National Provider Call:

Physician Quality Reporting System (PQRS) and Electronic Prescribing (eRx) Incentive Program

June 18, 2013

Medicare Learning Network

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Agenda

- CMS Updates/Announcements
- Presentation
  - Electronic Prescribing (eRx) Incentive Program
    - Background and eRx Payment Adjustment Overview
    - How to Avoid the 2014 eRx Payment Adjustment
  - Physician Quality Reporting System (PQRS)
    - Background and PQRS Payment Adjustment Overview
    - How to Avoid the 2015 PQRS Payment Adjustment
  - Resources & Where to Call for Help
- Question and Answer Session

eRx Incentive Program

BACKGROUND AND PAYMENT ADJUSTMENT OVERVIEW

eRx Incentive Program: Background

- A federally mandated Medicare Part B reporting program
  - Established in 2007 as a measure in the Physician Quality Reporting Initiative (PQRI)
  - Separate program in 2009
  - 2013 PFS Final Rule sets forth current requirements
- Designed to promote electronic prescribing by eligible professionals
  - Electronic prescribing is widely believed to improve accuracy of the prescription process and reduce potential for medical errors and increase health care quality
  - Provides incentive payments to successful electronic prescribers
    - No eRx incentive payments scheduled past 2013
  - Applies payment adjustment to eligible professionals who were unsuccessful electronic prescribers
    - No eRx payment adjustments scheduled past 2015

eRx Incentive Program: Background (cont.)

Incentive Payment and Payment Adjustment Amounts

Program Year	Incentive Amount	Payment Adjustment Amount
2009	2.0%	None
2010	2.0%	None
2011	1.0%	None
2012	1.0%	1.0%
2013	0.5%	1.5%
2014	None	2.0%
2015	None	1.0% *

** Eligible professionals who do not achieve meaningful use under the Medicare EHR Incentive Program and are subject to the 2014 eRx payment adjustment will receive an additional 1.0% EHR Incentive Program adjustment in 2015 (2.0% total EHR Incentive Program adjustment)*

eRx Incentive Program: Background (cont.)

- **12 months (January 1–December 31, 2013)**
  - **ONLY** applies to the 2013 eRx incentive payment
  - Last reporting period to earn an eRx Incentive Program incentive payment
  - Must generate eRx events and report the required number of denominator-eligible visits
  - Reporting Methods: claims, registry, or participating/qualified EHR
  - Claims must be processed into the National Claims History file (NCH) by **February 28, 2014**
- **6 months (January 1–June 30, 2013)**
  - **ONLY** applies to the 2014 eRx payment adjustment
  - Last reporting period to avoid the 2014 eRx payment adjustment
  - Must report the required number of eRx events (regardless of denominator eligibility) for *any* payable Medicare Part B PFS service
  - Reporting Method: **claims only**
  - Claims must be processed into the National Claims History file (NCH) by **July 26, 2013**

2014 eRx Payment Adjustment Overview

- eRx Payment Adjustment Analysis
  - **Individual Eligible Professionals**
    - Analyzed for each Taxpayer Identification Number/National Provider Identifier (TIN/NPI) combination
    - The eRx payment adjustment may be applied to each unsuccessful TIN/NPI
    - Analysis is based on the individual/rendering NPI - not group NPI
  - **eRx GPROs**
    - Analyzed at the TIN level under the TIN submitted at the time of final self-nomination
    - If an eRx GPRO is unsuccessful at avoiding a payment adjustment, all NPIs under the TIN during the unsuccessful reporting period will receive the payment adjustment
    - If an organization or eligible professional changes TINs, the participation under the old TIN does not carry over to the new TIN, nor is it combined for final analysis

2014 eRx Payment Adjustment Overview (cont.)

