

# **2012 Group Practice Reporting Option (GPRO)**

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

May 2, 2012 Monthly Support Call

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# Agenda



- ❖ Welcome
- ❖ Housekeeping Items
- ❖ Review of PQRS
- ❖ Review of eRx
- ❖ Help Desk Contact Information
- ❖ Question and Answer Session

# Housekeeping Items



## ❖ Technical Specifications:

- Your group must be running Internet Explorer 8
  - You will need to enable native XMLHTTP support as an Internet Option in Internet Explorer 8
- You will need to apply Microsoft Fix 50824
  - See Microsoft support page at <http://support.microsoft.com/kb/2643584>

## ❖ CMS conducts system maintenance approximately one weekend per month

- You will experience system outages during these "maintenance weekends"

# Review of PQRS

# 2012 GPRO PQRS Measures<sup>1</sup>



## ❖ 29 measures

### ○ 6 disease modules

- Diabetes Mellitus (DM), 8 measures
- Heart Failure (HF), 5 measures
- Coronary Artery Disease (CAD), 3 measures
- Hypertension (HTN), 1 measure
- Chronic Obstructive Pulmonary Disease (COPD), 1 measure
- Ischemic Vascular Disease (IVD), 2 measures

### ○ 2 patient care modules (individually sampled measures)

- Care Coordination/Patient Safety (Care), 2 measures
- Preventive Care (Prev), 7 measures

## ❖ Complete list available at:

[http://www.cms.gov/PQRS/22\\_Group\\_Practice\\_Reporting\\_Option.asp](http://www.cms.gov/PQRS/22_Group_Practice_Reporting_Option.asp)

<sup>1</sup> Not applicable to Accountable Care Organizations (ACOs) and Physician Group Practices (PGPs). ACOs and PGPs should follow their own program guidance on quality measurement and PQRS.

# Beneficiary Assignment and Sampling<sup>1</sup>



1. Identify National Provider Identifiers (NPI) associated with the GPRO Taxpayer Identification Number (TIN)
2. Identify beneficiaries with Part B claims submitted by the TIN/NPI combination
3. Exclude beneficiaries who are not qualified
  - Disqualification can include being in hospice, moved out of the country, or deceased
4. Determine if the beneficiary had more than 1 evaluation and management (E&M) visit for the GPRO TIN
5. Determine if the GPRO provided the plurality of care based on allowed E&M charges

<sup>1</sup> Not applicable to ACOs and PGPs. ACOs and PGPs should follow their own program guidance on quality measurement and PQRS.

# Beneficiary Assignment and Sampling, cont.<sup>1</sup>



6. Determine diagnosis for DM, CAD, HF, COPD, IVD, and HTN based on age and appropriate diagnosis and CPT/HCPCS codes on beneficiary's claims
7. Identify eligible beneficiaries for Preventive Care modules based on age, and also on gender for PREV-5
8. Randomly select 616 beneficiaries for Large GPROs and 327 beneficiaries for Small GPROs from the pool of qualified beneficiaries in each module
  - If there are not 616/327 qualified beneficiaries, select all patients
9. As each beneficiary is selected from the pool of qualified beneficiaries, assign them a number starting at 1
10. For the assigned and ranked beneficiaries, determine if the quality procedures for the pre-filled elements have been submitted on any of the beneficiary's claims

<sup>1</sup> Not applicable to ACOs and PGPs. ACOs and PGPs should follow their own program guidance on quality measurement and PQRS.

# Reporting Mechanism<sup>1</sup>



- ❖ GPROs will have access to a partially pre-populated database early in 2013
  - Claims from Parts A and B used to pre-populate fields
  - Includes demographic and utilization data for assigned set of beneficiaries for services provided during the 2012 reporting period
- ❖ Group practice will populate the remaining data fields via the Web Interface

<sup>1</sup> Not applicable to ACOs and PGPs. ACOs and PGPs should follow their own program guidance on quality measurement and PQRS.

