CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 513	**Date: July 2, 2009**
	Change Request 6514

Subject: Coding and Reporting Principles for the Physician Quality Reporting Initiative (PQRI) and the Electronic Prescribing (E-Prescribing) Incentive Programs

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is **to** give high-level overview on the coding and reporting principles for claims-based reporting of quality measures data for the 2009 PQRI and for claims-based reporting of the e-prescribing measure for the 2009 E-Prescribing Incentive Programs

New / Revised Material
Effective Date: June 1, 2009
Implementation Date: September 2, 2009

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	

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: 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:

One-Time Notification

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

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 513	Date: July 2, 2009	Change Request: 6514

SUBJECT: Coding and Reporting Principles for the Physician Quality Reporting Initiative (PQRI) and the Electronic Prescribing (E-Prescribing) Incentive Programs

Effective Date: June 1, 2009

Implementation Date: September 2, 2009

I. GENERAL INFORMATION

A. Background:

The 2006 Tax Relief and Health Care Act (P.L. 109-432) (TRHCA) required the establishment of a physician quality reporting system, including an incentive payment for eligible professionals (EPs) who satisfactorily report data on quality measures for covered services furnished to Medicare beneficiaries during the second half of 2007. CMS named this program the Physician Quality Reporting Initiative (PQRI).

For the 2009 PQRI, the Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173) (MMSEA) required the Secretary to select measures for 2009 through rulemaking and to establish alternative reporting criteria and alternative reporting periods for reporting on a group of measures, or measures groups, and for registry-based reporting. In addition, the Medicare Improvements for Patients and Providers Act (P.L. 110-275) (MIPPA), which was enacted on July 15, 2008, includes many provisions that impact the 2009 PQRI. Thus, for 2009, PQRI submission of quality data may be performed via claims or via a qualified registry. Multiple reporting options are available for each method of submission, including the option of reporting on individual quality measures or on measures groups.

Section 132 of the MIPPA also authorizes a new and separate incentive program for EPs who are successful electronic prescribers (e-prescribers) as defined by MIPPA. This new incentive is separate from and is in addition to the PQRI. To be considered a successful e-prescriber for 2009, an EP must report an e-prescribing measure in at least 50% of reportable cases. For 2009, the e-prescribing measure may be reported via claims only.

The purpose of this document is to give high-level overview on the coding and reporting principles for claims-based reporting of quality measures data for the 2009 PQRI and for claims-based reporting of the e-prescribing measure for the 2009 E-Prescribing Incentive Programs. The carriers and Part A/B MACs will find this information helpful in responding to provider inquiries about the PQRI and/or the E-Prescribing Incentive Program.

B. Policy: Coding and Reporting Principles for Claims-based Reporting of PQRI Measures

1. Introduction

To implement 2009 PQRI claims-based reporting of measures or measures groups, eligible professionals (EPs), using their individual national provider identifier (NPI) and submitting billable services on Part B claims for allowable Physician Fee Schedule (PFS) charges, may report the quality action for selected PQRI quality measure(s) or measures groups, which are comprised of 4 or more PQRI quality measures. In general, the PQRI quality measures consist of a unique denominator (eligible case) and numerator (quality action) that permit the calculation of the percentage of a defined patient population that receive a particular process of care or achieve a particular outcome, or for whom care was delivered using a particular structural element. It is important to

review and understand each measure specification, which provides definitions and specific instructions for reporting a measure.

EPs who choose to report individual PQRI quality measures should review the following documents:

- "*2009 PQRI Measure Specifications Manual for Claims and Registry*".

- *"2009 PQRI Implementation Guide,"* which describes important reporting principles underlying claims-based reporting of measures and includes a sample claim in CMS 1500 format.

Both documents can be found on the Measures/Codes section of the CMS PQRI website at http://www.cms.hhs.gov/PQRI/15_MeasuresCodes.asp#TopOfPage.

