

**Centers for Medicare & Medicaid Services (CMS)
PPS Exempt Cancer Quality Reporting (PCHQR)
Program
Measure Exception Form**

This exception must be renewed at least annually.

Specify the calendar year for Measure exception request(s).

* Indicates required fields

* **Measure Exception Information** (The exception(s) you are requesting must be selected.)

Select all that apply

<input type="checkbox"/> Surgical Site Infection (SSI) Select this option if the hospital performed a combined total of 9 or fewer colon surgeries and abdominal hysterectomies in the calendar year prior to the reporting year.	Calendar Year prior to Reporting Year <input style="width: 80px;" type="text"/> Number of Procedures Performed <input style="width: 80px;" type="text"/> Exclusion Requested for Calendar Year <input style="width: 80px;" type="text"/>
<input type="checkbox"/> Other (Please Describe) If additional space is required, please attach additional documentation <div style="border: 1px solid black; height: 150px; width: 100%;"></div>	Calendar Year prior to Reporting Year <input style="width: 80px;" type="text"/> Number of Procedures Performed <input style="width: 80px;" type="text"/> Exclusion Requested for Calendar Year <input style="width: 80px;" type="text"/>

Specified colon and abdominal hysterectomy surgical procedures:

Only hospitals that performed 9 or fewer of any of the specified colon surgeries **and** abdominal hysterectomies combined in the calendar year prior to the reporting year. The **NHSN Operative Procedure Category Mappings to International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) Codes** (Table 1 extract) is located on the *NHSN* website.

Facility Contact Information

*CMS Certification Number (CCN):	*Facility Name:
*CEO/Designee Last Name:	*CEO/Designee First Name:
*Title:	*CEO/Designee E-Mail Address:
*CEO/Designee Telephone Number:	Ext.:

Additional Comments

I hereby certify that the facility meets the exception criteria and therefore has no data to submit related to the specified measure(s)

Name _____

Position _____

Date _____

Complete and submit the Measure Exception via *My QualityNet* to “Global Exchange Groups”, “PPS-Exempt Cancer Hosp. QR Support”;

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 XXXX-XXXX. 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, Maryland 21244-1650.