# Satisfactorily Reporting<sup>1</sup>

## ❖ Large GPROs

- Report all GPRO measures
- Group will receive a sample of 616 beneficiaries per module
  - Complete data for 411 beneficiaries per measure
  - Complete for 100% of beneficiaries if there are < 411 in the sample

## ❖ Small GPROs

- Report all GPRO measures
- Group will receive a sample of 327 beneficiaries per module
  - Complete data for 218 beneficiaries per measure
  - Complete for 100% of beneficiaries if there are < 218 in the sample

<sup>1</sup> Not applicable to ACOs and PGPs. ACOs and PGPs should follow their own program guidance on quality measurement and PQRS.

# Patient Rank<sup>1</sup>



- ❖ When patients are selected for the sample, they are assigned a rank
  - The rank is the order in which the patient is randomly selected from the qualified pool of patients for a group
- ❖ The selection of patients for each module is done separately, and a patient may be selected for multiple modules
- ❖ The rank in each module will be assigned independently

<sup>1</sup> Not applicable to ACOs and PGPs. ACOs and PGPs should follow their own program guidance on quality measurement and PQRS.

# Completeness<sup>1</sup>



- ❖ A module is considered complete when the first 411 (large GPROs) or 218 (small GPROs) consecutively ranked patients are confirmed and all data abstracted for those patients
- ❖ If a patient in the first 411 or 218 ranked patients must be skipped, data must be completed for an equal number of additional consecutive beneficiaries until 411/218 patients have been confirmed and abstracted
  - For example, if the GPRO had to skip patients 125, 314, and 398, it would then need to complete data for patients 412, 413, and 414

<sup>1</sup> Not applicable to ACOs and PGPs. ACOs and PGPs should follow their own program guidance on quality measurement and PQRS.

# Skipping a Patient in a Module<sup>1</sup>



- ❖ Patients can be skipped for qualified reasons
  - Diagnosis cannot be confirmed
  - Medical record cannot be found
  - No longer qualified for the sample due to CMS-approved reasons
- ❖ Sampling does not include these patients, but the sample data only includes 10 months so the patient's situation could change

<sup>1</sup> Not applicable to ACOs and PGPs. ACOs and PGPs should follow their own program guidance on quality measurement and PQRS.

# Group Status Dashboard<sup>1</sup>



Group Status																Patient Status		
	CARE-1	CARE-2	COPD	CAD	DM	HF	HTN	IVD	PREV-5	PREV-6	PREV-7	PREV-8	PREV-9	PREV-10	PREV-11			
Analysis	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			
Complete	5	5	5	5	2	1	1	5	1	2	1	1	5	5	5			

- ❖ The count of completed patients in each module is shown on the Group Status Dashboard
  - The “Analysis” row shows the number of confirmed and completed beneficiaries in consecutively ranked order
  - The “Complete” row shows the number of completed patients in any order, including skipped patients

<sup>1</sup> Not applicable to ACOs and PGPs. ACOs and PGPs should follow their own program guidance on quality measurement and PQRS.

# Patient Status Dashboard<sup>1</sup>



Patient Status

Group Status    00:00:00 ?

First Name	Last Name	Gender	Date of Birth	Medicare ID	Current Mode	Locked By	Updated	Updated By							
LILLY	GINN	Female	7/12/1935	002204345B1	Browsing		--								
Complete	CARE-1	CARE-2	COPD	CAD	DM	HF	HTN	IVD	PREV-5	PREV-6	PREV-7	PREV-8	PREV-9	PREV-10	PREV-11
Rank	7	382	10	70	0	0	0	0	0	0	0	0	0	0	0
Dx	---	---	Yes	Yes	No	No	Yes	Yes	---	---	---	---	---	---	---

- ❖ The Patient Status Dashboard shows the status of the patient in each module
  - If the patient was not selected for a module, the rank is 0 and the status defaults to complete
  - Once abstraction is complete in a module, the indicator will change to a checkmark
  - Skipping a module will set the module to complete

<sup>1</sup> Not applicable to ACOs and PGPs. ACOs and PGPs should follow their own program guidance on quality measurement and PQRS.

