CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 355	**Date: JUNE 13, 2008**
	Change Request 6104

SUBJECT: 2008 Physician Quality Reporting Initiative (PQRI) Establishment of Alternative Reporting Periods and Reporting Criteria

I. SUMMARY OF CHANGES: CMS is taking steps to encourage physician and other eligible professionals participation in the Physician Quality Reporting Initiative (PQRI), a program designed to improve the quality of care provided to Medicare beneficiaries.

New / Revised Material
Effective Date: July 1, 2008
Implementation Date: July 7, 2008

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: 355	Date: June 13, 2008	Change Request: 6104

SUBJECT: 2008 Physician Quality Reporting Initiative (PQRI) Establishment of Alternative Reporting Periods and Reporting Criteria

Effective Date: July 1, 2008

Implementation Date: July 7, 2008

I. GENERAL INFORMATION

A. Background: The 2006 Tax Relief and Health Care Act (TRHCA) (P.L. 109-432) required the establishment of a physician quality reporting system, including an incentive payment for eligible professionals who satisfactorily report data on quality measures for covered services furnished to Medicare beneficiaries during the second half of 2007 (the 2007 reporting period). CMS named this program the Physician Quality Reporting Initiative (PQRI). The TRHCA requires CMS to pay eligible professionals who satisfactorily report data on quality measures an incentive payment equivalent to 1.5 percent of their total allowed charges for Medicare Physician Fee Schedule (PFS) covered professional services (referred to as total allowed charges) furnished during the 2007 reporting period (July 1, 2007 – December 31, 2007). The statute defines satisfactory reporting to be reporting of up to 3 applicable measures in at least 80 percent of the cases in which such measure is reportable. A total of 74 clinical quality measures were available for reporting for 2007. Reporting for 2007 occurred only via claims.

The TRHCA also required that CMS establish a PQRI measure set for 2008, including structural measures. In the 2008 PQRI, there are a total of 119 measures that eligible professionals can select from: 117 clinical quality measures, and 2 structural measures (use of electronic health records and electronic prescribing). (See 2008 PFS Final Rule published November 27, 2007, 72 Fed. Reg. 66222, at 66336-66359, available on the CMS Web site at: http://www.cms.hhs.gov/quarterlyproviderupdates/downloads/cms1385fc.pdf.) The complete specifications for the 119 measures that make up the 2008 PQRI are available at: http://www.cms.hhs.gov/PQRI/downloads/2008PQRIMeasureSpecifications123107.pdf.

The TRHCA also required CMS to address the submission of PQRI measures data through registries. In the 2008 PFS Final Rule, CMS described plans to test two methods for submission of quality measures data through registries during 2008. The 2008 PFS Final Rule did not provide for any incentive payment for eligible professionals who only submitted their quality measures data through registries under the testing process. The testing process is currently underway, with test data submission slated to begin in July, 2008. Data submission for the testing process will conclude by September 1, 2008.

The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) was enacted on December 29, 2007 (Pub. Law 110-173). MMSEA authorizes CMS to make PQRI incentive payments for satisfactory reporting quality measures data with respect to services furnished in 2008. For 2008, eligible professionals who meet the criteria for satisfactory submission of quality measures data on services furnished during the reporting period, January 1, 2008 – December 31, 2008, will earn an incentive payment of 1.5 percent of their total allowed charges for PFS covered professional services furnished during that same period (the 2008 calendar year).

The MMSEA requires that for 2008 and 2009 the Secretary establish alternative reporting periods and alternative criteria for satisfactorily reporting groups of measures. It also requires that for 2008 and 2009 the Secretary establish alternative reporting periods and alternative criteria for satisfactorily reporting quality

measures data through registries. In 2008, eligible professionals may earn an incentive payment of 1.5 percent of their total allowed charges for PFS covered professional services furnished during the respective alternative reporting periods based on data submitted via these mechanisms. While TRHCA established a cap on incentive payments for 2007, based on an average per measure payment amount, there is no cap on incentive payments under MMSEA for 2008 and 2009.

