Centers for Medicare & Medicaid Service (CMS)
PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program
Measure Exception Form

Specify the Calendar Year for each National Healthcare Safety Network (NHSN) hospital-acquired infection (HAI) measure exception request(s).

(*) Indicates required fields.

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

Select all that apply:

___ 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 _____

Number of Procedures Performed _____

Exclusion Requested for Calendar Year _____

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, 10th Revision Clinical Modifications (ICD-10-CM) Codes** is located on the NHSN website.

___ Other (Please Describe)

If additional space is required, please attach additional documentation.

Calendar Year Prior to Reporting Year _____

Number of Procedures Performed _____

Exclusion Requested for Calendar Year _____

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Facility Contact Information

***CMS Certification Number (CCN):** _____

***Facility Name:** _____

***CEO/Designee Last Name:** _____

***CEO/Designee First Name:** _____

***CEO/Designee Title:** _____

***CEO/Designee E-Mail 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 specified measure(s):

***Name:** _____

***Position:** _____

***Date:** _____

Additional Comments:

Complete and submit the Measure Exception Form via email to QRFormsSubmission@hsag.com. Following receipt of the form, an email will be sent confirming the form has been received.

Paperwork Reduction Act (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 0938-1175. The expiration date is 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, Maryland 21244-1650.