Each year, CMS randomly selects hospitals to participate in the validation requirement for Inpatient and Outpatient Quality Reporting programs. The selection of the 800 inpatient hospitals takes place around May of each year, and the selection of the 450 hospitals for outpatient takes place around November. **The purpose of the validation process is to verify that the data abstracted by the hospitals are consistent and reproducible and that hospital reported rates are reliable.**

After the quarterly data submission deadlines have passed, CMS randomly identifies the validation records for each selected hospital. On approximately the last day of the data submission month, the Clinical Data Abstraction Center (CDAC) mails green (inpatient) or yellow (outpatient) record request forms for each of the selected records to the hospital’s designated Medical Records contact. The exact date that the copied records must be received by the CDAC will be noted on the green or yellow (as appropriate) request forms. Outpatient records will be due to the CDAC 45 days after the request date. Inpatient records will be due 30 days after the request date. **Please note the different due dates.**

Due to the sheer volume of records that must be abstracted by the CDAC, hospitals are not allowed to send records or additional documentation after the record has been received by the CDAC. This applies even if the wrong record is sent, if pages are missing or are illegible, etc. The CDAC will abstract every case with the documentation that the hospital originally sent.

For these reasons, it is critical that hospitals have a process for reviewing each of their records after they have been copied and prior to them being sent to the CDAC.

To pass validation, there must be ≥75% agreement on the comparison of individual measure outcomes between the hospital’s and the CDAC’s findings.

Validation quarters that will apply to the upcoming Annual Payment Update (APU) determinations are as follows:

- **Inpatient FY 2014 APU:** 4Q2011, 1Q2012, 2Q2012, and 3Q2012
- **Outpatient CY 2014 APU:** 2Q2012, 3Q2012, 4Q2012, and 1Q2013
- **Inpatient FY 2015 APU:** 4Q2012, 1Q2013, 2Q2013, and 3Q2012
- **Outpatient CY 2015 APU:** 2Q2013, 3Q2013, 4Q2013 and 1Q2014

**Best Practice and Recommended Steps Prior to Mailing Copied Records to CDAC**

1. Verify that the patient’s name, date of birth, admission date, and discharge date on each copied record match the CDAC request form.

   *The first step of the validation abstraction process is a comparison by the CDAC abstractor of the medical record copy against the identifiers listed on the green or yellow request form. The identifiers are those submitted by the hospital or its vendor to the QIO Clinical Data Warehouse, such as the patient’s name, date of birth, admission and discharge dates, social security number, medical record number, and/or account number.*

   *For further detail about validation requirements, please refer to the validation general information and validation resources at:*  
   
   https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2Fpage%2FQnetTier2&cid=1140537255912 (Inpatient Validation)  
   
   https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2Fpage%2FQnetTier2&cid=1228758729356 (Outpatient Validation)
Regardless of who copies your medical records (hospital medical records staff, independent copying services, etc.), ALL record copies should be carefully reviewed prior to mailing them to CDAC!

The critical point to keep in mind is that errors pertaining to missing documentation are not subject to appeal.

2. Verify that all documents are present; including, but not limited to:
   - Face Sheet (and ED Registration Sheet, if present)
   - ED documentation (including all physician and nursing documentation)
   - History & Physical and the Discharge Summary
   - Physician orders and progress notes
   - Nursing admission history and notes
   - MARS
   - Laboratory, radiology, and other ancillary services reports
   - Surgical care documents (i.e., anesthesia pre-op evaluation, anesthesia report, and perioperative report)
   - A signed consent form if the patient was involved in a clinical trial in which patients with the same condition as the measure set were being studied
   - Copies of electronic documentation that was accessible during admission or encounter, and used by the hospital abstractor during the abstraction process

3. Make sure that none of the pages were skewed during the copying process so that parts of the page were cut off or are illegible.

4. If you have any multiple-page documents that have a date written on at least one page of the set (e.g., on page 1 of 6), you are allowed to hand write the date on the remaining pages of that set so the CDAC will know which pages go with which date.
   - If you do this, we recommend you use red ink and include a note to the CDAC, informing them of what you have done.

5. Additional tips:
   - Consider having an abstractor review your records prior to mailing as they are most familiar with the location of the information needed for abstraction.
   - A report listing the records selected for validation is available on My QualityNet approximately one to two weeks after the green or yellow record request forms are mailed out.
     - To download this report:
       - Log in to MyQualityNet and go to the “Run Reports” section.
       - Select the “Hospital Validation Reports” category and click on “Case Selection Report.”
       - Click on your hospital name and the appropriate quarter.
       - Leave the report format as “PDF,” click on “Request Report,” and then on the “View Reports” tab near the top of the window to see the report.
       - After you have sent your records to the CDAC, you can re-run the Case Selection Report to verify that CDAC has received them.
       - Once the CDAC has logged them in, you will see the log-in date in the final “Record Received” column.