B. Policy: Establishment of alternative reporting periods and alternative criteria for satisfactorily reporting quality measures for the 2008 Physician Quality Reporting Initiative (PQRI) as authorized by the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (P.L. 110-173) which was enacted on December 29, 2007.

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	
6104.1	Effective for dates of service on or after July 1, 2008, contractors shall recognize HCPCS code G8485 (Clinician intends to report the Diabetes measure) for intent to report the Diabetes measure group on 15 consecutive patients. This code will be included in the July Update to the 2008 Medicare Physician Fee Schedule Database.	X			X						
6104.2	Effective for dates of service on or after July 1, 2008, contractors shall recognize HCPCS code G8486 (Clinician intends to report the Preventive Care measure group) for intent to report the Preventive Care measure group on 15 consecutive patients. This code will be included in the July Update to the 2008 Medicare Physician Fee Schedule Database.	X			X						
6104.3	Effective for dates of service on or after July 1, 2008, contractors shall recognize HCPCS code G8487 (Clinician intends to report the Chronic Kidney Disease (CKD) measure group) for intent to report the Chronic Kidney Disease measure group. This code will be included in the July Update to the 2008 Medicare Physician Fee Schedule Database.	X			X						
6104.4	Effective for dates of service on or after July 1, 2008, contractors shall recognize HCPCS code G8488 (Clinician intends to report the End Stage Renal Disease (ESRD) measure group) for intent to report the End Stage Renal Disease measure group. This code will be included in the July Update to the 2008 Medicare Physician Fee Schedule Database.	X			X						

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	
6104.5	Contractor shall instruct providers that MMSEA authorized the Secretary to establish alternative reporting periods and alternative reporting criteria for measures groups and registry-based reporting for 2008 and 2009 PQRI.	X			X						
6104.6	Contractor shall instruct providers that there are 2 alternative reporting periods and 9 options for satisfactorily reporting for 2008 PQRI; 3 options are claims-based and 6 options are registry-based.	X			X						
6104.7	Contractor shall instruct providers that the 2 alternative reporting periods are January 1, 2008 – December 31, 2008, and July 1, 2008 – December 31, 2008. For claims-based reporting the July 1, 2008 – December 31, 2008, reporting period only applies to the reporting of measures groups. For registry-based reporting both reporting periods apply to measure groups and individual measures.	X			X						
6104.8	Contractor shall instruct providers that eligible professionals may select from among the following 9 options to participate in PQRI.	X			X						
6104.9	Contractor shall instruct providers on how to satisfactorily report using claims-based reporting for the reporting period January 1, 2008 – December 31, 2008 (Option 1): Eligible professionals electing this option to report individual PQRI measures must report 3 PQRI measures or 1 -2 measures if less than 3 measures apply to the eligible professional on 80 percent of applicable patient claims for 1 – 3 measures. The alternative reporting period of July 1, 2008 – December 31, 2008, does not apply to the reporting of individual PQRI measures using the claims-based method of reporting.	X			X						
6104.10	Contractor shall instruct providers on how to satisfactorily report using claims-based reporting for the reporting period July 1, 2008 – December 31, 2008 (Option 2): Eligible professionals electing this option to report measures groups must report all measures in one measures group that apply to each of 15 consecutive patients. To initiate the count of 15	X			X						