# Abstracting Patients<sup>1</sup>



Patient Status					Group Status	Save Patient	Cancel	Check Entries	00:00:00	?					
First Name LILLY	Last Name GINN	Gender Female	Date of Birth 7/12/1935	Medicare ID 002204345B1	Current Mode Browsing	Locked By	Updated	Updated By							
Complete Rank Dx	CARE-1 7	CARE-2 382	COPD 10 Yes	CAD 70 Yes	DM 0 No	HF 0 No	HTN 0 Yes	IVD 0 Yes	PREV-5 0	PREV-6 0	PREV-7 0	PREV-8 0	PREV-9 0	PREV-10 0	PREV-11 0

- ❖ Patients do not need to be abstracted in consecutive order
- ❖ For the patient shown above, all the modules can be completed at one time even though the rank is different in each module
- ❖ The lower ranked patients do not need to be completed before abstracting a patient

<sup>1</sup> Not applicable to ACOs and PGPs. ACOs and PGPs should follow their own program guidance on quality measurement and PQRS.

# Totals Report<sup>1</sup>



- ❖ The Totals Report has two sections
  - The Totals Summary provides detail on:
    - The number of patients in a module
    - The number of completed and skipped patients
    - The number of patients in consecutively completed order
  - The Details tab on the Totals Report provides information on specific patients counting toward completion

<sup>1</sup> Not applicable to ACOs and PGPs. ACOs and PGPs should follow their own program guidance on quality measurement and PQRS.

# Totals Summary<sup>1</sup>

## PREV-8: Pneumonia Vaccination

Report Title	Total	Details	Comments
All Ranked Patients	457	Details >>	
All Completed	457	Details >>	
All Incomplete	0	Details >>	
Consecutively Completed	457	Details >>	
Medical Record Not Found	1	Details >>	0.22% - threshold not exceeded.
Not Confirmed	0	Details >>	
Not Qualified For Sample	2	Details >>	0.44% - threshold not exceeded.
In Hospice	1	Details >>	
Moved Out of Country	0	Details >>	
Deceased	1	Details >>	
Not Qualified - Medical Reasons	0	Details >>	
No Qualifying Visits	0	Details >>	
For Analysis	454	Details >>	OK! Minimum requirement met.

- ❖ If the skips in a module exceed 10%, the module will be flagged
- ❖ The Comments section will indicate if the minimum requirement for the module has been met

<sup>1</sup> Not applicable to ACOs and PGPs. ACOs and PGPs should follow their own program guidance on quality measurement and PQRS.

# Totals Detail<sup>1</sup>

## DM: Diabetes Mellitus

Report Title	Total	Details	Comments
All Ranked Patients	243	Details >>	
All Completed	15	Details >>	
All Incomplete	228	Details >>	
Consecutively Completed	8	Details >>	
Medical Record Not Found	0	Details >>	
Not Confirmed	0	Details >>	
Not Qualified For Sample	0	Details >>	
In Hospice	0	Details >>	
Moved Out of Country	0	Details >>	
Deceased	0	Details >>	
Not Qualified - Medical Reasons	0	Details >>	
No Qualifying Visits	0	Details >>	
For Analysis	8	Details >>	WARNING! Minimum requirement not met.

## Details for DM: All Completed

Medicare ID	Last Name	First Name	Gender	Birth Date	Rank	Status	DM Confirmed
444484444A	JOHNSON	JAMES	Male	10/09/1950	1	Complete	Yes
006500800A	CHIN	DEBRA	Female	08/26/1956	2	Complete	Yes
452824444A	JOHNSON	KAREN	Female	04/28/1950	3	Complete	Yes
440037800A	CHIN	JEETER	Male	12/04/1956	4	Complete	Yes
D4474478444	JOHNSON	JAMES	Male	12/03/1950	5	Complete	Yes
450000400A	DOBBS	DIANNE	Female	06/19/1956	6	Complete	Yes
477777738A	JOHNSON	JAMES	Male	09/20/1950	7	Complete	Yes
466766558A	CHIN	LINDA	Female	06/25/1956	8	Complete	Yes
300778977A	JOHNSON	JAMES	Male	02/09/1950	18	Complete	Yes
009540051A	CHIN	LEONCE	Male	03/24/1956	53	Complete	Yes
460087354A	JOHNSON	SANTOS	Female	09/25/1950	91	Complete	Yes
400504400A	CHIN	OTTIS	Male	10/12/1956	121	Complete	Yes
400700877A	JOHNSON	KAREN	Female	05/27/1950	201	Complete	Yes
465190000A	CHIN	LINDA	Female	04/23/1956	217	Complete	Yes
400000086D	JOHNSON	KAREN	Female	02/24/1950	228	Complete	Yes

<sup>1</sup> Not applicable to ACOs and PGPs. ACOs and PGPs should follow their own program guidance on quality measurement and PQRS.