- Individual eligible professionals who meet **ALL** of the following criteria may be subject to the 2014 eRx payment adjustment:
  - Have more than 10% of an individual eligible professional's allowed charges for the 2013 eRx 6-month reporting period (1/1/13–6/30/13) comprised of codes in the denominator of the 2013 eRx measure;
  - Meet the taxonomy criteria (Doctor of Medicine, Doctor of Osteopathy, Doctor of Podiatric Medicine, Nurse Practitioner, or Physician Assistant) based on National Plan and Provider Enumeration System (NPPES) primary specialty taxonomy criterion for the 2013 eRx 6-month reporting period; **AND**
  - Have more than 100 cases containing an encounter code in the measure's denominator during the 2013 eRx 6-month reporting period

Note: *If the eligible professional does not meet one of the above criteria, (s)he will be automatically exempt from the 2014 eRx payment adjustment*

2014 eRx Payment Adjustment Overview (cont.)

- eRx GPROs who meet the following criteria may be subject to the 2014 eRx payment adjustment:
  - The group practice has 10% or more of their Medicare Part B PFS allowable charges (per TIN) for encounter codes in the measure's denominator for dates of service from **1/1/13–6/30/13**

2014 eRx Payment Adjustment Overview (cont.)

- Remittance Advice Codes for the 2014 eRx Payment Adjustment
  - Indicator "LE" for all Medicare Part B services rendered from January 1–December 31, 2014; **AND**
  - Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC):
    - **CARC 237** – Legislated/Regulatory Penalty
    - **RARC N545** (or NCPDP Reject Reason Code) – "Payment reduced based on status as an unsuccessful e-prescriber per the Electronic Prescribing (eRx) Incentive Program"
- If CMS determines the payment adjustment was applied in error, the claim will be re-processed to return the 2.0% and the Remittance Advice for the re-processed claim will include the following codes and messages:
  - **CARC 237** – Legislated/Regulatory Penalty
  - **RARC N546** (or NCPDP Reject Reason Code) – "Payment represents a previous reduction based on the Electronic Prescribing (eRx) Incentive Program"

eRx Incentive Program

HOW TO AVOID THE 2014 eRx PAYMENT ADJUSTMENT

Avoiding 2014 eRx Payment Adjustment: Participation

- Individual eligible professionals and eRx GPROs can avoid the 2014 eRx payment adjustment through one of the following steps:
  1. Was a successful electronic prescriber for the 2012 eRx 12-month (1/1/12-12/31/12) reporting period; **OR**
  2. Be a successful electronic prescriber for the 2013 eRx 6-month reporting period (1/1/13-6/30/13); **OR**
  3. Request a 2014 eRx hardship exemption, if applicable; **OR**
  4. Achieve Meaningful Use under the Medicare or Medicaid EHR Incentive Program during the 12-month (1/1/12-12/31/12) or 6-month (1/1/13-6/30/13) eRx reporting period; **OR**
  5. Demonstrate intent to participate in the Medicare or Medicaid EHR Incentive Program by registering (providing EHR certification ID) during the eRx 6-month reporting period (1/1/13-6/30/13) and adopt Certified EHR Technology

Resource: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive/Downloads/2013SE13__eRx2014PaymentAdjustment_032613.pdf

Avoiding 2014 eRx Payment Adjustment: Individual Reporting

Avoiding the 2014 eRx Payment Adjustment – Individual Eligible Professionals

2014 eRx Payment Adjustment Reporting Period	Reporting Mechanism	Reporting Options – Individual Eligible Professionals
12-month (Jan 1-Dec 31, 2012)	Claims, Qualified Registry, or Qualified EHR *(Direct EHR & EHR data submission vendor)*	Report on the 2012 electronic prescribing measure's numerator code at least 25 times for encounters associated with at least 1 of the denominator codes (same criteria as the 2012 eRx Incentive Program incentive)
6-month (Jan 1-Jun 30, 2013)	Claims	Report the electronic prescribing measure's numerator code at least 10 times on any payable Medicare PFS service