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	
	consecutive patients, the provider shall report the measures group specific "G code" on the claim for the first of the 15 consecutive patients. The reporting period of January 1, 2008 – December 31, 2008, does not apply to the reporting of measures groups using the claims-based method of reporting.										
6104.11	Contractor shall instruct providers on how to satisfactorily report using claims-based reporting for the reporting period July 1, 2008 – December 31, 2008 (Option 3): Eligible professionals electing this option to report measures groups must report all measures in one measures group on 80 percent of patients for the applicable measures group during the reporting period of July 1, 2008 – December 31, 2008. The provider shall report the measures group specific "G code" or the claim to indicate the intent to report the measures group. The reporting period of January 1, 2008 – December 31, 2008, does not apply to the reporting of measures groups using the claims-based method of reporting.	X			X						
6104.12	Contractor shall instruct providers on how to satisfactorily report using registry-based reporting for the reporting period January 1, 2008 – December 31, 2008 (Option 4): Eligible professionals electing this option to report individual PQRI measures using registries must report at least 3 PQRI measures on 80 percent of applicable Medicare FFS patients.	X			X						
6104.13	Contractor shall instruct providers on how to satisfactorily report using this registry-based reporting option for the reporting period July 1, 2008 – December 31, 2008 (Option 5): Eligible professionals electing to report individual PQRI measures using registries must report at least 3 PQRI measures on 80 percent of applicable Medicare FFS patients.	X			X						
6104.14	Contractor shall instruct providers on how to satisfactorily report using this registry-based reporting option for the reporting period July 1, 2008 – December 31, 2008 (Option 6): Eligible professionals electing to report measures groups using registries must report all measures in one measures group that apply to each of 15 consecutive patients. The	X			X						

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	
	consecutive patients may include, but not be exclusively, non-Medicare patients. The reporting of a measures group specific "G-code" is not required for registry-based reporting.										
6104.15	Contractor shall instruct providers on how to satisfactorily report using this registry-based reporting option for the reporting period January 1, 2008 – December 31, 2008 (Option 7): Eligible professionals electing to report measures groups using this registries option must report all measures in one measures group that apply to each of 30 consecutive patients. The consecutive patients may include, but not be exclusively, non-Medicare patients. The reporting of a measures group specific "G-code" is not required for registry-based reporting.	X			X						
6104.16	Contractor shall instruct providers on how to satisfactorily report using this registry-based reporting option for the reporting period July 1, 2008 – December 31, 2008 (Option 8): Eligible professionals electing to report measures groups using this registries option must report all measures in one measures group on 80 percent of Medicare FFS patients for the applicable measures group on services provided during the reporting period of July 1, 2008 – December 31, 2008.	X			X						
6104.17	Contractor shall instruct providers on how to satisfactorily report using registry-based reporting for the reporting period January 1, 2008 – December 31, 2008 (Option 9): Eligible professionals electing to report measures groups using this registries option must report all measures in one measures group on 80 percent of Medicare FFS patients for the applicable measures group for services provided during the reporting period of January 1, 2008 – December 31, 2008.	X			X						
6104.18	Contractor shall instruct providers that for 2008, there are 4 measures groups: Diabetes Mellitus, End Stage Renal Disease, Chronic Kidney Disease (CKD), and Preventive Care. Each of the measures groups contains at least 4 PQRI measures. Eligible professionals electing to report a group of measures must report all	X			X						

