CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1155	**Date: November 23, 2012**
	Change Request 8070

NOTE: This Transmittal is no longer sensitive and is being re-communicated July 19, 2013. The Transmittal Number, date of Transmittal and all other information remain the same. This instruction may now be posted to the Internet.

SUBJECT: Affordable Care Act (ACA) Model 4 Bundled Payments for Care Improvement - Episode of Care - Implementation Phase 3

I. SUMMARY OF CHANGES: This change request represents the third and final phase of implementation of the Bundled Payments for Care Improvement initiative, Model 4. This pilot program is being run under the CMS Innovation Center's model testing authority and is slated to be fully implemented in April 2013.

In conjunction with former CRs 7784 and 7887, this CR will allow claims to be processed under the policies of Bundled Payments Model 4. This CR specifically addresses issues related to MSN messages, crossover of claims, remittance advice, and reporting.

EFFECTIVE DATE: July 1, 2013
IMPLEMENTATION DATE: April 1, 2013 (Analysis and Design);
July 1, 2013 (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
N/A	

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with 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 obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions

regarding continued performance requirements.

IV. ATTACHMENTS:

One Time Notification

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

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 1155	Date: November 23, 2012	Change Request: 8070

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EFFECTIVE DATE: July 1, 2013
IMPLEMENTATION DATE: April 1, 2013 (Analysis and Design)
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I. GENERAL INFORMATION

A. Background: The Affordable Care Act (ACA) provides a number of new tools and resources to help improve health care and lower costs for all Americans. Bundling payment for services that patients receive across a single episode of care, such as heart bypass surgery or a hip replacement, is one way to encourage doctors, hospitals and other health care providers to work together to better coordinate care for patients, both when they are in the hospital and after they are discharged. Such initiatives can help improve health, improve the quality of care, and lower costs.

The Centers for Medicare and Medicaid Services (CMS) is working in partnership with providers to develop models of bundling payments through the Bundled Payments for Care Improvement initiative (BPCI). On August 23, 2011, CMS invited providers to apply to help test and develop four different models of bundling payments. In Model 4, the episode of care is defined as the acute care hospital stay and includes inpatient hospital services, Part B professional services furnished during the hospitalization, and hospital and Part B professional services for related readmissions. Applicants for this model will propose a target price for the episode that includes a single rate of discount off of expected payment (including both hospital and Part B professional services) for all beneficiaries with the agreed-upon Medicare Severity Diagnosis Related Group (MS-DRG). This model will require changes to payment starting in early 2013.

This implementation Change Request (CR) is the third in a multi-release series of change requests which together will implement the payment of claims for the Bundled Payments for Care Improvement Model 4. This CR continues the work that was begun with CR 7784 in the October 2012 release and CR 7887 in the January 2013 release. This CR focuses on implementing necessary changes to support the crossover of claims, remittance advice, Medicare Summary Notice (MSN) changes, and reporting.

B. Policy: Bundled Payments initiative Model 4 hospitals will receive a prospectively established bundled payment for agreed upon MS-DRGs. This will not apply to claims that are paid on a transfer per-diem basis. This payment will include both the DRG payment for the hospital and a fixed amount for the Part B physician services anticipated to be rendered during the admission. Separate payment for providers professional services rendered during the inpatient hospital stay will not be made. Participating Model 4 Bundled Payments Initiative hospitals receiving payment will take responsibility for distributing payment to providers who would otherwise be paid separately for professional services under the physician fee schedule (PFS). Claims from physicians must be processed as no-pay claims if they occur between the inpatient hospital admission and discharge date in order to prevent duplicate payment of physicians under the bundled payment. Physicians incentive payments will not be affected by participation in the Bundled Payments initiative.

