

Centers for Medicare & Medicaid Services (CMS) Quality Program Extraordinary Circumstances Exceptions (ECE) Request Form

A facility can request an exception from CMS quality reporting and payment program 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), issues 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. 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. 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 1** following the end of the reporting period.

An 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 Exception**

- | | |
|---|---|
| <input type="checkbox"/> Ambulatory Surgical Centers Quality Reporting (ASCQR) Program
<input type="checkbox"/> End-Stage Renal Disease Quality Incentive Program (ESRD QIP)
<input type="checkbox"/> Hospital-Acquired Condition (HAC) Reduction Program
<input type="checkbox"/> Hospital Inpatient Quality Reporting (IQR) Program (includes eCQMs)
<input type="checkbox"/> Hospital Outpatient Quality Reporting (OQR) Program | <input type="checkbox"/> Hospital Readmissions Reduction Program (HRRP)
<input type="checkbox"/> Hospital Value-Based Purchasing (VBP) Program
<input type="checkbox"/> Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program
<input type="checkbox"/> PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program
<input type="checkbox"/> Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program |
|---|---|

***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 _____

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Additional Contact Information

Name _____ Title _____

Address (must include physical street address) _____

City _____ State _____ ZIP Code _____

Telephone Number _____ Extension _____

Email Address _____

Exception or Extension Request Information

*Data Submission Requirement(s) Affected – Please indicate which requirement(s) were affected by the extraordinary circumstance.

- | | |
|--|---|
| <input type="checkbox"/> Chart-abstracted measure(s) | <input type="checkbox"/> Influenza Vaccination Among Healthcare Personnel (HCP) measure |
| <input type="checkbox"/> Claims-based measure(s) | <input type="checkbox"/> Web-based measure(s) |
| <input type="checkbox"/> CrownWeb | <input type="checkbox"/> Structural measure(s) |
| <input type="checkbox"/> Electronic Clinical Quality Measures (eCQMs) | <input type="checkbox"/> Non-measure related requirement(s)
(Please specify below) _____ |
| <input type="checkbox"/> NHSN Healthcare-associated infection (HAI) measure(s) | |
| <input type="checkbox"/> Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey data | |

*Submission quarter(s)/dates affected _____

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

*Date facility will restart data submission _____

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

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***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 negatively impacted performance on 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: _____**

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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. If unable to submit via Managed File Transfer, please submit via email to QRFormsSubmission@hsag.com, 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.

For SNF VBP only, please complete and submit this form to the SNF VBP mailbox at SNFVBP@rti.org.

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 12/31/2022)**. 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 Hospital Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contractor at (844) 472-4477.**