

**Centers for Medicare & Medicaid Services (CMS)
Inpatient Prospective Payment System (IPPS) Quality Reporting Programs
Measure Exception Form for PC and HAI Data Submission**

NOTE: This Measure Exception Form must be renewed at least annually.

This Measure Exception Form may be used for the following measures: Perinatal Care (PC-01) and Healthcare-Associated Infections [Surgical Site Infection (SSI), Catheter-Associated Urinary Tract Infection (CAUTI), and Central Line-Associated Bloodstream Infection (CLABSI)]. This form is used by the following programs: Hospital Inpatient Quality Reporting (IQR), Hospital Value-Based Purchasing (VBP), and Hospital-Acquired Condition (HAC) Reduction.

Fields marked with an asterisk (*) are required.

Specify the applicable quarter(s) for the Measure Exception request(s).

***IPPS Measure Exception Information (select all that apply)**

Perinatal Care (PC-01): Elective Delivery Prior to 39 Completed Weeks Gestation

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Hospital has no Obstetrics Department and does not deliver babies.

Calendar Year (YYYY) _____

January 1 through March 31

April 1 through June 30

July 1 through September 30

October 1 through December 31

Specified Colon and Abdominal Hysterectomy Surgical Procedures

Only hospitals that performed nine or fewer of any of the specified colon and abdominal hysterectomy combined in the calendar year prior to the reporting year are eligible for the SSI Measure Exception.

SSI – Colon Surgery (SSI-Colon and SSI-Abdominal Hysterectomy)

Hospital performed a **combined total of nine or fewer colon surgeries and abdominal hysterectomies** in the calendar year prior to the reporting year.

Calendar Year prior to reporting year (YYYY) _____ Number of procedures performed _____

Exclusion requested for Calendar Year (YYYY) _____

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***Facility Contact Information**

*CMS Certification Number (CCN): _____

*Facility Name: _____

*CEO/Designee Last Name: _____

*CEO/Designee First Name: _____

*Title: _____

*CEO/Designee Email Address: _____

*CEO/Designee Telephone Number: ____ - ____ - ____ ext. _____

I hereby certify that the facility meets the exception criteria and therefore has no data to submit related to the PC, SSI, CLABSI, and/or CAUTI measures, as indicated on this form.

*Name: _____

*Position: _____

*Signature: _____

Submission Instructions

Complete and submit this form via email to QRSupport@hcqis.org, secure fax to 877-789-4443, or *QualityNet Secure Portal*, Secure File Transfer “WAIVER EXCEPTION WITHHOLDING” group.

Following receipt of this request form, CMS will provide an email acknowledgement that the request has been received.

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 (Expires: xx/xx/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, MD 21244-1850. ****CMS Disclosure**** **Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Hospital Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contractor at (844) 472-4477.**