Payment rates may be updated quarterly to allow for changes made to the PFS and Inpatient Prospective Payment System (IPPS). Indirect Medical Education (IME) and Disproportionate Share Hospital (DSH)

payments to Model 4 hospitals will be calculated based on the non-discounted base DRG payment that would have been made in the absence of the model. Other applicable payment adjustors will also be calculated based on the base DRG that would otherwise have applied to the case, as opposed to the prospectively established amount paid through this initiative, which will be higher as it includes payment for Part B services, as well as the base DRG payment. No separate outlier payments will be made. The regular Part A deductible and daily coinsurance amounts (when applicable) will continue to be applied to the claim. A fixed Part B copayment will be applied to the claim. The fixed Part B portion of the negotiated bundled payment will first be applied to the Part B deductible, if applicable. Additionally, the beneficiary will be responsible for paying a fixed Part B copayment, calculated as an approximation of what the Part B coinsurance would have been in the absence of this Model. Both the copayment and the deductible to be paid by the beneficiary for the Part B services must appear on the Medicare Summary Notice along with the Part A deductible and any applicable coinsurance.

Hospitals will not be paid for a readmission to the same hospital under this model unless the DRG is expressly excluded as unrelated. Unrelated readmissions will be defined by CMS, and a list of DRGs defining unrelated readmissions will be provided for each included MS-DRG. Physicians services provided during a related readmission to the original treating hospital will not be paid separately. Related readmissions to a hospital other than the original treating hospital, as well as payments for physicians services during related readmissions to hospitals other than the original treating hospital, will be reconciled retrospectively by a BPCI payment reconciliation contractor and payment recouped, as applicable.

Hospitals participating in this initiative must submit a Notice of Admission (NOA) when a beneficiary expected to be included in the model is admitted. This policy was included in CR 7784, issued as part of the October 2012 release. Hospitals will be paid a 500 dollar payment upon submission of the NOA and will receive the balance of the prospectively established bundled payment when the hospital claim is processed. If the patient ultimately does not qualify for an episode payment based on an MS-DRG excluded from the Model 4 Bundled Payment Initiative, the 500 dollar NOA payment will be recouped. Hospitals must submit the final claim within 60 days of the beneficiary's hospital admission or submit an interim claim during that time period to demonstrate that the beneficiary is still an inpatient. Otherwise, the beneficiary will be considered to be not subject to episode payment and the 500 dollars will be recouped.

In association with this initiative, CMS will make changes to allow for the reporting of two new Claim Adjustment Reason Codes (CARCs) within the 2320 Claim Adjustment Segment (CAS), so that supplemental payers can more easily determine these amounts when adjudicating Medicare Health Insurance Portability and Accountability Act (HIPAA) 837 institutional coordination of benefits (COB)/crossover claims. The first CARC will be defined as Part B deductible on a Part A claim. The second CARC will be defined as Part B coinsurance on a Part A claim. This instruction also will result in the reporting of a new value code within the 2300 Health Care Information Codes (HI) Value Information (qualifier BE) portion of outbound HIPAA 837 institutional COB/crossover claims.

Additionally, CMS shall designate new Remittance Advice Remark Codes (RARCs) for use on the 835 Electronic Remittance Advice (ERA) and standard paper remittance advice (SPR).

As part of performance monitoring and evaluation of this initiative, analyses of BPCI Model 4 claims shall be performed by contractors to CMS. A contractor also will monitor for unbundling by inappropriate shifting of Medicare services outside of the acute inpatient hospitalization.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement.

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
8070.1	The shared system shall ensure that it always reports demo code 64 in the REF02 segment of the 2300 Demonstration Project Identifier loop, where REF01 equals P4, for all Model 4 BCPI crossover claims.							X				COBC
8070.2	The shared system shall reflect a new value code Y5 (Part B deductible on a Part A claim) and associated dollar amount within the 2300 HI segment of all outbound Model 4 BCPI crossover claims.							X				COBC
8070.2.1	The shared system shall also reflect value codes Y1, Y2, Y3, and Y4 within the 2300 HI segment of all outbound Model 4 BCPI crossover claims.							X				COBC
8070.3	The shared system shall reflect the new CARC (value TBD, defined as Part B deductible on a Part A claim) and associated dollar amount, as applicable, within the 2320 CAS.							X				COBC
8070.3.1	The shared system shall ensure that the dollar amount tied to this new CARC is identical to the dollar amount associated to the new value code Y5 as reported in 2300 HI of the outbound Model 4 BCPI crossover claim. (see requirement 8070.2)							X				COBC
8070.4	The shared system shall reflect the new CARC (value TBD, defined as Part B coinsurance on a Part A claim) and associated dollar amount within the 2320 CAS.							X				COBC
8070.4.1	The shared system shall ensure that the dollar amount tied to this new CARC is identical to dollar amount associated to value code Y3, as reported in 2300 HI of the outbound Model 4 BCPI crossover claim.							X				COBC
8070.5	The shared system shall ensure that all outbound Model 4 BCPI crossover claims balance, as per HIPAA 5010 requirements.							X				
8070.5.1	The shared system shall realize balance on Model 4 BCPI crossover claims by ensuring that when adding Medicares total payment amount (qualified by AMT*D							X				