EPs who choose to report PQRI measures groups should review the following documents:

- "*2009 PQRI Measures Groups Specifications Manual*". Note that the specifications for a measures group are different from those for individual measures because measures groups require a common denominator. Be sure you use the correct specifications.

- "*Getting Started with 2009 PQRI Reporting of Measures Groups*" – this is the implementation guide for reporting measures groups.

- (3) "*2009 PQRI Tip Sheet: PQRI Made Simple – Reporting the Preventive Care Measures Group*" – this tip sheet provides a useful worksheet to keep track of each patient reported when using the 30-consecutive patient sample method for a measures group.

You can find the first two documents on the Measures/Codes section of the CMS PQRI website at http://www.cms.hhs.gov/PQRI/15_MeasuresCodes.asp#TopOfPage. The third document can be found on the Educational Resources section of the CMS PQRI website at http://www.cms.hhs.gov/PQRI/30_EducationalResources.asp#TopOfPage.

2. PQRI Denominators and Numerators

Measures consist of two major components:
A denominator that describes the eligible cases for a measure (the eligible patient population associated with a measure's numerator)

A numerator that describes the quality action required by the measure for reporting and performance

Each component is defined by specific codes described in each measure specification along with reporting instructions and use of modifiers.

a. Use of CPT Category I Modifiers

PQRI measure specifications include specific instructions regarding inclusion of the CPT Category I modifiers. Unless otherwise specified, CPT Category I codes may be reported with or without CPT modifiers. Refer to each individual measure specification for detailed instructions regarding CPT Category I modifiers that qualify or do not qualify a claim for denominator inclusion.

Note that surgical procedures billed by an assistant surgeon(s) will be excluded from the denominator population so their performance rates will not be negatively impacted for PQRI. PQRI analyses will exclude otherwise PQRI-eligible CPT Category I codes, when submitted with assistant surgeon modifiers 80, 81, or 82. The primary surgeon, not the assistant surgeon, is responsible for performing and reporting the quality action(s) in applicable PQRI measures.

PQRI-eligible CPT Category I procedure codes, billed by surgeons performing surgery on the same patient, submitted with modifier 62 (indicating two surgeons, i.e., dual procedures) will be included in the denominator population for applicable PQRI measure(s). Both surgeons participating in PQRI will be fully accountable for the quality action(s) described in the PQRI measure(s).

b. Quality-Data Codes (QDCs)
QDCs are non-payable HCPCS codes comprised of specified CPT Category II codes and/or G-codes that describe the quality action required by a measure's numerator. Quality actions can apply to more than one condition, and therefore can also apply to more than one measure. Where necessary, to avoid shared CPT Category II codes, G-codes are used to distinguish quality actions across measures. Some measures require more than one quality action and therefore have more than one CPT Category II code, G-code, or a combination associated with them. EPs should review numerator reporting instructions carefully.

c. CPT Category II Codes
CPT Category II or CPT II codes, developed through the CPT Editorial Panel for use in performance measurement, serve to encode the quality action(s) described in a measure's numerator. PQRI measure specifications do not encompass all published CPT II codes; only a subset of codes that are selected by the measure developer for use in PQRI. CPT II codes consist of five alphanumeric characters in a string ending with the letter "F." CPT II codes are not modified or updated during the reporting period and remain valid for the entire program year as published in the measure specifications manuals and related documents for PQRI.

d. Use of CPT II Modifiers
CPT II modifiers are unique to CPT II codes and may be used to report PQRI measures by appending the appropriate modifier to a CPT II code as specified for a given measure. The modifiers for a code are mutually exclusive and their use is guided by the measure's coding instructions, which are included in the numerator coding section of the measure specifications. Use of the modifiers is unique to CPT II codes and may not be used with other types of CPT codes. Only CPT II modifiers may be appended to CPT II codes. Descriptions of each modifier are provided below to help identify circumstances when the use of an exclusion modifier may be appropriate. Note that in a pay-for-reporting model, accurate reporting on all selected applicable measures counts the same, whether reporting that the quality action was performed or not.
CPT II code modifiers fall into two categories, exclusion modifiers and the 8P reporting modifier.