Avoiding 2014 eRx Payment Adjustment: eRx GPRO Reporting

Avoiding the 2014 eRx Payment Adjustment – eRx GPRO

Group Practice Size	2014 eRx Payment Adjustment Reporting Period	Reporting Mechanism	Reporting Options – eRx GPRO
25-99 Eligible Professionals	12-month (Jan 1-Dec 31, 2012)	Claims, Qualified Registry, or Qualified EHR	Report the electronic prescribing measure's numerator for at least 625 times for encounters associated with at least 1 of the denominator codes (the same criteria as the 2012 eRx Incentive Program incentive)
100+ Eligible Professionals	12-month (Jan 1-Dec 31, 2012)	Claims, Qualified Registry, or Qualified EHR	Report the electronic prescribing measure's numerator for at least 2,500 times for encounters associated with at least 1 of the denominator codes (the same criteria as the 2012 eRx Incentive Program incentive)
2-24 Eligible Professionals	6-month (Jan 1-Jun 30, 2013)	Claims	Report the electronic prescribing measure's numerator code at least 75 times on any payable Medicare PFS service
25-99 Eligible Professionals	6-month (Jan 1-Jun 30, 2013)	Claims	Report the electronic prescribing measure's numerator code at least 625 times on any payable Medicare PFS service
100+ Eligible Professionals	6-month (Jan 1-Jun 30, 2013)	Claims	Report the electronic prescribing measure's numerator code at least 2,500 times on any payable Medicare PFS service

Avoiding 2014 eRx Payment Adjustment: Hardship Exemption

- 2014 eRx Payment Adjustment Hardship Exemptions
  - Unable to electronically prescribe due to local, state, or federal law, or regulation
  - Has or will prescribe fewer than 100 prescriptions for Medicare patients during the 6-month reporting period
  - Practices in a rural area without sufficient high-speed Internet access (G8642)
  - Practices in an area without sufficient available pharmacies for electronic prescribing (G8643)
  - Does not have prescribing privileges during the 6-month reporting period (G8644)
  - Eligible professionals or group practices who achieve Meaningful Use during certain eRx payment adjustment reporting period

    Determined by CMS through review of the EHR Incentive Program Attestation and Registration system and will be automatically processed by CMS
  - Eligible professionals or group practices who demonstrate intent to participate in the EHR Incentive Program and adoption of Certified EHR Technology

    Determined by CMS through review of the EHR Incentive Program Attestation and Registration system and will be automatically processed by CMS

Avoiding 2014 eRx Payment Adjustment: Hardship Exemption (cont.)

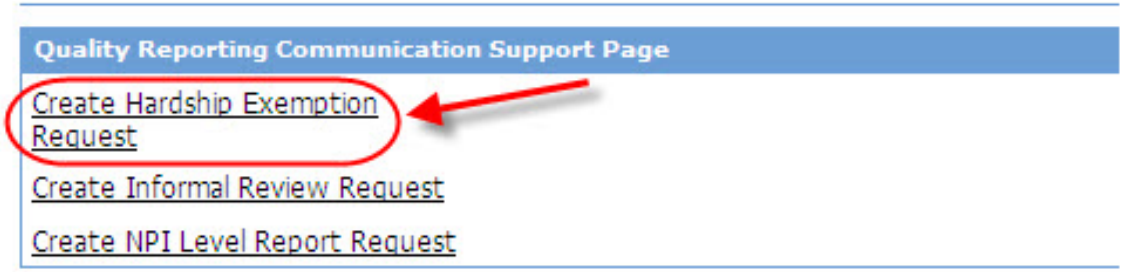
- Individual eligible professionals must request 2014 eRx hardship exemption or lack of prescribing privileges on or before **June 30, 2013**
  - Communication Support Page – Open until June 30, 2013
  - Claims
    - Select hardship exemptions, and lack of prescribing privileges, have been assigned G-codes
    - Report via any payable Medicare PFS claim with a date of **January 1–June 30, 2013**
    - Claims must be processed into National Claims History (NCH) by **July 26, 2013**
- 2013 eRx GPROs must indicate hardship exemptions during self-nomination or submit an exemption request via the Communication Support Page on or before **June 30, 2013**
- CMS will review hardship exemption requests on a case-by-case basis

Avoiding 2014 eRx Payment Adjustment: Hardship Exemption (cont.)

