

§ 419.46

42 CFR Ch. IV (10–1–14 Edition)

after application of the reduction under paragraph (b) of this section.

[71 FR 68228, Nov. 24, 2006, as amended at 72 FR 66933, Nov. 27, 2007]

§ 419.46 Participation, data submission, and validation requirements under the Hospital Outpatient Quality Reporting (OQR) Program.

(a) *Participation in the Hospital OQR Program.* To participate in the Hospital OQR Program, a hospital as defined in section 1886(d)(1)(B) of the Act and is paid under the OPSS must—

(1) Register on the QualityNet Web site before beginning to report data;

(2) Identify and register a QualityNet security administrator as part of the registration process under paragraph (a)(1) of this section; and

(3) Complete and submit an online participation form available at the QualityNet.org Web site if this form has not been previously completed, if a hospital has previously withdrawn, or if the hospital acquires a new CMS Certification Number (CCN). For Hospital OQR Program purposes, hospitals that share the same CCN are required to complete a single online participation form. Once a hospital has submitted a participation form, it is considered to be an active Hospital OQR Program participant until such time as it submits a withdrawal form to CMS or no longer has an effective Medicare provider agreement. Deadlines for the participation form are described in paragraphs (a)(3)(i) and (ii) of this section, and are based on the date identified as a hospital's Medicare acceptance date.

(i) If a hospital has a Medicare acceptance date before January 1 of the year prior to the affected annual payment update, the hospital must complete and submit to CMS a completed Hospital OQR Notice of Participation Form by July 31 of the calendar year prior to the affected annual payment update.

(ii) If a hospital has a Medicare acceptance date on or after January 1 of the year prior to the affected annual payment update, the hospital must submit a completed participation form no later than 180 days from the date identified as its Medicare acceptance date.

(b) *Withdrawal from the Hospital OQR Program.* A participating hospital may withdraw from the Hospital OQR Program by submitting to CMS a withdrawal form that can be found in the secure portion of the QualityNet Web site. The hospital may withdraw any time from January 1 to November 1 of the year prior to the affected annual payment updates. A withdrawn hospital will not be able to later sign up to participate in that payment update, is subject to a reduced annual payment update as specified under § 419.43(h), and is required to submit a new participation form in order to participate in any future year of the Hospital OQR Program.

(c) *Submission of Hospital OQR Program data.* (1) *General rule.* Except as provided in paragraph (d) of this section, hospitals that participate in the Hospital OQR Program must submit to CMS data on measures selected under section 1833(17)(C) of the Act in a form and manner, and at a time, specified by CMS.

(2) *Submission deadlines.* Submission deadlines by measure and by data type are posted on the QualityNet Web site.

(3) *Initial submission deadlines for a hospital that did not participate in the previous year's Hospital OQR Program.*

(i) If a hospital has a Medicare acceptance date before January 1 of the year prior to the affected annual payment update, the hospital must submit data beginning with encounters occurring during the first calendar quarter of the year prior to the affected annual payment update, in addition to submitting a completed Hospital OQR Notice of Participation Form under paragraph (a)(3)(i) of this section.

(ii) If a hospital has a Medicare acceptance date on or after January 1 of the year prior to the affected annual payment update, the hospital must submit data for encounters beginning with the first full quarter following submission of the completed Hospital OQR Notice of Participation Form under paragraph (a)(3)(ii) of this section.

(iii) Hospitals with a Medicare acceptance date before or after January 1 of the year prior to an affected annual

payment update must follow data submission deadlines as specified in paragraph (c)(2) of this section.

(d) *Exception.* CMS may grant an extension or waiver of one or more data submission deadlines and requirements in the event of extraordinary circumstances beyond the control of the hospital, such as when an act of nature affects an entire region or locale or a systemic problem with one of CMS' data collection systems directly or indirectly affects data submission. CMS may grant an extension or waiver as follows:

(1) Upon request by the hospital. Specific requirements for submission of a request for an extension or waiver are available on the QualityNet Web site.

(2) At the discretion of CMS. CMS may grant waivers or extensions to hospitals that have not requested them when CMS determines that an extraordinary circumstance has occurred.

(e) *Validation of Hospital OQR Program data.* CMS may validate one or more measures selected under section 1833(17)(C) of the Act by reviewing documentation of patient encounters submitted by selected participating hospitals.

(1) Upon written request by CMS or its contractor, a hospital must submit to CMS supporting medical record documentation that the hospital used for purposes of data submission under the program. The specific sample that a hospital must submit will be identified in the written request. A hospital must submit the supporting medical record documentation to CMS or its contractor within 45 days of the date identified on the written request, in the form and manner specified in the written request.

(2) A hospital meets the validation requirement with respect to a fiscal year if it achieves at least a 75-percent reliability score, as determined by CMS.

(f) *Reconsiderations and appeals of Hospital OQR Program decisions.* (1) A hospital may request reconsideration of a decision by CMS that the hospital has not met the requirements of the Hospital OQR Program for a particular fiscal year. Except as provided in paragraph (d) of this section, a hospital must submit a reconsideration request

to CMS via the QualityNet Web site, no later than the first business day of the month of February of the affected payment year.

(2) A reconsideration request must contain the following information:

(i) The hospital's CMS Certification Number (CCN);

(ii) The name of the hospital;

(iii) The CMS-identified reason for not meeting the requirements of the affected payment year's Hospital OQR Program as provided in any CMS notification to the hospital;

(iv) The hospital's basis for requesting reconsideration. The hospital must identify its specific reason(s) for believing it should not be subject to the reduced annual payment update;

(v) The hospital-designated personnel contact information, including name, email address, telephone number, and mailing address (must include physical mailing address, not just a post office box);

(vi) The hospital-designated personnel's signature;

(vii) A copy of all materials that the hospital submitted to comply with the requirements of the affected Hospital OQR Program payment determination year; and

(viii) If the hospital is requesting reconsideration on the basis that CMS determined it did not meet the affected payment determination year's validation requirement set forth in paragraph (e)(1) of this section, the hospital must provide a written justification for each appealed data element classified during the validation process as a mismatch. Only data elements that affect a hospital's validation score are eligible to be reconsidered.

(3) A hospital that is dissatisfied with a decision made by CMS on its reconsideration request may file an appeal with the Provider Reimbursement Review Board under part 405, subpart R, of this chapter.

[78 FR 75196, Dec. 10, 2013]

Subpart E—Updates

§ 419.50 Annual review.

(a) *General rule.* Not less often than annually, CMS reviews and updates groups, relative payment weights, and the wage and other adjustments to