State of New Mexico Health Care Authority
Division of Health Improvement, District Operations Bureau

INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR) REQUEST

The information collected on this form is for use in the Independent informal Dispute Resolution (IIDR) process. IIDR is provided by 42 CFR §488.331 and 488.431 as required under §6111 of the Patient and Affordable Care Act of 2010. Completion of the form is not required by statute; however, all of the information must be provided, as described below, to request an IIDR following imposition by CMS of a Civil Monetary Penalty (CMP.) If you have questions about the completion of the form or the IIDR process, please email Review Office at HFLC.Review@hca.nm.gov.

1) Complete this form fully and submit with accompanying documentation and rationales to DOH within **ten (10) calendar days of receipt of the Enforcement Letter from CMS which imposes CMPs.** Use additional copies of the form if you need more space in any section. Return by mail, fax or email by deadline.
2) Failure to provide all the information and documentation as requested on this form will invalidate this IIDR request. Any materials received after Day 10 will **NOT** be considered.
3) Facility must submit **one copy of all supporting documents which has been properly redacted** (with coded identifiers replacing actual resident and facility identifiers) according to rules outlined in the IIDR policies and **a second copy which has not been redacted.**

To Be Completed by Facility Requesting Independent Informal Dispute Resolution				
Facility Name	Facility License number	Event ID Number	Date CMS-2567 received	Date CMS Letter received

Facility Address	City	Zip

Contact Name (Administrator/DON)	Phone number		Date IIDR Request Submitted

Yes No
☐ ☐ Has CMS imposed a civil monetary penalty (CMP) for this survey?
☐ ☐ Are any deficiencies being disputed for this survey cited at Scope and Severity level G or above? *(List **all** disputed deficiencies below)*
☐ ☐ Has an Informal Dispute Resolution (IDR) process been requested for any tags on this survey as well? Date requested: __ _____
☐ ☐ Are any NM State tags being disputed through an IDR process? *(The IDR process for State tags will continue but all Federal tags will be dropped from the IDR process. Be sure to re-submit all Federal tags still in dispute via this IIDR process.)* Date requested: _____

Please note: IIDR replaces any Informal Dispute Resolution (IDR) process in progress for disputed Federal tags from this survey. The IDR process for disputed NM State tags will continue and the Facility will receive separate notification of that outcome. This request effectively terminates any pending IDR for Federal tags.

REASON FOR REQUEST: Enter **all Federal tags** or codes being disputed and the **primary reason** for requesting IIDR (from the following list) in the space below. Enter only **one** reason here for each tag/code. Facilities may use the IIDR process to dispute the factual basis of the cited deficiencies. This process may not be used to challenge scope and severity of deficiencies, unless the scope and severity constitutes Substandard Quality of Care (SQC.)

01 Errors in Citation Details
02 Incorrect Scope (only if SQC)
03 Incorrect Severity (only if SQC)
04 Wrong Tag / Code
05 New Information Available
06 Code Interpretation
07 Other (explain)

Tag/Code	Scope and Severity	Reason for IIDR	Tag/Code	Scope and Severity	Reason for IIDR

ATTACHMENTS: In addition to this request form, a valid request shall include:

- **Attachment A –Brief IIDR Description:** A concise, written statement explaining why the facility believes each disputed deficiency should not be cited. Description should briefly make clear reference to each attachment supporting the facility's position and explain its relevance to the disputed deficiency. (Plans of correction are not reviewed as criteria to determine if a deficiency exists.)
- **Attachments B, C, D, etc -Supporting documentation** *(Please submit only documents that directly support your rationale.)*
  - Any attachments must be clearly labeled with an attachment letter (A,B, C, etc), a descriptive title and the deficiency(ies) to which it pertains.
  - The relevant sections of each attachment should be highlighted and briefly referenced in the Brief Description.
  - Please also indicate below whether attachments were provided to, or requested by, surveyors at the time of the survey
  - Completed Facility forms used in documentation should be specific to survey findings and their relevance explained in the Brief Description. Providing a blank form would not support that the form existed or was completed at the time of the survey.

Attachment	Descriptive Title	# of pages	Support for which Disputed Tag(s)/Code(s)?	Surveyor requested or received	
A	***IIDR Brief Description***	6	***All***	Yes	No
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐

RESIDENT COMMENTS: Federal Regulations (42 CFR 488.331 and 488.431) govern the IIDR process and require that the State provide an opportunity to provide written comments to any *involved resident* or the resident's representative. An *involved resident* is a resident who filed a complaint or was the subject of a complaint that led to a deficiency finding that is being disputed. **Please refer to the Resident Identification List from the survey and provide the most current contact information available for any and all sampled residents and their legal representatives.** Failure to do so may invalidate the IIDR request.
Please note that these comments will be part of a deliberative process and, as such, will not be subject to disclosure.

Yes ☐ No ☐ Were there any complaints investigated as part of this survey?

If there were any complaints investigated as part of this survey ("yes" above), you must provide the most current contact information available for any and all sampled residents and their legal representatives. Please refer to the Resident Identification List to identify which residents were sampled. Failure to provide this information in full may invalidate the IIDR request.
Please note: DHI may send each sampled resident a letter about the survey process. All letters to those still residing at the facility will be sent in a packet to the facility contact listed on this form for prompt delivery to the residents. Failure to deliver these letters, unopened, and notify the State agency of delivery within one (1) day of their receipt may terminate the IIDR.

Sampled Resident #1 (Current mailing address and phone)	**Sampled Resident #2** (Current mailing address and phone)	**Sampled Resident #3** (Current mailing address and phone)
Sampled Resident #1's Legal Representative (Current mailing address and phone) Relationship to Resident:	Sampled Resident #2's Legal Representative (Current mailing address and phone) Relationship to Resident:	Sampled Resident #3's Legal Representative (Current mailing address and phone) Relationship to Resident:
Sampled Resident #4 (Current mailing address and phone)	**Sampled Resident #5** (Current mailing address and phone)	**Sampled Resident #6** (Current mailing address and phone)
Sampled Resident #4's Legal Representative (Current mailing address and phone) Relationship to Resident:	Sampled Resident #5 's Legal Representative (Current mailing address and phone) Relationship to Resident:	Sampled Resident #6's Legal Representative (Current mailing address and phone) Relationship to Resident:
Attach additional pages as needed		

The parties requesting this IIDR understand that an independent entity will review each disputed tag and recommend whether to modify the tag, retain it or cite additional deficiencies. The State of NM Heath Facility Licensing and Certification Bureau will notify the facility and CMS of that independent recommendation and its own, final, decision regarding the disputed deficiencies. This process will be completed within 60 days of receipt of this completed, eligible request.

_____ _____
Authorized Facility Signature (Administrator) Date signed

_____
Printed Name & Title

Completed form plus both copies of attachments (redacted and not) must be submitted within 10 days of receiving notice from CMS of an opportunity for IIDR: Review Office, 2040 S Pacheco, 2nd Fl, Rm #206, Santa Fe, NM 87505 or fax Fax (505) 476-8980. For the option to submit the IIDR via email, please email your request to HFLC.Review@hca.nm.gov and we will send a secure email in which the IIDR can be attached and remain secure.

TO BE COMPLETED BY NM STATE SURVEY AGENCY			
Date Received	All required documentation submitted?	Request complete?	Involved Resident contact current?
CMP imposed?	Eligible for IIDR?	Federal citation number (s):	Event ID number:
State IDR continuing?	Date Sent to Independent Reviewer:	Date Due from Independent Reviewer:	Date of HFL&C IIDR Committee mtg: