A facility may request an exception, as specified by CMS, for quality reporting and value-based purchasing programs 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), issues with CMS data-collection systems that directly affected the ability of facilities to submit data, or extreme circumstances that prevent facilities from electronic clinical quality measure (eCQM) or electronic health record (EHR)-based reporting. Please refer to the *Federal Register* and *Code of Federal Regulations* for program-specific rules on availability of this exception. To request an exception, please complete and submit this form.

For events affecting the submission of data, this form must be submitted **within 90 calendar days of the extraordinary circumstance, except the submission of eCQMs under the Hospital Inpatient Quality Reporting Program, which has an ECE Request deadline of April 1** following the end of the reporting period. At the latest, you should submit your ECE no later than 90 days from the submission deadline for the quarter requested.

For events affecting the Hospital Value-Based Purchasing, Hospital Acquired-Condition Reduction, and Hospital Readmissions Reduction Programs, this form must be submitted **no later than 90 calendar days of the extraordinary circumstance.** At the latest, you should submit your ECE no later than 90 days from the last date of the quarter requested.

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

## \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## 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**

\*Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Address (must include physical street address) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Zip Code \_\_\_\_\_\_\_\_

\*Telephone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Extension \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Additional Contact Information**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (must include physical street address)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_ ZIP Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Extension\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Dates**

\*Date of Request \*Date of Extraordinary Circumstance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Program(s) and Program Requirement(s) for Which Facility is Requesting Exception**

Please indicate which program requirement(s) and quarter(s) were affected by the extraordinary circumstance.

| **Program** | **Measure and/or Program Requirement** | **Quarter(s)** |
| --- | --- | --- |
| Ambulatory Surgical Center Quality Reporting (ASCQR) Program | [ ]  Web-based measure(s)  |  |
| [ ]  COVID-19 Vaccination Among Healthcare Personnel (HCP) measure via National Healthcare Safety Network (NHSN) |  |
| [ ]  Other (Please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| End-Stage Renal Disease Quality Incentive Program (ESRD QIP) | [ ]  In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS) Survey |  |
| [ ]  National Healthcare Safety Network (NHSN) |  |
| [ ]  ESRD Quality Reporting System (EQRS)  |  |
| [ ]  Validation |  |
| [ ]  Other (Please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Hospital-Acquired Condition (HAC) Reduction Program | [ ]  NHSN Healthcare-associated infection (HAI) measure(s)  |  |
| [ ]  Validation |  |
| [ ]  Other (Please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Hospital Inpatient Quality Reporting (IQR) Program | [ ]  Chart-abstracted measure(s)  |  |
| [ ]  Electronic Clinical Quality Measures (eCQMs)  |  |
| [ ]  Hybrid measure(s) |  |
| [ ]  Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey |  |
| [ ]  Influenza Vaccination Among Healthcare Personnel (HCP) measure |  |
| [ ]  COVID-19 Vaccination Among Healthcare Personnel (HCP) measure |  |
| [ ]  Web-based measure(s)  |  |
| [ ]  Structural measure(s)  |  |
| [ ]  Population and Sampling |  |
| [ ]  Validation |  |
| [ ]  Other (Please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Hospital Outpatient Quality Reporting (OQR) Program | [ ]  Chart-abstracted measure(s)  |  |
| [ ]  Web-based measure(s)  |  |
| [ ]  COVID-19 Vaccination Among Healthcare Personnel (HCP) measure National Healthcare Safety Network (NHSN) |  |
| [ ]  Validation  |  |
| [ ]  Other (Please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Hospital Readmissions Reduction Program (HRRP) | [ ]  Other (Please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Hospital Value-Based Purchasing (VBP) Program | [ ]  Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey |  |
| [ ]  NHSN Healthcare-associated infection (HAI) measure(s) |  |
| [ ]  Other (Please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program | [ ]  Chart-abstracted measure(s)  |  |
| [ ]  COVID-19 Vaccination Among Healthcare Personnel (HCP) measure |  |
| [ ]  Other (Please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program | [ ]  Web-based measure(s)  |  |
| [ ]  Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey |  |
| [ ]  Influenza Vaccination Among Healthcare Personnel (HCP) measure |  |
| [ ]  COVID-19 Vaccination Among Healthcare Personnel (HCP) measure |  |
| [ ]  NHSN Healthcare-associated infection (HAI) measure(s) |  |
| [ ]  Other (Please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

# Exception or Extension Request Information

\*Date ECE relief would end

## \*Provide justification for the ECE end date.

**\*Enter specific reasons for requesting an exception. Please include the specific requirements or data for which you are seeking an exception. Please indicate how the extraordinary circumstance prevented your facility from submitting accurate data for the measure(s) for which an exception 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.**

**Additional Comments (Attach additional documentation/comments if necessary.)**

\*CEO/Designee Signature: \*Date:

# Extraordinary Circumstances Exceptions Request Form Submission Instructions

Complete and submit this form, via the *Hospital Quality Reporting Secure Portal*, Managed File Transfer to QRFormsSubmission@hsag.com. You may instead submit via email to QRFormsSubmission@hsag.com or secure fax to (877) 789-4443.

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. CMS will strive to complete its review of each ECE request within 90 calendar days of receipt of the request.

**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 15 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 Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contractor at (844) 472-4477.**