CMS Hospital Inpatient Quality Reporting Program Validation Review for Reconsideration Request

If the Centers for Medicare & Medicaid Services (CMS) determines that a hospital **did not meet** any of the Hospital Inpatient Quality Reporting (IQR) Program requirements due to a confidence interval validation score of less than 75 percent and the hospital would like to request a reconsideration, the hospital **must** complete and submit this form, along with a copy of the entire medical record (as previously sent to the Clinical Data Abstraction Center [CDAC] Contractor) for the appealed element(s). This form and the entire medical record **must be received** by the Validation Support Contractor, **within 30 days** following the date of receipt of the Hospital IQR Program Annual Payment Update (APU) Notification Letter. CMS strongly recommends sending the medical record(s) to the "Validation Support Contract" group via the CMS Managed File Transfer (MFT) application: https://qnetmft.cms.gov/. Contact validation@telligen.com for assistance. If unable to submit via MFT, you may mail to:

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

Following the receipt of the request form/medical records, 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.

Fields marked with (*) indicates required field

***Facility Information:**

*CMS Certification Number (CCN): __________________ *Hospital Name: __________________________________

***Designated Personnel Contact Information:**

*Name and Title: ____

*Email Address: ____

*Telephone Number: ______-______-_______ Ext. __________

***Validation Review for Reconsideration Request Form:**

Fields marked with (†) can be found on the Case Detail Report.
If you need to request reconsideration for more elements, or if additional space is needed to describe the rationale, you may attach another document to accompany this form.

Patient ID*†	Abstraction Control #*†	Discharge Quarter*†	Discharge Date*†	Data Element Name*†	**Rationale:** Please provide written justification in the space below for each appealed data element classified as a mismatch. Mismatched data elements that affect a hospital's validation score would be subject to reconsiderations. Supplemental information that was not located in the original medical record sent to the CMS Clinical Data Abstraction Center (CDAC) cannot be accepted.

Patient ID*†	**Abstraction Control #*†**	**Discharge Quarter*†**	**Discharge Date*†**	**Data Element Name*†**	**Rationale:** Please provide written justification in the space below for each appealed data element classified as a mismatch. Mismatched data elements that affect a hospital's validation score would be subject to reconsiderations. Supplemental information that was not located in the original medical record sent to the CMS Clinical Data Abstraction Center (CDAC) cannot be accepted.

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***These elements are displayed on the Case Detail Report.**

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 **0938-1022 (Expires XX/XX/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, MD 21244-1850. ****CMS Disclosure**** **Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Validation Support Contractor at validation@hcqis.org.**