1) Exclusion modifiers may be appended to a CPT II code to indicate that an action specified in the measure was not provided due to medical, patient, or system reason(s) documented in the medical record. These modifiers serve as denominator exclusions for the purpose of measuring performance. Some measures do not allow performance exclusions. Reasons for appending a performance measure exclusion modifier fall into one of three categories:

1P Performance measure exclusion modifier due to medical reasons

Includes:

- not indicated (absence of organ/limb, already received/performed, other)
- contraindicated (patient allergic history, potential adverse drug interaction, other)
- other medical reasons

2P Performance measure exclusion modifier due to patient reasons

Includes:

- Patient declined
- Economic, social, or religious reasons
- Other patient reasons

3P Performance measure exclusion modifier due to system reasons

Includes:

- Resources to perform the services not available (eg, equipment, supplies)

• Insurance coverage or payer-related limitations
• Other reasons attributable to health care delivery system

2) The 8P reporting modifier is available for use only with CPT II codes to facilitate reporting a denominator eligible case when an action described in a measure is not performed and the reason is not specified. Instructions for appending this reporting modifier to CPT Category II codes are included in applicable measures. Use of the 8P reporting modifier indicates that the patient is eligible for the measure; however, there is no indication in the record that the action described in the measure was performed, nor was there any documented reason attributable to the exclusion modifiers.

- **8P Performance measure reporting modifier - action not performed, reason not otherwise specified**

The 8P reporting modifier facilitates reporting an eligible case on a given measure when the quality action does not apply to a specific encounter. EPs can use the 8P modifier to receive credit for satisfactory reporting but will not receive credit for performance.

For example, a clinician has selected and submitted QDCs during the reporting period for 2009 PQRI Measure #6, Oral Antiplatelet Therapy. The clinician sees a patient during an encounter and the claim for services for that encounter contains ICD-9-CM and CPT codes that will draw the patient into the measures' denominator during analysis. The 8P modifier serves to include the patient in the numerator when reporting rates are calculated for PQRI.

3. Claims-Based Reporting Principles
The following principles apply to the reporting of QDCs for PQRI measures:

- The CPT Category II code(s) and/or G-code(s), which supply the numerator, must be reported:
  - on the same claim as the denominator billing code(s)
  - for the same beneficiary
  - for the same date of service (DOS)
  - by the same EP (individual NPI) who performed the covered service as the payment codes, usually ICD-9-CM, CPT Category I or HCPCS codes, which supply the denominator.

- All diagnoses reported on the base claim, regardless of the order listed, will be included in PQRI analysis, as some PQRI measures require reporting more than one diagnosis on a claim. For line items containing a QDC, only a single reference number in the diagnosis pointer field will pass into the National Claims History File. To report a QDC for a measure that requires reporting of multiple diagnoses, enter the reference number in the diagnosis pointer field that corresponds to one of the measure's diagnoses listed on the base claim. Regardless of the reference number in the diagnosis pointer field, both primary and all secondary diagnoses are considered in PQRI analysis.

- Up to four diagnoses can be reported in the header on the CMS-1500 paper claim and up to eight diagnoses can be reported in the header on the electronic claim. However, only one diagnosis can be linked to each line item, whether billing on paper or electronically.

- If your billing software limits the number of line items available on a claim, you may add a nominal amount such as a penny, to one of the line items on that second claim for a total charge of one penny. PQRI analysis will subsequently join both claims based on the same beneficiary for the same date-of-service, for the same TIN/NPI and analyze as one claim. Providers should work with their billing software vendor/clearinghouse regarding line limitations for claims to ensure that diagnoses or QDCs are not dropped.