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	in the 2320 loop) to all 2320 CAS (Group Code PR and CO) adjustment amounts, the resulting sum will always be the total charge submitted on the incoming claim, as reflected in 2300 CLM02.											
8070.6	The Part A shared system shall ensure that it includes the new Part B deductible on a Part A claim CARC, when applicable, on all 835 Electronic Remittance Advices (ERAs) or standard paper remittance advices (SPRs).							X				
8070.6.1	The shared system shall ensure that it includes the new Part B coinsurance on a Part A claim CARC on all 835 ERAs and SPRs.							X				
8070.6.2	The shared system shall include the new "Part B deductible under a Bundled Payment for Care Improvement initiative" RARC, when applicable, on all 835 ERAs or SPRs.							X				
8070.6.2.1	The shared system shall ensure that in the relevant scenario the new RARC will appear in the MIA segment and the new CARC will be displayed on the CAS segment on the 835 ERA or SPR.							X				
8070.6.3	The shared system shall include the new "Part B coinsurance under a Bundled Payment for Care Improvement initiative" RARC on outbound 835 ERAs or SPRs.							X				
8070.6.3.1	The shared system shall ensure that in the relevant scenario the new RARC will appear in the MIA segment and the new CARC will be displayed on the CAS segment on the 835 ERA or SPR.							X				
8070.7	Contractors shall assign CARC code XX and RARC code XX (under development) when a Part B deductible is applied to identify Part B deductible on a Part A claim and displayed on the Remittance Advice. • CARC XX- Part B deductible on a Part A claim. This is deductible from the professional side • RARC XX- Part B deductible under a demonstration project or pilot program.	X			X			X				

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
8070.8	Contractors shall assign CARC code XX (under development) and RARC code M137 when a Part B coinsurance amount is applied to identify Part B coinsurance on a Part A claim and displayed on the Remittance Advice. • CARC XX - Part B coinsurance on a Part A claim This is co-insurance from the professional side • Adjusted RARC M137 - Part B coinsurance under a demonstration project or pilot program.	X			X			X				
8070.9	Contractors shall assign CARC code XX (under development) to identify a claim as a readmission (processed with '1' in the readmission indicator field.) • CARC XX- This claim has been identified as a readmission.	X			X			X				
8070.10	Contractors shall assign CARC code XX and RARC code XX (under development) when a claim billed out of sequence and paid fee-for-service is identified as a readmission and cancelled. The claim should be resubmitted to receive the corrected payment. • CARC XX - This claim has been identified as a readmission. • RARC XX - The bundled payment for the episode of care includes payment for related readmissions. You may resubmit your claim to receive a corrected payment.	X			X			X				
8070.11	FISS shall create a new reason code to RTP a claim when a Model 4 claim (demo code 64 present) matches an NOA for admission date and beneficiary, but not provider. **NOTE**: This is related to BR 7887.26	X			X			X				
8070.12	Contractors shall assign CARC code 226 and RARC code XX (under development) when a NOA is cancelled because a matching claim is not received within 60 days. A match consists of beneficiary, admit date and provider.	X			X			X				

