the claim whenever they are provided in the HOPD setting. It is extremely important that hospitals report all HCPCS codes consistent with their descriptors, CPT and/or CMS instructions and correct coding principles, as well as all charges for all services they furnish, whether payment for the services is made separately or is packaged. For the entire list of current and historical device category codes created since August 1, 2000, which is the implementation date of the hospital OPPS, refer to Table 4. We note this list can also be found in Chapter 4, Section 60.4.2 (Complete List of Device Pass-through Category Codes) of the Medicare Claims Processing Manual, Pub.100-04.

f. Device Pass-Through Category Removal

As discussed in the October 2022 OPPS and ASC Update CRs, we had conditionally approved a new device for pass-through status effective October 1, 2022. Specifically, we had established HCPCS code C1834 (Pressure sensor system, includes all components (e.g., introducer, sensor), intramuscular (implantable), excludes mobile (wireless) software application), effective October 1, 2022. However, after further review, we have determined that the conditional approval was in error, and consequently, we are deleting the code on March 31, 2023. We note that we have no claims data for C1834, so there should be no reprocessing of claims for HCPCS code C1834.

5. Drugs, Biologicals, and Radiopharmaceuticals
a. New CY 2023 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals Receiving Pass-Through Status Starting April 1, 2023

Twelve (12) new certain drugs, biologicals, and radiopharmaceuticals receiving pass-through status HCPCS codes will be established on April 1, 2023. These HCPCS codes are listed in Table 5, attachment A.

There are two (2) new certain drugs, biologicals, and radiopharmaceuticals receiving pass-through status HCPCS codes with a status indicator change for April 1, 2023. These codes are listed in Table 6, attachment A.

b. Existing HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals with Pass-Through Status Ending on March 31, 2023

Eight (8) HCPCS codes for certain drugs, biologicals, and radiopharmaceuticals in the outpatient setting that will have their pass-through status end on March 31, 2023. These codes are listed in Table 7, attachment A. Therefore, effective April 1, 2023, the status indicator for these codes is changing from "G" to either "K" or "N". For more information on OPPS status indicators, refer to OPPS Addendum D1 of the Calendar Year 2023 OPPS/ASC final rule for the latest definition. These codes, along with their short descriptors and status indicators are also listed in the April 2023 Update of the OPPS Addendum B.

c. Newly Established HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals as of April 1, 2023

Twenty-two (22) new drug, biological, and radiopharmaceutical HCPCS codes will be established on April 1, 2023. These HCPCS codes are listed in Table 8, attachment A.

d. HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals Deleted on March 31, 2023

Two (2) drug, biological, and radiopharmaceutical HCPCS codes have been deleted on March 31, 2023. These HCPCS codes are listed in Table 9, attachment A.

e. HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals that will have a Changing Status Indicator and APC for April 1, 2023.

One (1) drug, biological, and radiopharmaceutical HCPCS code will have a changing status indicator and APC for April 1, 2023. See Table 10, attachment A.

f. Drugs and Biologicals that will have Manual Adjudication Status on April 1, 2023

HCPCS code J1411 (Injection, etranacogene dezaparvovec-drlb, per therapeutic dose) is receiving pass-through status starting April 1, 2023 as listed in Table 5, attachment A. Due to the magnitude of the required payment rate and technical operational limitations, MACs will manually pay claims following the ASP methodology, after consulting with CMS for pricing instructions. Due to the manual payment for HCPCS code J1411 by the MAC, a zero ($0.00) payment rate will be assigned to APC 9138, which will serve as an additional prompt for the MAC to manually price the code after receiving pricing instructions from CMS.

HCPCS code J3399 (Injection, Onasemnogene abeparvovec-xioi, per treatment, up to 5x10^15 vector genomes) is having its status indicator changed from "A" to "K" starting April 1, 2023 as listed in Table 10, attachment A. Due to the magnitude of the required payment rate and technical operational limitations, MACs will manually pay claims following the ASP methodology, after consulting with CMS for pricing instructions. Due to the manual payment for HCPCS code J3399 by the MAC, a zero ($0.00) payment rate will be assigned to APC 9141, which will serve as an additional prompt for the MAC to manually price the code after receiving pricing instructions from CMS.

g. Drugs and Biologicals with Payments Based on Average Sales Price (ASP)

For CY 2023, payment for the majority of nonpass-through drugs, biologicals, and therapeutic radiopharmaceuticals is generally made at a single rate of ASP plus 6 percent (or ASP plus 6 or 8 percent of the reference product for biosimilars). In CY 2023, a single payment of ASP plus 6 percent for pass-through drugs, biologicals, and radiopharmaceuticals is generally made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items (or ASP plus 6 or 8 percent of the reference product for biosimilars). Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. Effective April 1, 2023, payment rates for many drugs and biologicals have changed from the values published in the CY 2023 OPPS/ASC final rule with comment period as a result of the new ASP calculations based on sales price submissions from the third quarter of CY 2022. In cases where adjustments to payment rates are necessary, changes to the payment rates will be incorporated in the April 2023 Fiscal Intermediary Standard System (FISS) release. CMS is not publishing the updated payment rates in this Change Request implementing the April 2023 update of the OPPS. However, the updated payment rates effective April 1, 2023, can be found in the April 2023 update of the OPPS Addendum A and Addendum B on the CMS website at https:/www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS

h. Drugs and Biologicals Based on ASP Methodology with Restated Payment Rates

Some drugs and biologicals paid based on ASP methodology will have payment rates that are corrected retroactively. These retroactive corrections typically occur on a quarterly basis. The list of drugs and biologicals with corrected payments rates will be accessible on the CMS website on the first date of the quarter at https:/www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/OPPS-Restated-Payment-Rates.html