- QDCs must be submitted with a line-item charge of zero dollars ($0.00) at the time the associated covered service is performed.
    - The submitted charge field cannot be blank.
    - The line item charge should be $0.00.
    - If a system does not allow a $0.00 line-item charge, a nominal amount can be substituted - the beneficiary is not liable for this nominal amount.
    - Entire claims with a zero charge will be rejected. (Total charge for the claim cannot be $0.00.)
    - Whether a $0.00 charge or a nominal amount is submitted to the carrier/contractor, the PQRI QDC line is denied and tracked.
    - QDC line items will be denied for payment, but are then passed through the claims processing system for PQRI analysis. EPs will receive a Remittance Advice (RA) associated with the claim which will contain the PQRI QDC line-item and will include a standard remark code (N365) and a message that confirms that the QDC(s) passed into the National Claims History (NCH) file. N365 reads: "This procedure code is not payable. It is for reporting/information purposes only." The N365 remark code does NOT indicate whether the QDC is accurate for that claim or for the measure the EP is attempting to report.

- Multiple EPs' QDCs can be reported on the same claim using their individual NPI. Therefore, when a group is billing, they should follow their normal billing practice of placing the NPI of the individual EP who rendered the service on each line item on the claim including the QDC line(s).

- Some measures require the submission of more than one QDC in order to properly report the measure. Report each QDC as a separate line item, referencing one diagnosis and including the rendering provider NPI.

- Solo practitioners should follow their normal billing practice of placing their individual NPI in the billing provider field, (#33a on the CMS-1500 form or the electronic equivalent).

- EPs may submit multiple codes for more than one measure on a single claim.

- Multiple CPT Category II and/or G-codes for multiple measures that are applicable to a patient visit can be reported on the same claim, as long as the corresponding denominator codes are also line items on that claim.

- If a denied claim is subsequently corrected through the appeals process to the Carrier/AB MAC, with accurate codes that also correspond to the measure's denominator, then QDCs that correspond to the numerator should also be included on the corrected claim as instructed in the measure specifications.

- Claims may NOT be resubmitted for the sole purpose of adding or correcting QDCs.

a. Submission through Carriers/Medicare Administrative Contractors (MACs)
QDCs shall be submitted to carriers/MACs either through:
Electronic submission, which is accomplished using the **ASC X 12N Health Care Claim Transaction (Version 4010A1)**.

CPT Category II and/or temporary G-codes should be submitted in the **SV101-2** "Product/Service ID" Data Element on the **SV1** "Professional Service" Segment of the **2400 "Service Line" Loop**.

- It is also necessary to identify in this segment that a HCPCS code is being supplied by submitting the HC in data element SV101-1 within the SV1 "Professional Service" Segment.

- Diagnosis codes are submitted at the claim level, **Loop 2300**, **in data element HI01**, and if there are multiple diagnosis codes, **in HI02 through HI08** as needed with a single reference number in the diagnosis pointer.
- In general for group billing, report the NPI for the rendering provider in **Loop 2310B** (Rendering Provider Name, claim level) or **2420A** (Rendering Provider Name, line level), using data element **NM109 (NM108=XX)**.

OR

Paper-based submission, which is accomplished by using the **CMS-1500 claim form (version 08-05)**. Relevant ICD-9-CM diagnosis codes are entered in **Field 21. Service codes** (including CPT, HCPCS, CPT Category II and/or G-codes) with any associated modifiers are entered in **Field 24D** with a single reference number in the diagnosis pointer **Field 24E** that corresponds with the diagnosis number in Field 21.
For group billing, the **National Provider Identifier (NPI)** of the rendering provider is entered in Field 24J.
The **Tax Identification Number (TIN)** of the employer is entered in **Field 25**.

b. Group NPI Submission
When a group bills, the group's NPI is submitted at the claim level, therefore, the individual rendering physician's NPI must be placed on each line item, including all allowed charges and quality-data line items.

c. Solo NPI Submission
The individual NPI of the solo practitioner must be included on the claim line as is the normal billing process for submitting Medicare claims. For PQRI, the QDC must be included on the same claim that is submitted for payment at the time the claim is initially submitted in order to be included in PQRI analysis.

