

Hospital Compare

Request Form for Withholding/Footnoting Data for Public Reporting

Overview

Hospitals and other facilities participating in the Hospital Inpatient Quality Reporting (IQR) Program, Hospital Outpatient Quality Reporting (OQR) Program, PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program, Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program, Ambulatory Surgical Center Quality Reporting (ASCQR) Program, Hospital Value-Based Purchasing (HVBP) Program, Hospital Readmissions Reduction Program (HRRP), and/or Hospital-Acquired Condition (HAC) Reduction Program, respectively, agree to have data publicly reported on [Hospital Compare](#). Hospitals voluntarily publicly reporting inpatient data on *Hospital Compare* with an Optional Public Reporting Notice of Participation have the option to withhold data from public reporting on [Hospital Compare](#), for those measures listed in **Table 1**.

Hospitals and other facilities participating in the Hospital IQR Program, Hospital OQR Program, PCHQR Program, IPFQR Program, ASCQR Program, HVBP Program, HRRP, and/or HAC Reduction Program can submit a request for CMS review to add a footnote to claims-based measure data included in public reporting on [Hospital Compare](#), for those measures listed in **Table 2**.

Request Form Submission Information

Please complete the applicable sections of this form and **fax or email the completed form** to the Hospital Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contractor via:

Secure fax:
1-877-789-4443

Email:
QRFormsSubmission@hsag.com.

Contact Information

All hospitals and facilities must provide the required contact information; required fields are marked with an asterisk (*).

Facility/Hospital Specifics

*Facility Name:	
*CMS Certification Number (CCN)/National Provider Identifier (NPI):	
*Street Address:	
*City, State, ZIP Code:	
*Facility Contact Name:	
*Facility Contact Phone Number:	

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Facility/Hospital Chief Executive Officer (or designee)

*Name:	
*Title:	
*Date:	
*Signature:	

Withholding/Footnoting Form

This section of the form provides the instructions for completing the withholding/footnoting form and is divided into subsections for those hospitals voluntarily participating in inpatient public reporting on *Hospital Compare* and those hospitals and facilities included in the Hospital IQR, Hospital OQR, PCHQR, IPFQR, ASCQR, HVBP, HRRP, and/or HAC Reduction Programs.

Hospitals Voluntarily Participating in Inpatient Public Reporting

The following information is applicable only to those hospitals *voluntarily participating* in inpatient public reporting on *Hospital Compare* with an Optional Public Reporting Notice of Participation.

This form must be received no later than **the last day of the applicable preview period**, for hospitals not participating in public reporting on *Hospital Compare* with an Optional Public Reporting Notice of Participation.

NOTE: Forms received after the end of the preview period will not be considered for that Hospital Compare release.

My hospital has reviewed its Preview Report. For this preview period, we wish to withhold from public reporting data submitted for the measure(s) as indicated below.

Hospitals voluntarily participating in inpatient public reporting on *Hospital Compare* with an Optional Public Reporting Notice of Participation may withhold any or all of the measures listed in the following table, by marking the Withhold column.

Table 1: Inpatient Measures for Withholding for Hospitals Voluntarily Participating in Public Reporting

Measure ID	Withhold	Measure ID	Withhold
IMM-2		PSI 3	
IMM-3/HCP		PSI 4	
ED-1b		PSI 6	
ED-2b		PSI 8	
MORT-30-AMI		PSI 9	
MORT-30-CABG		PSI 10	
MORT-30-COPD		PSI 11	
MORT-30-HF		PSI 12	
MORT-30-PN		PSI 13	
MORT-30-STK		PSI 14	

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Measure ID	Withhold	Measure ID	Withhold
READM-30-AMI		PSI 15	
READM-30-CABG		PSI 90	
READM-30-COPD		PC-01	
READM-30-HF		SEP-1	
READM-30-PN		HCAHPS	
READM-30-HOSPWIDE		HAI-1 (CLABSI)	
READM-30-HIP-KNEE		HAI-2 (CAUTI)	
COMP-HIP-KNEE		HAI-3 (SSI: Colon)	
EDAC-30-AMI		HAI-4 (SSI: Hysterectomy)	
EDAC-30-HF		HAI-5 (MRSA)	
EDAC-30-PN		HAI-6 (C. diff.)	
PAYM-30-AMI		PAYM-90-HIP-KNEE	
PAYM-30-HF		MSPB	
PAYM-30-PN			

Facilities Participating in Hospital IQR, OQR, PCHQR, IPFQR, ASCQR, HVBP, HRRP, and/or HAC Reduction Programs

The following form is intended to allow facilities to request a footnote be added to their data on the *Hospital Compare* website in the event that the facility identifies errors in their claims-based measure data during the preview or review and correction period. The footnote would be added to the data and would indicate that the facility has identified errors in their data. **NOTE:** *Forms received after the end of the applicable program-specific Preview Period or Review and Corrections Period will not be considered.*

My facility has reviewed its Preview Report and/or Review and Corrections Report. We wish to request CMS review to add a footnote to public reporting data calculated for the program(s) and measure(s) as indicated below.

Facilities may request CMS review to footnote any or all of the claims-based measures listed in the following table, by marking the Footnote column for the requested measure(s).

Table 2: Measures for Footnoting¹

Measure ID	Footnote	Measure ID	Footnote
MORT-30-AMI		PSI 10	
MORT-30-CABG		PSI 11	
MORT-30-COPD		PSI 12	
MORT-30-HF		PSI 13	
MORT-30-PN		PSI 14	
MORT-30-STK		PSI 15	
READM-30-AMI		PSI 90	
READM-30-CABG		MSPB	
READM-30-COPD		OP-8	
READM-30-HF		OP-9	
READM-30-HOSPWIDE		OP-10	
READM-30-PN		OP-11	
READM-30-HIP-KNEE		OP-13	

¹ Footnoting does not affect a facility's payment adjustment.

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Measure ID	Footnote	Measure ID	Footnote
COMP-HIP-KNEE		OP-14	
EDAC-30-AMI		OP-32	
EDAC-30-HF		FUH-7	
EDAC-30-PN		FUH-30	
PAYM-30-AMI		READM-30-IPF	
PAYM-30-HF		PCH-30	
PAYM-30-PN		PCH-31	
PAYM-90-HIP-KNEE		ASC-1	
PSI 3		ASC-2	
PSI 4		ASC-3	
PSI 6		ASC-4	
PSI 8		ASC-12	
PSI 9			

Justification

In order to review your request for footnoting of claims-based measures, you will need to submit the following information in the box below:

- Provide the number of claims that are impacted, including the encounter dates.
- Provide a description of the problem.
- Provide the plan to fix the claims in error.

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 12/31/2022)**. 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 Hospital Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contractor at (844) 472-4477.**