CMS Quality Reporting Program
APU Reconsideration Request Form

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

*Indicates required field

*Facility Information:

*Program Requesting Reconsideration: ☐ Inpatient ☐ Psych ☐ Outpatient ☐ ASC

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

*CMS Certification Number (CCN) **(Not required for ASC)**: _____

***National Provider Identification (NPI) **(Required for ASC only)**: _____

*Facility Name: _____

*CEO Contact Information (Required for Inpatient and Psych) or Designated Contact Information (Required for Outpatient and ASC):

Please ensure within your organization that U.S. Mail and deliveries from overnight services directed to this address will reach the necessary party.

*Name: _____

*Email Address: _____

*Telephone Number: _____-_____-_____ Ext. _____

*Mailing Address (must include physical address; P.O. Box addresses are not valid):

_____

*City: _____

*State: ____ *ZIP Code: _____-_____

****QualityNet* Security Administrator Contact Information (Not required for ASC):

*Name: _____

*Email Address: _____

*Telephone Number: _____-_____-_____ Ext. _____

*Mailing Address (must include physical street address; P.O. Box addresses are not valid):

_____

*City: _____

*State: ____ *ZIP Code: _____-_____

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*Reconsideration Request Information:

***CMS-Identified Reason Facility Did Not Meet the APU Requirements**: These details were provided in the formal CMS APU Notification Letter that was sent to your CEO/Designee.

_____

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***Reason for Reconsideration Request:** Please state your facility's reason for requesting reconsideration. This must identify the specific reason(s) for believing your facility did meet the Quality Reporting Program requirements and should receive the full APU. **Please Note:** A facility must submit all documentation and evidence that supports its request for reconsideration at the time that it submits its request. This includes copies of any communications, such as emails that the facility believes demonstrate its compliance with the program requirements.

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Reconsideration Request Form Submission Information:

Complete and submit this form via the *QualityNet Secure Portal*, Secure File Transfer "APU" group, via secure fax to 877-789-4443, or email to QRSupport@hcqis.org.

Following receipt of the request form, an email acknowledgement will be sent confirming the form has been received. Once a determination has been made, CMS will provide the formal decision regarding the reconsideration request.

Additional Comments:

_____

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Validation Review for Reconsideration Request Information:

***Was one of your reasons for not meeting the annual requirement(s) related to Validation?**

If Yes, PLEASE NOTE: Requests related to validation element mismatches for the clinical process measures require additional facility actions. In addition to filing the Reconsideration Request Form as outlined above, hospitals must:

- Complete the Validation Review for Reconsideration Request Form, including written justification for each data element classified during the validation process as a mismatch that you wish to appeal.
- Mail a paper copy of the entire medical record (as previously sent to the Clinical Data Abstraction Center [CDAC] Contractor) for the appealed element(s), along with the completed Validation Review for Reconsideration Request Form, to the Validation Support Contractor at:

  Telligen
  Attn: Validation Support Contractor
  1776 West Lakes Parkway
  West Des Moines, IA 50266

Medical records must be received by the deadline identified on the APU Notification Letter.

CMS will review the data elements that were labeled as mismatched, as well as the written justifications provided by the facility, and make a decision on the validation reconsideration request.

***Designated Personnel Signature _____ Date ____/____/____**

(Required)