

Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program

Data Accuracy and Completeness Acknowledgement (DACA) for FY 2014 and Subsequent Fiscal Years.

This is required for providers participating in the Inpatient Psychiatric Quality Reporting Program

I acknowledge that to the best of my ability all of the information reported for this Inpatient Psychiatric Facility (IPF) for the Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program, as required for the Fiscal Year 2014 and subsequent fiscal years IPFQR Program requirements, is accurate and complete. This information includes the following:

- *Measure sets as defined for the IPFQR Program*
- *Current Notice of Participation and QualityNet Security Administrator.*

I understand that this acknowledgement covers all IPFQR information reported by this IPF (and any data or survey vendor(s) acting as agents on behalf of this facility) to CMS and its contractors for the FY 2014 and subsequent fiscal years.

To the best of my knowledge, this information was collected in accordance with all applicable requirements. I understand that this information is used as the basis for the public reporting of quality of care.

I understand that this acknowledgement is required for purposes of meeting any Fiscal Year 2014 IPFQR Program requirements.

Yes, I Acknowledge*

Name

Position _____ (Entered by User)

Password _____ (Entered by User)

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-XXXX . The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program Notice of Participation Text

Last Updated 2/13/2012

Please review the Notice of Participation below, choose an option and enter your Password to confirm.

Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program Notice of Participation Agreement

The Inpatient Psychiatric Facility (IPF) agrees to follow procedures for participating in the IPFQR Program as outlined in the *federal regulations(link tbd)* found in the Federal Register, or is indicating its decision to decline participation. The IPF understands that participation in the IPFQR Program is voluntary for the applicable fiscal year.

Each IPF must complete this " IPFQR Notice of Participation" (IPFQR Notice) as outlined in the IPFQR *QualityNet (link tbd)* and in the *federal regulations(link tbd)* found in the Federal Register. In an effort to alleviate the burden associated with submitting this form annually, effective with the IPFQR Notice submitted for participation in FY 2014 program year or later, an IPF that indicated its intent to participate will be considered an active IPFQR Program participant until CMS determines a need to resubmit the IPFQR Notice, or the IPF submits a request for withdrawal to CMS.

This information is in compliance with the CMS guidelines for IPFs submitting their quality performance data in accordance with section 1886(s)(4) of the Social Security Act. Pursuant to section 1886(s)(4) (E) of the Act, IPFs agreeing to participate in the IPFQR Program will have their data publicly displayed on the CMS' website after being afforded the opportunity to review their data.

We entities operating under the submitted Provider ID...

- Agree to participate.*
- Do not agree to participate.*
- Request to be withdrawn from participation.*

This acknowledgement (to participate or not to participate or to withdraw) remains in effect until an electronically signed acknowledgement applying changes has been entered.
By entering my password, I hereby issue this IPFQR Notice of Participation with the specified direction contained within:

Links

IPFQR Reference Checklist

(site)

QualityNet

<http://www.qualitynet.org/>

Federal Regulations

TBD

Social Security Act, Section 1886(s)(4)

http://www.ssa.gov/OP_Home/ssact/title18/1886.htm

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Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program

Decline to Participate

Agreement

The facility named below agrees to follow procedures for participating in the Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program as outlined in the **federal regulations** found in the Federal Register and is **indicating its decision to decline participation**.

Each facility must complete the online electronic “Notice of Participation” or the “Decline to Participate” paper form as outlined in the federal regulations found in the Federal Register. In an effort to alleviate the burden associated with completing this annually, effective with the Notice of Participation submitted for participation in the FY 2014 or later Inpatient Psychiatric Facility Quality Reporting Program, a facility that has previously indicated its intent to participate will be considered an active Patient Psychiatric Facility Quality Reporting Program participant until such time as the facility submits a withdrawal to CMS.

This information is in compliance with the CMS guidelines for facilities submitting their quality performance data, facilities must also continue to display quality information for public viewing as required by section 1886(d)(1)(B)(v) in accordance with paragraph (4) of the Social Security Act. Before this information is displayed, facilities will be permitted to review their information as it is recorded. Based on section 1886(d)(1)(B)(v) in accordance with paragraph (4) of the Social Security Act, for program year beginning with FY 2014, CMS is required to add other measures that reflect consensus among affected parties. Eligible facilities must follow the regulations as outlined in the federal regulations and as summarized on the *QualityNet* Web site.

CMS must publish on CMS.gov the facility’s submitted data for the required measures. Data at the hospital level will be provided to the Secretary.

To participate, a hospital must access the online QualityNet Notice of Participation tool.

To *DECLINE* to participate, the below signature states the signer has read and agrees to the foregoing provisions and the participation decision, and acknowledges same by signing here.

Facility’s Name _____

CMS Certification Number (CCN) _____

Signature of CEO (or Designee) _____

Signer’s Name, Printed or Typed _____

Signer’s Title _____

Date Signed _____

If declining to participate, submit this completed and signed “Decline to Participate” form directly to your IPF Support Contractor.