4. Timeliness of Quality Data Submission
Claims processed by the Carrier/MAC must reach the national Medicare claims system data warehouse (National Claims History file) by February 28, 2010 to be included in the analysis. Claims for services furnished toward the end of the reporting period should be filed promptly. Claims that are resubmitted only to add QDCs will not be included in the analysis.

5. Analysis of PQRI Data: Reporting Frequency and Performance Timeframes
Instructions for some measures limit the frequency of reporting necessary in certain circumstances, such as for patients with chronic illness for whom a particular process of care is provided only periodically. Some measures, due to their complexity, are reportable as registry only or measures group only.

Each measure specification includes a reporting frequency for each denominator-eligible patient seen during the reporting period. The reporting frequency described in the instructions applies to each individual EP participating in PQRI. PQRI uses the reporting frequency to analyze each measure for determination of satisfactory reporting:

- Patient-Process: Report a minimum of once per reporting period per individual EP (NPI).
- Patient-Intermediate: Report a minimum of once per reporting period per individual EP (NPI).
- Patient-Periodic: Report once per timeframe specified in the measure for each individual EP (NPI) during the reporting period.
- Episode: Report once for each occurrence of a particular illness/condition by each individual EP (NPI) during the reporting period.
- Procedure: Report each time a procedure is performed by the individual EP (NPI) during the reporting period.
- Visit: Report each time the patient is seen by the individual EP (NPI) during the reporting period.

A measure's performance timeframe is defined in the measure's description and is distinct from the reporting frequency requirement. The performance timeframe, unique to each measure, delineates the timeframe in which the quality action described in the numerator may be accomplished.

C. Policy: Coding and Reporting Principles for Claims-based Reporting of the E-Prescribing Measure

1. Introduction

Similar to the PQRI, the e-prescribing measure consists of a unique denominator (eligible case) and numerator (quality action) that permit the calculation of the percentage of a defined patient population for whom care was delivered using a particular structural element. Also, similar to PQRI, claims-based reporting of the e-prescribing measure requires EPs, using their individual national provider identifier (NPI) and submitting billable services on Part B claims for allowable PFS charges, to report the quality action for the e-prescribing measure. It is important to review and understand the e-prescribing measure specification, which provides definitions and specific instructions for reporting the measure.

EPs who choose to participate in the E-Prescribing Incentive Program should review the following documents, which are available on the E-Prescribing Measure section page of the E-Prescribing Incentive Website at http://www.cms.hhs.gov/ERXIncentive:

- "*E-Prescribing Measure Specifications*"
- "*Claims-based Reporting Principles for E-Prescribing*" – this provides guidance about how to report the e-prescribing measure on claims
- "*Sample E-Prescribing Claim*" – this provides a detailed sample of an individual NPI reporting the e-prescribing measure on a CMS-1500 claim.

Educational resources to assist EPs in successfully participating in the E-Prescribing Incentive Program are also available on the Educational Resources section page of the E-Prescribing Incentive Website at http://www.cms.hhs.gov/ERxIncentive/09_Educational_Resources.asp#TopOfPage.

2. Claims-based Reporting Principles

The following principles apply for claims-based reporting of the e-prescribing measure:

- Report one of the three e-prescribing codes listed below as the claim numerator:
  - G8443 - "All prescriptions created during the encounter were generated using a qualified e-prescribing system."
  - G8445 - "No prescriptions were generated during the encounter. Provider does have access to a qualified e-prescribing system"
  - G8446 - "Provider does have access to a qualified e-prescribing system and some or all of the prescriptions generated during the encounter were printed or phoned in as required by the State or Federal Law or regulations, patient request or pharmacy system being unable to receive electronic transmission; or because they were for narcotics or other controlled substances."
- The e-prescribing code, which supplies the numerator, must be reported:
  - on the same claim as the denominator billing code
  - for the same beneficiary
  - for the same date of service (DOS)
  - by the same EP (individual NPI) who performed the covered service

