MassHealth Hospital Clinical Quality Incentive Program: Data Validation Re-evaluation Request

INSTRUCTIONS

Hospitals must complete and submit this form to request a re-evaluation of their original validation results using instructions in the Executive Office of Health and Human Services (EOHHS) Technical Specifications Manual. All required information must be included on this PDF fillable form.

HOSPITAL CONTACT INFORMATION

Hospital Name

_____

Mailing Address _____ City, State, Zip Code _____

Quality Contact Name _____ Phone Number _____ Email _____

Date of Request _____ Quarter Data Period _____ MassHalth Inpatient Provider ID _____

BASIS FOR RE-EVALUATION

Only hospitals that have not met an overall agreement rate (0.80) may request a re-evaluation of validation results on any quarter that fell below the threshold. Enter all required information applicable to each column header in the blank spaces provided below.

MEASURE DATA ELEMENT INFORMATION

MP Validation Control Number (Listed on case detail report) _____

Quality Measure ID Number _____

Data Element Name (Listed on case detail report) _____

Hospital Rationale (Explain the reason why the hospital's abstraction is correct. Information that was not contained in the original record submitted will not be considered as part of re-evaluation.)

MP Validation Control Number (Listed on case detail report) _____

Quality Measure ID Number _____

Data Element Name (Listed on case detail report) _____

Hospital Rationale (Explain the reason why the hospital's abstraction is correct. Information that was not contained in the original record submitted will not be considered as part of re-evaluation.)

MEASURE DATA ELEMENT INFORMATION (Continued)

MP Validation Control Number (Listed on case detail report) ______________________

Quality Measure ID Number ______________

Data Element Name (Listed on case detail report) __________________________

Hospital Rationale (Explain the reason why the hospital's abstraction is correct. Information that was not contained in the original record submitted will not be considered as part of re-evaluation.)

MP Validation Control Number (Listed on case detail report) ______________________

Quality Measure ID Number ______________

Data Element Name (Listed on case detail report) __________________________

Hospital Rationale (Explain the reason why the hospital's abstraction is correct. Information that was not contained in the original record submitted will not be considered as part of re-evaluation.)

MP Validation Control Number (Listed on case detail report) ______________________

Quality Measure ID Number ______________

Data Element Name (Listed on case detail report) __________________________

Hospital Rationale (Explain the reason why the hospital's abstraction is correct. Information that was not contained in the original record submitted will not be considered as part of re-evaluation.)

SUBMITTING YOUR REQUEST

Please submit the completed form with a typed cover letter via email to MassQEX Help Desk at Massqexhelp@telligen.com.

The hospital has 10 business days from the date of notification on their year-end validation results to submit the request. Please refer to the applicable version of EOHHS Technical Specifications Manual, Section 6, for details on how to submit your request.

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