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		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	measures in the group that are applicable to the patient.										
6104.19	The contractor shall instruct the providers that the individual measures in the Diabetes Mellitus measures group includes: Measure Number 1 – Hemoglobin A1c Poor Control in Type 1 or 2 Diabetes Mellitus Measure Number 2 – Low Density Lipoprotein Control in type 1 or 2 Diabetes Mellitus Measure Number 3 – High Blood Pressure Control in Type 1 or 2 Diabetes Mellitus Measure Number 117 – Dilated Eye Exam in Diabetic Patient Measure Number 119 – Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients	x			X						
6104.20	The contractor shall instruct the providers that the individual measures in the End Stage Renal Disease (ESRD) measures group includes: Measure Number 78 – Vascular Access for Patients Undergoing Hemodialysis Measure Number 79 – Influenza Vaccination in Patients with ESRD Measure Number 80 – Plan of Care for ESRD Patients with Anemia Measure Number 81 – Plan of Care for Inadequate Hemodialysis in ESRD Patients	X			X						
6104.21	The contractor shall instruct the providers that the individual measures in the Chronic Kidney Disease	X			X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
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	(CKD) measures group includes: Measure Number 120 – ACE Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy in Patients with CKD Measure Number 121 – CKD: Laboratory Testing (Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile) Measure Number 122 – CKD: Blood Pressure Management Measure Number 123 – CKD: Plan of Care: Elevated Hemoglobin for Patients Receiving Erythropoiesis-Stimulating Agents (ESA)										
6104.22	The contractor shall instruct the providers that the individual measures in the Preventive Care measures group includes: Measure Number 39 – Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older Measure Number 48 – Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older Measure Number 110 – Influenza Vaccination for Patients > 50 Years Old Measure Number 111 – Pneumonia Vaccination for Patients 65 Years and Older Measure Number 112 – Screening Mammography Measure Number 113 – Colorectal Cancer Screening Measure Number 114 – Inquiry Regarding Tobacco Use Measure Number 115 – Advising Smokers to Quit	X			X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
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	Measure Number 128 – Universal Weight Screening and Follow-Up										
6104.23	Contractor shall instruct providers that the alternative reporting period for quality measures data for measures groups submitted through claims-based reporting is July 1, 2008 – December 31, 2008. The claims-based reporting mechanism for measures groups will be first available July 1, 2008.	X			X						
6104.24	Contractor shall instruct providers that the alternative reporting periods for quality measures data for measures groups submitted through registry-based data submission are January 1, 2008 – December 31, 2008, or July1, 2008 – December 31, 2008.	X			X						
6104.25	Contractor shall instruct providers that these alternative reporting criteria for quality measures data for measures groups apply regardless of whether the measures are reported through claims-based submission or through registry-based reporting. However, the "G-code" described in 6104.1 - 6104.4 and 6104.10 required for claims-submission of measures groups will not be implemented until July 1, 2008. Therefore, the July 1, 2008 – December 31, 2008, reporting period is the only available reporting period for measures groups data submitted on claims.	X			X						
6104.26	Contractor shall instruct providers that the alternative reporting criteria for quality measures data for measures groups reported for the January 1, 2008 – December 31, 2008, reporting period are 30 consecutive patients for whom the measures of one measures group apply; or 80 percent of Medicare patients for whom the measures of the measures group apply, without regard to whether the patients are consecutive. The January 1, 2008 – December 31, 2008, reporting period for measures groups applies only to registry-based reporting, not claims submission. See 6104.15 and 6104.17.	X			X						
6104.27	Contractor shall instruct providers that the alternative reporting criteria for quality measures data for	X			X						

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	measures groups reported for the July 1, 2008 – December 31, 2008, reporting period are: 15 consecutive patients for whom the measures of one measure group apply for measures groups reported through registry-based reporting; 15 consecutive Medicare patients for whom the measures of one measures group apply for measures groups reported through the claims mechanism; or 80 percent of Medicare patients for whom the measures of the measures group apply, without regard to the submission mechanism used or whether the patients are consecutive. See 6104.10, 6104.14 and 6104.16										
6104.28	Contractor shall instruct providers that the "Patients" or "Medicare patients" means Part B Medicare Fee-For-Service (FFS) patients. Non-FFS Medicare (e.g., Medicare Part C patients including those enrolled in Private FFS plans) and/or Non-Medicare patients may only be included in registry-based reporting under the consecutive patient criteria. "Non-Medicare patients" means persons not enrolled in Part B or Part C of Medicare.	X			X						
6104.29	Contractor shall instruct providers that the term "Consecutive" means next in order by date of service. Patients are considered consecutive without regard to gender even though some measures in a group (e.g., preventive care measures) may apply only to males or only to females.	X			X						
6104.30	Contractor shall instruct providers that the "Patients for whom the measures of one measures group apply" means patients to who services are furnished during the reporting period and for whom the measures of a particular group apply as defined by the denominator of the measures.	X			X						
6104.31	Contractor shall instruct providers that the measures groups reporting requires that eligible professionals must report on each of the measures in the measures group that is applicable to the patient.	X			X						
6104.32	Contractor shall instruct providers about the "G-Code" for Claims-based submission of measures groups. Eligible professionals must initiate the 15 consecutive	X			X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
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	Medicare patients beginning on or after July 1, 2008, for measures groups submitted by the claims mechanism, by reporting a group-specific "G-Code." This indicates the eligible professional's intent to report a specific measures group starting with the patient for whom the "G-Code" is submitted. The use of a "G-Code" is not required for registry-based submission with respect to measures groups. See 6104.1 – 6104.4.										
6104.33	Contractor shall instruct providers that the alternative reporting criteria for registry-based reporting of individual measures are a minimum of 3 PQRI measures applicable to the services furnished by the eligible professional during the reporting period for at least 80 percent of the cases in which each such measure is reportable.	X			X						
6104.34	Contractor shall instruct providers that although quality measures data on consecutive patients reported through registry-based reporting for measures groups may include some non-Medicare patients, the string of consecutive patients must be established in such a way as to include some Medicare patients. Quality measures data that is reported through the claims mechanism or under other registry-based reporting criteria can only include Medicare patients.	X			X						
6104.35	Contractor shall instruct providers that to qualify to submit data under the registry-based reporting alternatives for 2008, a registry must have been in existence on January 1, 2008, and the registry also must meet certain technical and other requirements that CMS specifies. CMS posted those registry requirements on May 1, 2008, on the CMS Web site.	X			X						
6104.36	Contractor shall instruct providers that the requirements for qualified registries will include, but not be limited to, submission of a self-nomination by a certain date. Registries that participated and/or self-nominated for the 2008 registry testing process will need to submit a new self-nomination specific to this new process in order to be considered for potential qualification.	X			X						

