

Centers for Medicare & Medicaid Services (CMS) Quality Reporting Program Extraordinary Circumstances Extension/Exemption (ECE) Request Form

A facility can request an extension of or exemption from various Quality Reporting requirements due to extraordinary circumstances beyond the control of the facility. Such circumstances may include (but are not limited to) natural disasters (such as a severe hurricane or flood), systemic problems with CMS data collection systems that directly affected the ability of facilities to submit data, or extreme circumstances preventing facilities from electronic clinical quality measure (eCQM) or electronic health record (EHR)-based reporting (e.g., extraordinary infrastructure challenges or vendor issues outside of the facility's control). To request an extension or exemption, please complete and submit this form. This form must be submitted **within 90 calendar days of the extraordinary circumstance for all programs, except the submission of eCQMs under the Hospital IQR Program, which has an ECE Request deadline of April 1st** following the end of the reporting period calendar year.

Asterisk (*) indicates required fields. All sections must be complete and specific in order for the CMS to consider the request.

***Dates**

*Date of Request _____ *Date of Extraordinary Circumstance _____

***Program(s) for Which Facility Is Requesting Extension/Exemption**

<input type="checkbox"/> Hospital Inpatient	<input type="checkbox"/> Hospital Inpatient - eCQM	<input type="checkbox"/> Inpatient Psychiatric Facility	<input type="checkbox"/> PPS-Exempt Cancer Hospitals	<input type="checkbox"/> Hospital Value-Based Purchasing
<input type="checkbox"/> Hospital-Acquired Condition Reduction	<input type="checkbox"/> Hospital Readmissions Reduction	<input type="checkbox"/> Hospital Outpatient	<input type="checkbox"/> Ambulatory Surgical Centers	<input type="checkbox"/> ESRD QIP

Note: Please refer to the *Federal Register* for program-specific rules on the availability of this extension/exemption.

***Facility Contact Information**

*Facility Name _____

*CMS Certification Number (CCN) _____

*National Provider Identifier Number (NPI) (ASC only) _____

(Place additional NPIs in Additional Comments section.)

***CEO/Designee Contact Information**

*Last Name _____ *First Name _____

*Address (must include physical street address) _____

*City _____ *State _____ *ZIP Code _____

*Telephone Number _____ Ext. _____ *Email Address _____

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Additional Contact Information

Last Name _____ First Name _____

Address (must include physical street address) _____

City _____ State _____ ZIP Code _____

Telephone Number _____ Extension _____ Email Address _____

Extension or Exemption Request Information

*Measure(s) affected (State "None" if not applicable) _____

*Submission quarter(s)/dates affected (State "None" if not applicable) _____

*Validation quarter(s)/dates affected (State "None" if not applicable) _____

*Date facility will restart data submission _____

***Provide justification for the submission restart date.**

***Enter specific reasons for requesting an extension or exemption. Please include the specific requirements or data that should be extended or exempted. Please indicate how the extraordinary circumstance negatively impacted performance on the measure(s) for which an extension/exemption is being sought (if applicable). Attach supporting documentation when necessary.**

***Provide evidence of the impact of the extraordinary circumstance including (but not limited to) photographs, web links, newspaper, and other media articles. Attach supporting documentation when necessary.**

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Additional Comments (Attach additional documentation/comments if necessary):

*CEO/Designee Signature: _____ *Date: _____

Extraordinary Circumstances Extension/Exemption Request Form Submission Instructions

Complete and submit this form via the *QualityNet Secure Portal*, Secure File Transfer “WAIVER EXCEPTION WITHHOLDING” group. If unable to submit via Secure File Transfer, please submit via e-mail to QRSupport@hcqis.org, secure fax to 877-789-4443, or mail to 3000 Bayport Drive, Suite 300, Tampa, FL 33607. The Support Contractor will forward, as directed, to CMS.

For ESRD QIP only, please complete and submit this form to the ESRD QIP mailbox at ESRDQIP@cms.hhs.gov.

Following receipt of the request form, CMS will: (1) Provide a written acknowledgement using the contact information provided in the request, to the CEO and any additional designated facility personnel, notifying them that the facility’s request has been received and (2) provide a formal response to the CEO and any additional designated facility personnel using the contact information provided in the request notifying them of our decision.

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**. 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 estimates(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 21244-1650.

Expiration Date: xx-xx-xxxx