- Requesting a Hardship Exemption - Communication Support Page

STEP 1: Go to the Communication Support Page at https://www.qualitynet.org/portal/server.pt/community/communications_support_system/234

STEP 2: Click on "Create Hardship Exemption Request" *(see image)*

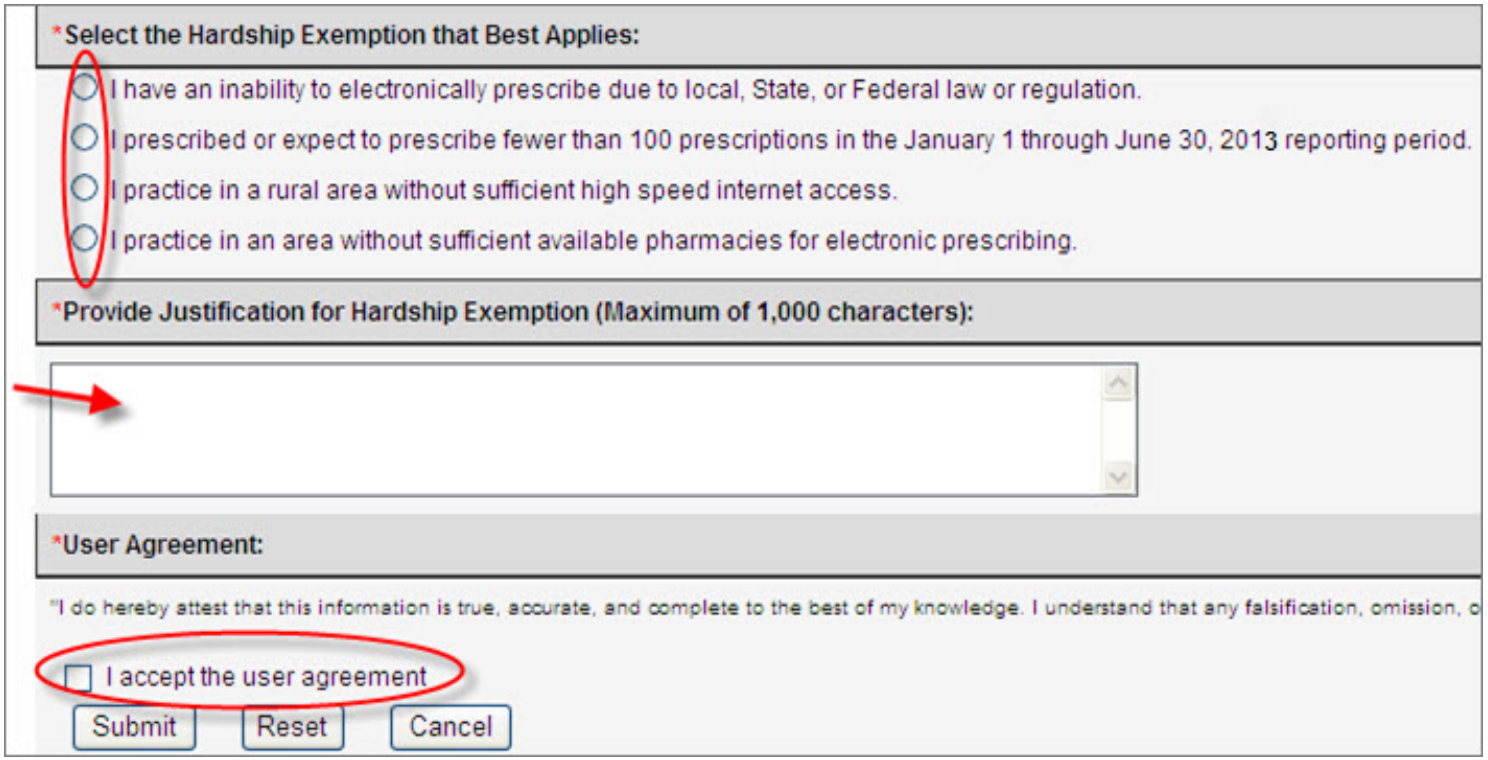


STEP 3: Select "Individual Eligible Professional" or "Group Practice (a group practice that self-nominated and is approved to participate in the 2013 eRx Group Practice Reporting Option Only)"

Avoiding 2014 eRx Payment Adjustment: Hardship Exemption (cont.)

- Requesting a Hardship Exemption - Communication Support Page (cont.)