- The e-prescribing code must be submitted with a line-item charge of zero dollars ($0.00) at the time the associated covered service is performed.
    - The submitted charge field cannot be blank.
    - The line item charge should be $0.00.
    - If a system does not allow a $0.00 line-item charge, a nominal amount can be substituted - the beneficiary is not liable for this nominal amount.
    - Entire claims with a zero charge will be rejected. (Total charge for the claim cannot be $0.00.)
    - Whether a $0.00 charge or a nominal amount is submitted to the carrier/Medicare Administrative Contractor (MAC), the e-prescribing code line is denied and tracked.
    - E-prescribing line items will be denied for payment, but are passed through the claims processing system to the National Claims History database (NCH), used for e-prescribing claims analysis. EPs will receive a Remittance Advice (RA) which includes a standard remark code (N365). N365 reads: "This procedure code is not payable. It is for reporting/information purposes only." The N365 remark code does **NOT** indicate whether the e-prescribing code is accurate for that claim or for the measure the EP is attempting to report. N365 only indicates that the e-prescribing code passed into NCH.

- When a group bills, the group NPI is submitted at the claim level, therefore, the individual rendering/performing physician's NPI must be placed on each line item, including all allowed charges and quality-data line items.

- Solo practitioners should follow their normal billing practice of placing their individual NPI in the billing provider field, (#33a on the CMS-1500 form or the electronic equivalent).

- Claims may **NOT** be resubmitted for the sole purpose of adding or correcting an e-prescribing code.

3. Submission Through Carriers/MACs

E-prescribing codes shall be submitted to carriers/MACs either through:
Electronic submission using the ASC X 12N Health Care Claim Transaction (Version 4010A1), or via paper-based submission, using the CMS-1500 claim form.

Electronic Submission:
E-prescribing codes should be submitted in the **SV101-2** "Product/Service ID" Data Element on the **SV1** "Professional Service" Segment of the **2400 "Service Line" Loop**.

It is also necessary to identify in this segment that a HCPCS code is being supplied by submitting the HC in data element SV101-1 within the SV1 "Professional Service" Segment.

Diagnosis codes are submitted at the claim level, **Loop 2300, in data element HI01**, and if there are multiple diagnosis codes, in **HI02 through HI08** as needed with a single reference number in the diagnosis pointer.

In general for group billing, report the NPI for the rendering provider in **Loop 2310B** (Rendering Provider Name, claim level) or **2420A** (Rendering Provider Name, line level), using data elements **NM108 and NM109**.

Paper-based Submission:
Paper-based submissions are accomplished using the CMS-1500 claim form (version 08-05). Relevant ICD-9-CM diagnosis codes are entered in Field 21. Service codes (including CPT, HCPCS, CPT Category II and/or G-codes) with any associated modifiers are entered in **Field 24D** with a single reference number in the diagnosis pointer **Field 24E** that corresponds with the diagnosis number in Field 21.

For group billing, the NPI of the rendering/performing provider is entered in **Field 24J** and the TIN of the employer is entered in **Field 25**.

4. Timeliness of Quality Data Submission

Claims processed by the Carrier/MAC must reach the national Medicare claims system data warehouse (National Claims History file) by February 28, 2010 to be included in the analysis. Claims for services furnished toward the end of the reporting period should be filed promptly. Claims that are resubmitted only to add QDCs will not be included in the analysis

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6514.1	Contractors shall use the provider education article that will be available shortly after the CR is released for educational purposes.	X			X						
6514.2	Contractors shall comply with policy described in sections 1.B. and 1.C. of this change request above.	X			X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6514.3.	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/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 site 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 your 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						

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
None.	

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Diane Stern, diane.stern@cms.hhs.gov, (410) 786-1133

Post-Implementation Contact(s): Sylvia Publ, Sylvia.publ@cms.hhs.gov, (312) 353-9815

VI. FUNDING

Section A: 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.

Section B: *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.