# 2012 Public Reporting<sup>1</sup>



- ❖ Posted on the Physician Compare web site <http://www.medicare.gov/find-a-doctor/provider-search.aspx>
- ❖ Names of PQRS GPROs who satisfactorily report Physician Quality Measures
- ❖ Performance rates for PQRS GPRO measures

<sup>1</sup> Not applicable to ACOs and PGPs. ACOs and PGPs should follow their own program guidance on quality measurement and PQRS.

# Supporting Documentation<sup>1</sup>




- ❖ Supporting documentation includes
  - Electronic Health Record (EHR) Specifications
  - Data Guidance
  - Topic Evaluation Codes
  - Topic Medical Exclusions
  - Topic Drug Codes
- ❖ XML format can be used to both export and upload data

<sup>1</sup> Not applicable to ACOs and PGPs. ACOs and PGPs should follow their own program guidance on quality measurement and PQRS.

# Resources/Where to Begin<sup>1</sup>



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### Group Practice Reporting Option

In accordance with section 1848(m)(3)(C) of the Social Security Act (the Act), CMS created a new group practice reporting option (GPRO) for the Physician Quality Reporting System in 2010. Group practices that satisfactorily report data on Physician Quality Reporting System measures for a particular reporting period are eligible to earn a Physician Quality Reporting System incentive payment equal to a specified percentage of the group practice's total estimated Medicare Part B PFS allowed charges for covered professional services furnished during the reporting period.

2012 Physician Quality Reporting System GPRO Requirements

A document titled "2012 Group Practice Reporting Option (GPRO) Requirements" has been posted in the "Downloads" section below. This document describes the GPRO Requirements for submission of 2012 Physician Quality Reporting System and Electronic Prescribing (eRx) Incentive Program data.

2012 Physician Quality Reporting System GPRO Measures

For purposes of determining whether a group practice satisfactorily submits Physician Quality Reporting System quality measures data for 2012, each group practice selected to participate in the 2012 Physician Quality Reporting System GPRO will be required to report 29 quality measures. A list of the 29 2012 Physician Quality Reporting System GPRO measures can be found in the "2012 Physician Quality Reporting System (Physician Quality Reporting) Group Practice

[http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Group\\_Practice\\_Reporting\\_Option.html](http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Group_Practice_Reporting_Option.html)

<sup>1</sup> Not applicable to ACOs and PGPs. ACOs and PGPs should follow their own program guidance on quality measurement and PQRS.

# Resources/Where to Begin<sup>1</sup>



located on the **"Measures Codes"** section page at left. For individual and measures groups reporting requirements, please see the GPRO II Self Nomination Requirements document, which is located in the **"Downloads"** section below.

## 2011 Physician Quality Reporting System GPRO

The following documents specific to the 2011 Physician Quality Reporting System GPRO reporting are available in the **"Downloads"** section below:

**GPRO Requirements for Submission of 2011 Physician Quality Reporting System Data.** To participate in the 2011 Physician Quality Reporting System GPRO, a group practice must comply with certain requirements, submit a self-nomination letter to CMS, and be selected to participate in the 2011 Physician Quality Reporting System GPRO. The GPRO requirements and instructions for submitting the self-nomination letter can be found in the **"Downloads"** section below.

### Downloads

~~[2012 Group Practice Reporting Option \(GPRO\) Requirements \[PDF, 69KB\]](#)~~

[2012 Physician Quality Reporting GPRO I Measure Specifications and Release Notes \[ZIP, 351KB\]](#)

~~[2011 Physician Quality Reporting GPRO I Measure Specifications and Release Notes \[ZIP, 217KB\]](#)~~

[2011 Physician Quality Reporting System GPRO I Measures List \[PDF, 58KB\]](#)

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[http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Group\\_Practice\\_Reporting\\_Option.html](http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Group_Practice_Reporting_Option.html)

<sup>1</sup> Not applicable to ACOs and PGPs. ACOs and PGPs should follow their own program guidance on quality measurement and PQRS.

