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

A hospital or healthcare facility that has experienced an extraordinary circumstance(s) that affected the ability of the healthcare facility to comply with one or more applicable quality reporting and value-based purchasing program reporting requirements may submit this form to CMS **within 60 calendar days of the date the extraordinary circumstance occurred** (or by April 1st or June 15th following the end of the reporting year in which the extraordinary circumstance occurred for electronic clinical quality measures (eCQMs) for the Hospital Inpatient Quality Reporting Program and Hospital Outpatient Quality Reporting Program, respectively) to request an exception or extension for the requirement(s). An extraordinary circumstance is an event beyond the control of a healthcare facility (for example, a natural or man-made disaster such as a hurricane, tornado, earthquake, terrorist attack, or bombing, or issues with CMS-designated information systems that directly affect the ability of the facility to submit data).

CMS may grant either an exception or, if appropriate under the circumstances, an extension of time to comply with one or more reporting requirements indicated. Please refer to the *Federal Register* and *Code of Federal Regulations* for additional information regarding program-specific ECE policies.

Note: An ECE request form may be submitted for multiple programs, requirements, and/or reporting periods. CMS reviews ECE requests on a case-by-case basis. The **submission of an ECE request does not guarantee complete or partial approval.**

An asterisk (*) indicates required fields. All sections must be complete and specific for 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 _____

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***Program(s) and Program Requirement(s) for Which Facility is Requesting an ECE**

Please indicate which program requirement(s) and reporting period(s) for each requirement which you are requesting exception or extension for an extraordinary circumstance.

Program	Measure and/or Program Requirement	Reporting Periods
Ambulatory Surgical Center Quality Reporting (ASCQR) Program	☐ National Healthcare Safety Network (NHSN) Measures	
	☐ Web-based Measure(s)	
	☐ Patient-Reported Outcome-Based Performance Measure(s) (PRO-PMs)	
	☐ Outpatient and Ambulatory Surgical Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS)	
	☐ 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	☐ National Healthcare Safety Network (NHSN) Measures	
	☐ Validation	
	☐ Other (Please specify): _____	
Hospital Inpatient Quality Reporting (IQR) Program	☐ Chart-abstracted Measure(s)	
	☐ Electronic Clinical Quality Measures (eCQMs)	
	☐ Hybrid Measure(s)	
	☐ Patient-Reported Outcome-Based Performance Measure(s)	
	☐ Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey	
	National Healthcare Safety Network (NHSN) Measures ☐ Influenza Vaccination Coverage Among Healthcare Personnel ☐ Patient Safety Structural Measure ☐ CAUTI-Onc ☐ CLABSI-Onc	
	☐ Web-based Structural Measure(s)	

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	☐ Population and Sampling	
	☐ Chart-abstracted Validation ☐ eCQM Validation	
	☐ Other (Please specify): _____	
Hospital Outpatient Quality Reporting (OQR) Program	☐ Chart-abstracted Measure(s)	
	☐ Web-based Measure(s)	
	☐ National Healthcare Safety Network (NHSN) Measures	
	☐ Electronic Clinical Quality Measures (eCQMs)	
	☐ Patient-Reported Outcome-Based Performance Measure(s)	
	☐ Outpatient and Ambulatory Surgical Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS)	
	☐ 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)	
	☐ Severe Sepsis and Septic Shock Management Bundle (Composite Measure)	
	☐ Other (Please specify): _____	
Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program	☐ Chart-abstracted Measure(s)	
	☐ Web-based Measure(s)	
	☐ National Healthcare Safety Network (NHSN) Measure(s)	
	☐ Chart-abstracted Measure(s)	
	☐ Other (Please specify): _____	
Rural Emergency Hospital Quality Reporting (REHQR)	☐ Chart-abstracted Measure(s)	
	☐ Web-based Measure(s)	
	☐ Other (Please specify): _____	

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Program	Measure and/or Program Requirement	Reporting Periods
Program		
PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program	☐ Web-based Measure(s)	
	☐ Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey	
	☐ National Healthcare Safety Network (NHSN) Measure(s)	
	☐ Other (Please specify): _____	

ECE Request Information

*Date ECE relief would end _____

***Provide justification for the ECE end date and provide details if there are any reason(s) your healthcare facility may not be able to fully complete reporting requirements if an extension (versus an exception) is granted.**

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***Enter the specific requirement(s) or data for which you are seeking an ECE. Provide details as to how the extraordinary circumstance prevented your healthcare facility from complying with the reporting requirement(s) for the program(s) and/or requirement(s) for which this ECE is being sought.**

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

Provide any additional information you would like CMS to consider when assessing and determining your ECE request.

*CEO/Designee Signature: _____ *Date: _____

Extraordinary Circumstances Exception Request Form Submission Instructions

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

For ESRD QIP only, please complete and submit this form to the ESRD QIP mailbox at esrdqps-admin@arborresearch.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 12-31-2028)**. 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.**