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Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program

WITHDRAWAL OF PARTICIPATION

This form must be completed and mailed or faxed to your Inpatient Psychiatric Facility Quality Reporting Support Contractor contact if your facility wants to withdraw from participation Inpatient Psychiatric Facility Quality Reporting.

Our facility is withdrawing from participation in Inpatient Psychiatric Facility Quality Reporting at this time. Based on this withdrawal, it is our understanding that our facility will not be listed as a participant on the CMS.gov web site.

Facility Name: _____

CMS Certification Number (CCN) _____

City, State, ZIP Code: _____

Facility/Health System CEO (or designee):

Name (please print): _____

Title: _____

Date: _____ Signature: _____

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Quality Reporting Program Reconsideration Request Form

When CMS determines that a facility did not meet the Quality Reporting Program requirement(s), the facility may submit a request for reconsideration to CMS, by the deadline identified on the Annual Payment Update Notification letter.

*** Indicates required fields**

Facility Contact Information

*Program Requesting Waiver: Inpatient __ Outpatient __ Inpatient Psych __ PPS-exempt Cancer __ ASC __

Other (Please specify) _____

*Date of Request (MM/DD/YYYY): ____/____/____

*CMS Certification Number (CCN): _____

*Facility Name: _____

Provide the facility's CEO contact information. This will be used for official correspondence. Please ensure within your organization that U.S. Mail and deliveries from overnight services that are directed to this address will reach the necessary party(ies).

*CEO Last Name: _____

*CEO First Name: _____

*CEO E-Mail Address: _____

*CEO Address Line 1: (must include physical street address): _____

CEO Address Line 2: _____

*CEO City: _____

*CEO State: __ *CEO Zip Code: ____ - ____

*CEO Telephone Number: ____ - ____ - ____ ext. _____

Additional Contact Last Name: _____

Additional Contact First Name: _____

Additional Contact E-Mail Address: _____

Additional Contact Address Line 1: (must include physical street address): _____

Additional Contact Address Line 2: _____

Additional Contact City: _____

Additional Contact State: ____ Additional Contact Zip Code: ____ - ____

Additional Contact Telephone Number: ____ - ____ - ____ ext. _____

Reconsideration Request Information

***Reason Facility Failed to Meet the Annual Payment Update Requirements:** These details were provided in the formal CMS notification letter that was sent to your CEO by the Centers for Medicare & Medicaid Services (CMS).

***Reason for Reconsideration Request:** Please state your reason for requesting reconsideration. You must identify the specific reason(s) for believing your facility did meet the Quality Reporting Program requirement(s) and should receive the full annual payment update.

*Was your reason for not meeting the annual requirement(s) related to Validation? Yes ___ No ___

IF APPLICABLE, PLEASE NOTE: Requests related to validation element mismatches for the clinical process measures require additional facility **actions as follows:**

- Complete the Validation Review for Reconsideration Request.
 - Provide written justification for each data element you wish to appeal and mail a copy of the entire medical record (as previously sent to the Clinical Data Abstraction Center (CDAC) contractor) for the appealed element(s).

- o Medical records must be received by the deadline identified on the Annual Payment Update Notification letter.

[Link to part 2 form]

Additional information can be found at QualityNet.org

Additional Comments:

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Quality Reporting Program

Extraordinary Circumstance/Disaster Extension or Waiver Request Form

A facility can request an extension or waiver of various Quality Reporting Program requirements due to extraordinary circumstances beyond the control of the facility. To request an extension or waiver, complete and submit this form **within 30 days of the disaster or extraordinary circumstance**.

ALL sections must be complete and specific in order for Centers for Medicare and Medicaid Services to consider the request.

*Indicates required fields

Facility Contact Information

*Program Requesting Waiver: Inpatient __ Outpatient __ Inpatient Psych __ PPS-exempt Cancer __
ASC __

Other (Please specify) _____

*Date of Request (MM/DD/YYYY): ____/____/____

*Date of Extraordinary Circumstance/Disaster (MM/DD/YYYY): ____/____/____

*CMS Certification Number (CCN): _____

*Facility Name: _____

*CEO Last Name: _____

*CEO First Name: _____

*CEO E-Mail Address: _____

*CEO Address Line 1: (must include physical street address): _____

CEO Address Line 2: _____

*CEO City: _____

*CEO State: __ *CEO Zip Code: ____ - ____

*CEO Telephone Number: ____ - ____ - ____ ext. _____

Additional Contact Last Name: _____

Additional Contact First Name: _____

Additional Contact E-Mail Address: _____

Additional Contact Address Line 1: (must include physical street address): _____

Additional Contact Address Line 2: _____

Additional Comments:

Disaster Waiver Request Form Submission

In the event the facility is unable to submit the form electronically, it can be submitted by fax or mailed to their QIO or CMS designee.

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