# Review of eRx

# Requirements for eRx



- ❖ Reporting period
  - January 1, 2012 to December 31, 2012
- ❖ Report via claims, qualified registry or qualified electronic health record (EHR) data submission vendor per self-nomination letter
  - Cannot report GPRO eRx via EHR direct vendor
- ❖ See the separate eRx GPRO measure specification:  
[https://www.cms.gov/apps/ama/license.asp?file=/ERxIncentive/downloads/2012\\_GPROeRx\\_Measure\\_ReleaseNotes\\_ClaimsBasedRptgPrinciples\\_111011.zip](https://www.cms.gov/apps/ama/license.asp?file=/ERxIncentive/downloads/2012_GPROeRx_Measure_ReleaseNotes_ClaimsBasedRptgPrinciples_111011.zip)

# eRx Incentive



- ❖ Incentive payment of 1% of Part B PFS allowed charges for successful electronic prescribers
- ❖ Adopt a qualified eRx system
- ❖ Successfully report for eligible eRx events via the same reporting method
  - January 1, through December 31, 2012
    - Small GPROs:  $\geq 625$  unique encounters
    - Large GPROs:  $\geq 2,500$  unique encounters
- ❖  $\geq 10\%$  of total allowed charges must be for services in the measure denominator

# Successful eRx Submission for Incentive, cont.



Reporting Mechanism	Group Size	Reporting Period	Criteria for Successful eRx Submission
Claims	25-99 Eligible Professionals	January 1, 2012 – December 31, 2012	Submit both a denominator CPT code and the numerator G-code (G8553) on the same claim representing the eligible encounter for at least 625 unique MPFS encounters.
Claims	100+ Eligible Professionals	January 1, 2012 – December 31, 2012	Submit both a denominator CPT code and the numerator G-code (G8553) on the same claim representing the eligible encounter for at least 625 unique MPFS encounters for at least 2,500 unique MPFS encounters.
Registry or EHR Data Submission Vendor		January 1, 2012 – December 31, 2012	Submit a denominator CPT code and electronically generated and transmitted prescription (not faxed) for at least 625 unique MPFS encounters.
Registry or EHR Data Submission Vendor		January 1, 2012 – December 31, 2012	Submit a denominator CPT code and electronically generated and transmitted prescription (not faxed) for at least 2,500 unique MPFS encounters.

# eRx Payment Adjustments



- ❖ Payment adjustments may occur for eligible professionals who are not successful electronic prescribers
  - For those who are not successful, the 2013 fee schedule for furnished services will be 98.5% of what would otherwise apply to such PFS services
    - Requirements are used to determine if payment adjustment will or will not be levied, not to determine incentive eligibility
    - Payment adjustment applies whether or not the practice participates in the eRx Incentive Program

# Avoiding eRx 2013 Payment Adjustment



- ❖ Participate as an eRx GPRO

## **AND one of the following:**

- ❖ Selected as 2011 eRx GPRO and successfully electronically prescribed for 2011 eRx incentive
- ❖ Report required eRx events from January 1 to June 30, 2012 **via claims**
- ❖ Request and receive hardship exemption by June 30, 2012

# Avoiding eRx 2013 Payment Adjustment, cont.



Group Size	Reporting Period	Reporting Mechanism	Criteria for Avoiding the 2013 eRx Payment Adjustment
25-99 Eligible Professionals	January 1, 2012 – June 30, 2012	Claims	Report G8553 <b>for at least 625 unique MPFS encounters</b> . The eRx G-code can be reported on any Medicare Part B claim that includes a billable Part B service, <u>regardless</u> of whether the claim contains coding in the eRx measure's denominator.
100+ Eligible Professionals	January 1, 2012 – June 30, 2012	Claims	Report G8553 <b>for at least 2,500 unique MPFS encounters</b> . The eRx G-code can be reported on any Medicare Part B claim that includes a billable Part B service, <u>regardless</u> of whether the claim contains coding in the eRx measure's denominator.