Providers may resubmit claims that were affected by adjustments to a previous quarter's payment files.

6. Skin Substitutes

The payment for skin substitute products that do not qualify for pass-through status will be packaged into the payment for the associated skin substitute application procedure. For payment packaging purposes, the skin substitute products are divided into two groups: 1) high cost skin substitute products and 2) low cost skin substitute products. New skin substitute HCPCS codes are assigned into the low-cost skin substitute group unless CMS has pricing data that demonstrates that the cost of the product is above either the mean unit cost of $47 or the per day cost of $837 for CY 2023.

a. New Skin Substitute Products as of April 1, 2023

There are seven (7) new skin substitute HCPCS codes that will be active as of April 1, 2023. These codes are listed in Table 11, attachment A.

7. OPPS Payment Files (Addenda A and B) Format Change

Effective January 1, 2023, the Inflation Reduction Act of 2022 specifies that drug companies that raise their prices for certain Medicare Part B drugs faster than the rate of inflation must pay Medicare a rebate. Beneficiary coinsurance for certain Part B drugs (including biological products) with prices that increased at a rate faster than the rate of inflation will be adjusted so beneficiary coinsurance is based on the lower inflation-adjusted payment amount. This new inflation rebate applies to certain Medicare Part B single source drugs and biological products, including biosimilar biological products.

Starting April 1, 2023, when the Medicare Part B payment amount for a Part B rebatable drug for a calendar quarter is higher than the inflation-adjusted payment amount:

- Patient coinsurance will be based on 20% of the inflation-adjusted payment amount for the quarter and will be reflected as a percentage (that is less than 20%) of the Medicare Part B payment amount.
- The Medicare portion of the payment will be increased to the difference between the Medicare Part B payment amount and patient coinsurance, minus any Part B deductible and sequestration.
- Patients must be charged the correct amount of coinsurance, which may change quarterly.

Additional information pertaining to the IRA and its impact is included in the CY2023 OPPS/ASC final rule (CMS-1772-FC).

Due to this change, effective April 1, 2023, the OPPS Addenda A and B will include the following changes:

1. Addition of a new column for **"Adjusted Beneficiary Copayment"** to identify - any copayment adjustment due to either the inpatient deductible amount copayment cap, or the inflation-adjusted copayment of a Part B rebatable drug per Inflation Reduction Act (IRA) provisions.
2. Revision to the **"Note"** column which can now contain multiple messages including, but not limited to, inflation-adjusted copayment of a Part B rebatable drugs, the copayment for a code will be capped at the inpatient deductible of $1,600.00; or that the 8% of the reference product add-on applied for a biosimilar.

8. Coverage Determinations

As a reminder, the fact that a drug, device, procedure, or service is assigned a HCPCS code and a payment rate under the OPPS does not imply coverage by the Medicare program but indicates only how the product, procedure, or service may be paid if covered by the program. Medicare Administrative Contractors (MACs)

determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, MACs determine that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

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	
13136.1	Medicare contractors shall adjust, as appropriate, claims brought to their attention with any retroactive changes that were received prior to implementation of the April 2023 OPPS I/OCE.	X		X						
13136.2	Medicare contractors shall manually insert the rate for J1411 in the HCPCS file after a claim is received. The claim will suspend a reason code 36467. When a contractor receives a claim with J1411, contact CMS at: OutpatientPPS@cms.hhs.gov for pricing instructions.	X								
13136.3	Medicare contractors shall manually insert the rate for J3399 in the HCPCS file after a claim is received. Medicare contractors shall remove the HCPCS file indicators to make contractor manually price J3399 on the claim. The claim will suspend a reason code 36467. When a contractor receives a claim with J3399, contact CMS at: OutpatientPPS@cms.hhs.gov for pricing instructions.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
13136.4	Medicare Learning Network® (MLN): CMS will market provider education content through the MLN Connects® newsletter shortly after CMS releases the	X		X		

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	CR. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 instructions for distributing the MLN Connects newsletter information to providers and link to relevant information on your website. You may supplement MLN content with your local information after we release the MLN Connects newsletter. Subscribe to the “MLN Connects” listserv to get MLN content notifications. You don’t need to separately track and report MLN content releases when you distribute MLN Connects newsletter content per the manual section referenced above.					

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): Marina Kushnirova, marina.kushnirova@cms.hhs.gov

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

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: 1