STEP 4: Fill out the "Requestor Contact Information" section
STEP 5: Select the hardship that best applies, provide justification, review the "User Agreement", check the box to accept and click "Submit"



Avoiding 2014 eRx Payment Adjustment: Hardship Exemption (cont.)

- Communication Support Page Resources:
  - *Communication Support Page User Manual* can be accessed through the "? Help" icon at the bottom of website pages 
  - Tips for Using the Quality Reporting Communication Support Page at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive/Downloads/Tips_for_Using_CSP_2013_Final.pdf

PQRS

BACKGROUND AND PAYMENT ADJUSTMENT OVERVIEW

PQRS Background

- A federally mandated Medicare Part B reporting program
  - Established in 2007
  - 2013 PFS Final Rule sets forth current requirements
- Designed to promote reporting of quality information
  - Intended to measure the quality of care patients receive and provide feedback reports to eligible professionals who provide care
  - Provides incentive payments for satisfactory reporting of quality measures for covered PFS services provided to FFS beneficiaries
    - No PQRS incentive payments are scheduled past 2014
  - Applies payment adjustment to eligible professionals who do not satisfactorily report
    - Negative payment adjustment for 2013 reporting period will be assessed starting 2015

PQRS Background (cont.)

PQRS Incentive and Payment Adjustment Amounts

Program Year	Incentive Amount	Payment Adjustment Amount
2007	1.5%	None
2008	1.5%	None
2009	2.0%	None
2010	2.0%	None
2011	1.0%	None
2012	0.5%	None
2013	0.5%	None
2014	0.5%	None
2015	None	1.5% *Based on 2013 participation*
2016 and beyond	None	2.0% *Based on 2014 participation*

PQRS Background (cont.)

- PQRS Eligible Professionals – Incentive Payment and Payment Adjustment
  - **Physicians**
    - Doctor of Medicine, Doctor of Osteopathy, Doctor of Podiatric Medicine, Doctor of Optometry, Doctor of Dental Surgery, Doctor of Dental Medicine, Doctor of Chiropractic
  - **Practitioners**
    - Physician Assistant, Nurse Practitioner, Clinical Nurse Specialist, Certified Registered Nurse Anesthetist (and Anesthesiologist Assistant), Certified Nurse Midwife, Clinical Social Worker, Clinical Psychologist, Registered Dietician, Nutrition Professional, Audiologists (as of 1/1/2009)
  - **Therapists**
    - Physical Therapist, Occupational Therapist, Qualified Speech-Language Therapist

PQRS Payment Adjustment Overview

- 2015 PQRS Payment Adjustment Analysis
  - Individual eligible professionals are analyzed for each TIN/NPI combination
    - The PQRS payment adjustment may be applied to each unsuccessful TIN/NPI
    - Analysis is based on the individual/rendering NPI - not group NPI
    - If an eligible professional changes TINs, the participation under the old TIN does not carry over to the new TIN, nor is it combined for final analysis
  - PQRS GPROs are analyzed at the TIN level
    - Analyzed at the TIN level under the TIN submitted at the time of final self-nomination/registration
    - If a group is unsuccessful at avoiding a payment adjustment, all NPIs under the TIN during the unsuccessful reporting period will receive the payment adjustment
    - If an organization changes TINs, the participation under the old TIN does not carry over to the new TIN, nor is it combined for final analysis

PQRS Payment Adjustment Overview (cont.)

- 2015 PQRS Payment Adjustment Application
  - Applied two years after the reporting program year
    - 2013 PQRS reporting - 2015 PQRS payment adjustment
    - 2014 PQRS reporting - 2016 PQRS payment adjustment
  - Applies to all Part B covered professional services under the Medicare PFS during the payment adjustment period
    - **1.5% adjustment in 2015** (receive 98.5% of their Medicare Part B PFS amount that would otherwise apply to such services)
    - **2.0% adjustment in 2016** (receive 98.0% of their Medicare Part B PFS amount that would otherwise apply to such services)

Note: *If you are a group practice consisting of 100 or more eligible professionals, beginning with 2013 program year, your physicians may also be subject to the 2015 Value-based Payment Modifier (VM); see the CMS VM website for more information. The VM downward adjustment does not apply to ACOs.*