# Hardship Exemptions

- ❖ May be granted if CMS determines that compliance with eRx requirements would result in significant hardship
  - Reviewed on a case-by-case basis
  - Must be renewed annually
- ❖ Submit a hardship exemption request via the QNET Communications Support Page  
[https://www.qualitynet.org/portal/server.pt/community/communications\\_support\\_system/234#](https://www.qualitynet.org/portal/server.pt/community/communications_support_system/234#)
- ❖ Deadline for hardship request is June 30, 2012

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## E-Prescribing Incentive Program

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## Overview

### Electronic Prescribing (eRx) Incentive Program

Click on the "[Spotlight](#)" link to the left to view

"What's New" (recently posted items) for the eRx Incentive Program

**Background.** The Electronic Prescribing (eRx) Incentive Program is a reporting program that uses a combination of incentive payments and payment adjustments to encourage electronic prescribing by eligible professionals. The program provides an incentive payment to practices with eligible professionals (identified on claims by their individual National Provider Identifier [NPI] and Tax Identification Number [TIN]) who successfully e-prescribe for covered Physician Fee Schedule (PFS) services furnished to Medicare Part B Fee-for-Service (FFS) beneficiaries (including Railroad Retirement Board and Medicare Secondary Payer). Beginning in 2012, the program also applies a payment adjustment to those eligible professionals who are not successful electronic prescribers on their Medicare Part B services. This website serves as the primary and authoritative source for all publicly available information and CMS-supported educational and implementation support materials for the eRx Incentive Program.

The eRx Incentive Program is mandated by federal legislation. CMS implements the eRx Incentive Program through regulations published in the **Federal Register**. Information regarding the relevant statutes and regulations can be found by clicking on the "[Statutes/Regulations](#)" section page to the left.

### No Sign Up or Pre-Registration

There is no sign-up or pre-registration for individual eligible professionals to participate in the eRx Incentive Program. However, there are certain limitations on who can qualify for an eRx incentive payment. First, an eligible professional must have and use a qualified eRx system and report on his or her adoption and use of the eRx system. Second, the eligible professional must meet the criteria for a successful electronic prescriber specified by CMS for a particular reporting period. Finally, at least 10% of a successful electronic prescriber's Medicare Part B covered services must be made up of codes that appear in the denominator of the eRx measure. A list of professionals eligible to participate in

<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive/index.html?redirect=/ERXincentive/>

# 2012 eRx Measure Specifications



**Claims-Based Reporting Principles for the 2009 eRx Incentive Program.** Guidance about how to report the eRx measure on claims for the 2009 eRx Incentive Program can be found under the **"Downloads"** section below.

**Sample E-Prescribing Claim.** This document, which is available in the **"Downloads"** section below, provides a detailed sample of an individual NPI reporting the e-prescribing eRx measure on a CMS-1500 claim for the 2009 eRx Incentive Program.

## Downloads

[2012\\_eRx\\_MeasureSpec\\_ReleaseNotes\\_Claims-BasedRptgPrinciples\\_111011 \[ZIP, 473KB\]](#)

[2012 eRx CMS-1500 Claims Example \[PDF, 395KB\]](#)

[2011 eRx Measure Specifications, Release Notes and Claims-Based Reporting Principles \[ZIP, 539KB\]](#)

[2010 eRx Measure Specifications and Release Notes \[ZIP, 75KB\]](#)

[Claims-BasedReportingPrinciplesforeRx122209 \[PDF, 87KB\]](#)

[2009EPrescribingSpecifications012209 \[PDF, 36KB\]](#)

[Claims-Based Reporting Principles for the 2009 eRx Incentive Program \[PDF, 22KB\]](#)

[Sample Electronic Prescribing Claim for the 2009 eRx Incentive Program \[PDF, 36KB\]](#)

## Related Links

[eRx FAQs](#)

[http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive/E-Prescribing\\_Measure.html](http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive/E-Prescribing_Measure.html)

# For Remaining Questions...



## QualityNet Help Desk

Monday – Friday: 7:00 am - 7:00 pm CT

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