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	• RARC XX - This pilot program requires an interim or final claim within 60 days of the Notice of Admission, and a claim was not received.											
8070.13	Contractors shall assign CARC code B5 and RARC code XX (under development) to a rejected claim when any of the beneficiary eligibility conditions in BR 7887.24 are not met. • RARC XX – This beneficiary did not meet the inclusion criteria for the demonstration project or pilot program.	X			X							
8070.14	Contractors shall assign the same CARC and RARC codes in BR 8070.13 to the cancelled NOA in BR 7887.25.1.	X			X			X				
8070.15	FISS shall look for and cancel a matching NOA (beneficiary, admission date, provider number) using the same CARC and RARC codes in 8070.13 when CWF rejects a claim because beneficiary eligibility conditions are not met.							X				
8070.16	After processing by the CWF, the claim shall come back to the A/B MAC for final processing. If the claim is to be paid under Model 4 BPCI, the A/B MAC shall be responsible for processing the global payment and sending Model 4 BPCI specific Medicare Summary Notices (MSNs) to beneficiaries as appropriate.	X			X			X				CMS
8070.17	CWF shall return Trailer 11 with information so that FISS can calculate how much is left of the beneficiary's Part B deductible for the calendar year on Demo 64 claims.										X	
8070.17.1	FISS shall calculate how much is left for the beneficiary's Part B deductible using information from Trailer 11 and use this to populate the MSN.							X				
8070.18	The following MSN messages shall be displayed as appropriate for Model 4 BPCI claims. ***NOTE**: The blanks in MSN message 37.17 should be*	X			X			X				

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	populated with dollar amounts, including dollar signs. • **New MSN Message 37.17** The "Maximum You May Be Billed column includes _____ for your Part B deductible, _____ for your Part B coinsurance, _____ for your Part A deductible, and _____ for your Part A coinsurance and/or lifetime reserve coinsurance. ***Spanish*** La columna "Cantidad Máxima Que Podría Ser Facturado" incluye _____ por su deducible de la Parte B, _____ por su coseguro de la Parte B, _____ por su deducible de la Parte A, y _____ por su coseguro de días de reserva de por vida y/o coseguro de la Parte A. • **New MSN Message 60.16** This claim is being processed under a demonstration or payment model pilot. All hospital and doctor services related to your hospital stay have been combined into a single payment. You may have to pay any unmet deductible and coinsurance amounts. ***Spanish*** Esta reclamación está siendo procesada bajo un proyecto especial o programa piloto de pago. Todos los servicios médicos y hospitalarios relacionados con su estadía en el hospital han sido combinados en un solo pago. Es posible que tenga que pagar deducibles y copagos no cubiertos.											
8070.18.1	The following MSN messages shall be displayed as appropriate for Model 4 BPCI claims. • **New MSN Message 32.3** ***NOTE****: the blank in this message should be populated with the net reimbursement, including dollar signs.* Medicare has paid _____ for hospital and doctor services. You shouldn't be billed separately by your doctor(s) for services you got during this inpatient stay. Spanish:Medicare ha pagado _____ por los servicios	X			X			X				

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	del médico y hospital. No le deben facturar a usted por los servicios del médico(s) que recibió durante su estadía en el hospital. • **Existing MSN Message 37.9** *(**NOTE**: this message should only appear on claims on which the bene is liable for some portion of the Part B deductible)* You have now met (_____) of your (_____) Part B deductible for (year). Spanish: Usted ha cumplido con (_____) de sus (_____) del deducible de la Parte B para (año).											
8070.18.2	The MSN messages 32.2 and 60.2, which were referred to in BR 7887.62, shall not be used, in light of the new messages described in BR 8070.18 above.	X			X			X				
8070.18.3	The MSN message 60.11, which was referred to in BR 7887.62, shall be use with the revised language as follows: • **Revised MSN Message 60.11** These services are covered by a demonstration project or payment model pilot. It will pay for all services related to this hospital stay. If you have already paid a provider for any of these services, you should receive a refund. ***Spanish*** Estos servicios están cubiertos por un proyecto especial o programa piloto de pago. Se pagará por todos los servicios relacionados con esta estadía en el hospital. Si usted ya le pagó a un proveedor por alguno de estos servicios, deberá recibir un reembolso	X			X			X				
8070.19	MCS shall prepare a process to take the Model 4 BPCI participating hospital's list documents and convert them into an automated file.								X			
8070.19.1	MCS shall ensure the file reads the added hospital's identifying information and point of contact data as identified in BR 8070.21.								X			
8070.20	MCS shall use the automated file to load the hospital's								X			