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	
6104.37	Contractor shall instruct providers that the requirements will include, but not be limited to, the registry having entered (or entering) into appropriate legal arrangements that provide for the registry's receipt of patient-specific data from eligible professionals, as well as the registry's disclosure of quality measure results and numerator and denominator data on behalf of eligible professionals who wish to participate in the PQRI program.	X			X						
6104.38	Contractor shall instruct providers that each registry seeking to submit data for the PQRI program will be required to meet all technical and other requirements CMS identifies for registries to submit such information.	X			X						
6104.39	Contractor shall instruct providers that CMS will post on the CMS Web site by August 31, 2008, the names of those registries that qualify. This publication will be accomplished through familiar CMS communications channels, including a posting to the CMS PQRI Web site (at: http://www.cms.hhs.gov/pqri).	X			X						
6104.40	Contractor shall instruct providers that the Registry-based submissions under the 2008 registry-based reporting alternatives will begin after the completion of the 2008 registry testing process.	X			X						
6104.41	Contractor shall instruct providers that the eligible professionals must comply with all applicable laws in establishing a relationship with a registry whereby the registry will report quality measures data to CMS on their behalf based on the data the eligible professional submits to the registry. The eligible professional will need to document and be able to demonstrate that this relationship has been established, and must attest to the validity of the data submitted by the eligible professional to the registry. The registry-based submission must meet the criteria for satisfactory reporting for PQRI measure results and/or measures group results.	X			X						
6104.42	Contractor shall instruct providers that the Registries must submit to CMS all required data that will include	X			X						

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	
	reporting and performance rates on PQRI measures or PQRI measures groups and numerator and denominators for the performance rates. Registries must attest that the eligible professional has satisfactorily reported data for clinical quality measures or measures groups under the PQRI program. Registries must specify the reporting criteria and reporting periods for which the eligible professional satisfactorily reported. Registries must also attest that all applicable statutory, regulatory, and contractual requirements for reporting of information to CMS have been met.										
6104.43	Contractor shall instruct providers that the eligible professionals who submit measures both through registries and through claims-based submission will be eligible to receive an incentive payment provided they meet the requirements for satisfactory reporting under either reporting mechanism. Qualification under both submission mechanisms will result in only one incentive bonus payment based on the longest reporting period for which the eligible professional satisfactorily reports.	X			X						
6104.44	Contractor shall instruct providers that the Registry reporting for each eligible professional must be on 2008 PQRI measures for patient services furnished during the applicable reporting period.	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	
6104.45	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	X			X						

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	
	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. .										

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

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

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

VI. FUNDING

Section A:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B:

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.