2013 PQRS

HOW TO AVOID THE 2015 PQRS PAYMENT ADJUSTMENT

Avoiding 2015 PQRS Payment Adjustment

- Individual Eligible Professionals
  1. Meet the criteria for satisfactory reporting for the 2013 PQRS incentive payment; **OR**
  2. Report 1 valid measure or 1 valid measures group; **OR**
     - One instance of a measure or measures group can be submitted according to the requirements set forth in the 2013 PQRS measure specifications
  3. Elect to participate in the CMS-calculated administrative claims-based reporting mechanism **July 15, 2013 through October 15, 2013**
     - **STEP 1**: Prior to signing up for your PQRS reporting mechanism, individuals will need to register for a CMS IACS account if they do not already have an IACS account, or add the appropriate IACS role if they already have an existing account
       - Registration for IACS begins **June 3, 2013** at https://applications.cms.hhs.gov/
     - **STEP 2:** Beginning **July 15th**, go to https://portal.cms.gov/ and select the **PV PQRS** option, near the bottom of the page to register
     - For additional information, please go to http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Self-Nomination-Registration.html

Avoiding 2015 PQRS Payment Adjustment (cont.)

2013 PQRS GPRO

1. Meet the criteria for satisfactory reporting for the 2013 PQRS incentive payment under the GPRO; **OR**
2. Report 1 valid measure; **OR**
3. Elect to participate in the CMS-calculated administrative claims-based reporting mechanism **July 15, 2013 through October 15, 2013**
   - **STEP 1**: Prior to signing up for your PQRS reporting mechanism, group practices will need to register for a CMS IACS account if they do not already have an IACS account, or add the appropriate IACS role if they already have an existing account
     - Registration for IACS begins **June 3, 2013** at https://applications.cms.hhs.gov/
   - **STEP 2:** Beginning **July 15th**, go to https://portal.cms.gov/ and select the **PV PQRS** option, near the bottom of the page to register
   - For additional information, please go to http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Self-Nomination-Registration.html
   - Not available to ACO GPROs

Note: *If participating in PQRS through another CMS program (such as the Medicare Shared Savings Program), please check the program's requirements for information on how to simultaneously report under PQRS and the respective program.*

Criteria for Satisfactory Reporting for the 2013 PQRS Incentive

Eligible Professionals: 2013 PQRS Reporting Options for Satisfactory Reporting

Measure Type	Reporting Mechanism	2013 PQRS Reporting Options for Incentive Payment for Individual Eligible Professionals
Individual Measures	Claims	Report at least 3 measures; OR If less than 3 measures apply to the eligible professional, report 1-2 measures (subject to the MAV); AND Report each measure for at least 50% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies. *Measures with a 0% performance rate will be considered in analysis but will not be considered satisfactorily reported for incentive eligibility.*
Individual Measures	Registry	Report at least 3 measures; AND Report each measure for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies. *Measures with a 0% performance rate will not be counted.*
Individual Measures	Qualified Direct EHR Product	Option 1: Report on ALL 3 PQRS EHR measures that are also Medicare EHR Incentive Program core measures. If the denominator for one or more of the Medicare EHR Incentive Program core measures is 0, report on up to 3 PQRS EHR measures that are also Medicare EHR Incentive Program alternate core measures; AND Report on 3 additional PQRS EHR measures that are also measures available for the Medicare EHR Incentive Program Option 2: Report at least 3 measures, AND Report each measure for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies. *Measures with a 0% performance rate will not be counted.*

Criteria for Satisfactory Reporting for the 2013 PQRS Incentive (cont.)

Eligible Professionals: 2013 PQRS Reporting Options for Satisfactory Reporting (cont.)