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	data and point of contact information into their system. **NOTE**: Future updates to the Model 4 BPCI participating hospital list will be sent under the cover of a new CR.											
8070.21	CMS shall provide MCS with a list of hospitals participating in the Model 4 BPCI with a contact person via TDL. The file layout shall be developed during the Requirements phase of the CR. The participating hospital file shall include the following information for each Model 4 BPCI hospital in the weekly report. • Facility number (13 A/N) • Facility name (50 A/N) • Attention-Contact Name (50 A/N) • Address 1 (50 A/N) • Address 2 (50 A/N) • City (30 A/N) • State (2 A/N) • Zip Code (9N)								X			CMS
8070.21.1	CMS shall send MCS a test file detailing the participating Model 4 BPCI hospitals by MM/DD/YYYY.											CMS
8070.21.1.1	CMS shall send an e-mail notification to MCS on or about MM/DD/YYYY indicating the Model 4 participating hospital file name.											CMS
8070.22	Contractors shall read the HxxTFACL spitab table for facility information if the hospital is not found on the file sent by CMS.								X			
8070.22.1	Contractors shall update the HxxTFACL spitab table with the missing facility information.	X				X						
8070.23	Contractors shall modify the demonstration hospital report to add a section for reporting Part B “no pay” claims data relative to the Model 4 BPCI.								X			
8070.23.1	Contractors shall prepare the report on a weekly basis								X			

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	for each Model 4 BPCI hospital showing all Part B Model 4 BPCI claims (i.e. those processed as "no pay") processed in the previous week for services rendered at that Model 4 BPCI hospital. The report shall also show Model 4 BPCI claims that have been retroactively adjusted and reprocessed as traditional Medicare fee-for-service claims. **NOTE**: The intent of this report is to allow the hospital to determine how the global payment should be distributed											
8070.23.1.1	Contractors shall sort the report for the Model 4 BPCI section by facility NPI, HIC, date of admission, rendering NPI, and date of service.								X			
8070.23.1.2	Contractors shall include a record for each claim line processed in the report and the amount that would have normally been paid under traditional Medicare fee-for-service rules for each covered service								X			
8070.24	The Contractors shall run the Model 4 BPCI hospital report weekly. See attachment.								X			
8070.25	MCS shall present the weekly report(s) utilizing the EFT naming standards for electronic distribution at both EDCs.								X			
8070.25.1	The EDC will make the files available for download by Model 4 BPCI hospitals.											EDC
8070.26	FISS shall ensure that when determining the "conventional" PPS payment, that all of the regular IPPS Pricer payment outputs flow through to the PS&R for informational only purposes to be used in cost report settlement (particularly the base DRG amount), even though the claim is not being paid the conventional PPS amount (except for DSH, IME, and capital as described in CR 7887).							X				
8070.27	***NOTE:*** *that the beneficiary eligibility criteria listed below represent an adjustment to the criteria listed in*										X	

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	BR 7887.24. CWF shall edit their processing to follow the below criteria, as these are a corrected version and take precedence over the criteria listed in BR 7887.24. Under BPCI Model 4, CWF shall verify a beneficiary's eligibility against a claim when an NOA is NOT present as follows: • Beneficiary is eligible for Part A and enrolled in Part B, • At the time of admission, beneficiary either (a) has at least l day of utilization left and that day is also a day of entitlement or (b) has at least one lifetime reserve day remaining, • Beneficiary does not have End Stage Renal Disease, • Beneficiary is not enrolled in any managed care plans, • Beneficiary must not be covered under the United Mine Workers, and • Medicare must be the primary payer											

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Other
		Part A	Part B					
8070.28	MLN Article: 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 sites and include information about it in a listserv message	X	X		X	X		

Number	Requirement	Responsibility						
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Other
		Part A	Part B					
	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.							

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	CR 7784: Affordable Care Act (ACA) Model 4 Bundled Payments for Care Improvement - Episode of Care - Implementation Phase One
	CR 7887: Affordable Care Act (ACA) Model 4 Bundled Payments for Care Improvement - Episode of Care - Implementation Phase Two

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

V. CONTACTS

Pre-Implementation Contact(s): Pamela Pelizzari, 443-845-4057 or pamela.pelizzari@cms.hhs.gov, Louisa Rink, Louisa.Rink@cms.hhs.gov, Sarah Shirey-Losso, Sarah_Shirey-Losso@cms.hhs.gov.

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

VI. FUNDING

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

Section B: For Medicare Administrative Contractors (MACs):
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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.