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.

Once this form has been completed, please submit via *Managed File Transfer* to QRFormsSubmission@hsag.com, via secure fax to 877-789-4443, or email QRFormsSubmission@hsag.com.

Following the 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.

*Indicates required field

*Facility Information:

*Program Requesting Reconsideration: ☐ Inpatient ☐ Psych ☐ Outpatient ☐ Ambulatory Surgical Center (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 and Title: _____

*Email Address: _____

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

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

_____

*City: _____

*State: ____ *ZIP Code: _____-_____

*Security Official Contact Information (Not required for ASC):

*Name and Title: _____

*Email Address: _____

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

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

_____

*City: _____

*State: ____ *ZIP Code: _____-_____

*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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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 may require additional facility actions.

Electronic Clinical Quality Measure (eCQM) Validation:

No further actions are required.

Chart-Abstracted Validation:

In addition to filing the Reconsideration Request Form as outlined above, facilities must also complete a Validation Review for Reconsideration Request Form (available on the *QualityNet* website) which includes fields to provide written justification for each mismatched case that you wish to appeal. Facilities may also include medical records for appealed cases, if applicable.

Additional information/instructions on how to submit the form and medical records to the Validation Support Contractor can be found on the Validation Review for Reconsideration Request Form. **The Validation Review for Reconsideration Request Form and any medical records (if applicable) 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.

SIGNATURE

***CEO/Designated Personnel Signature**_____

Date _____/____/____