Measure Type	Reporting Mechanism	2013 PQRS Reporting Options for Incentive Payment for Individual Eligible Professionals
Individual Measures	Participating EHR Data Submission Vendor	**Option 1:** Report on ALL 3 PQRS EHR measures that are also Medicare EHR Incentive Program core measures. If the denominator for one or more of the Medicare EHR Incentive Program core measures is 0, report on up to 3 PQRS EHR measures that are also Medicare EHR Incentive Program alternate core measures; **AND** Report on 3 additional PQRS EHR measures that are also measures available for the Medicare EHR Incentive Program **Option 2:** Report at least 3 measures; **AND** Report each measure for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies. *Measures with a 0% performance rate will not be counted.*
Measures Groups	Claims	Report at least 1 measures group; **AND** Report each measures group for at least 20 Medicare Part B FFS patients. *Measures groups containing a measure with a 0% performance rate will not be counted.*
Measures Groups	Registry	Report at least 1 measures group; **AND** Report each measures group for at least 20 patients, a majority (11) of which must be Medicare Part B FFS patients. *Measures groups containing a measure with a 0% performance rate will not be counted.*

Note: *If participating in PQRS through another CMS program (such as the Medicare Shared Savings Program), please check the program's requirements for information on how to simultaneously report under PQRS and the respective program and avoid the payment adjustment.*

Criteria for Satisfactory Reporting for the 2013 PQRS Incentive (cont.)

PQRS GPRO: 2013 PQRS Reporting Options for Satisfactory Reporting

Reporting Mechanism	Group Practice Size	2013 Registered Group (PQRS GPRO) Reporting Options for Incentive Payment
Registry	All Group Practices	Report at least 3 measures, **AND** Report each measure for at least 80% of the group practice's Medicare Part B FFS patients seen during the reporting period to which the measure applies. *Measures with a 0% performance rate will not be counted.*
GPRO Web Interface	25-99 eligible professionals only	Report on all measures included in the Web Interface; **AND** Populate data fields for the first 218 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample (with an over-sample of 283) for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 218, then report on 100% of assigned beneficiaries.
GPRO Web Interface	100+ eligible professionals only	Report on all measures included in the Web Interface; **AND** Populate data fields for the first 411 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample (with an over-sample of 534) for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 411, then report on 100% of assigned beneficiaries.

***Note**: If participating in PQRS through another CMS program (such as the Medicare Shared Savings Program), please check the program's requirements for information on how to simultaneously report under PQRS and the respective program and avoid the payment adjustment.*

CMS Staff

RESOURCES & WHERE TO CALL FOR HELP

Resources

- **CMS PQRS Website**
  http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS
- **CMS eRx Incentive Program Website**
  http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive
- **Medicare Shared Savings Program**
  http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Quality_Measures_Standards.html
- **CMS Value-based Payment Modifier (VM) Website**
  http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html
- **Communication Support Page**
  https://www.qualitynet.org/portal/server.pt/community/communications_support_system/234
- **Medicare and Medicaid EHR Incentive Programs**
  http://www.cms.gov/Regulations-and-Guidance/Legislation/ EHRIncentivePrograms
- **FFS Provider Listserv**
  https://list.nih.gov/cgi-bin/wa.exe?A0=PHYSICIANS-L
- **Frequently Asked Questions (FAQs)**
  https://questions.cms.gov/

Acronyms

- **ACO** – Accountable Care Organization
- **EHR** – Electronic Health Record
- **eRx** – Electronic prescribing
- **NPI** – National Provider Identifier
- **PFS** – Physician Fee Schedule
- **PQRS** – Physician Quality Reporting System
- **TIN** – Tax Identification Number (Employer Identification Number/EIN or Social Security Number/SSN)
- **VM** – Value-based Payment Modifier

Where to Call for Help

- **QualityNet Help Desk:**
  - Portal password issues
  - PQRS/eRx feedback report availability and access
  - IACS registration questions
  - IACS login issues
  - PQRS and eRx Incentive Program questions

866-288-8912 (TTY 877-715-6222)

7:00 a.m.–7:00 p.m. CST M-F or **qnetsupport@sdps.org**

You will be asked to provide basic information such as name, practice, address, phone, and e-mail

- **Provider Contact Center:**
  - Questions on status of 2012 PQRS/eRx Incentive Program incentive payment (during distribution timeframe)
  - See *Contact Center Directory* at http://www.cms.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip
- **EHR Incentive Program Information Center:**

888-734-6433 (TTY 888-734-6563)

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- We appreciate your feedback!

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Thank You

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QUESTIONS & ANSWERS