

Quality ID #356: Unplanned Hospital Readmission within 30 Days of Principal Procedure
– National Quality Strategy Domain: Effective Clinical Care
– Meaningful Measure Area: Admissions and Readmissions to Hospitals

2019 COLLECTION TYPE:
MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:
Outcome – High Priority

DESCRIPTION:
Percentage of patients aged 18 years and older who had an unplanned hospital readmission within 30 days of principal procedure

INSTRUCTIONS:
This measure is to be submitted **each time** a surgical procedure listed in the denominator is performed during the performance period ending November 30th. There is no diagnosis associated with this measure. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Submission Type:
Measure data may be submitted by individual MIPS eligible clinicians, groups, or third party intermediaries. The listed denominator criteria are used to identify the intended patient population. The numerator options included in this specification are used to submit the quality actions as allowed by the measure. The quality-data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third party intermediaries that utilize this modality for submissions; however, these codes may be submitted for those third party intermediaries that utilize Medicare Part B claims data. For more information regarding Application Programming Interface (API), please refer to the Quality Payment Program (QPP) website.

DENOMINATOR:
Patients aged 18 years and older undergoing a surgical procedure

Denominator Criteria (Eligible Cases):
All patients aged 18 years and older

AND

Patient procedure during the performance period (CPT): 11004, 11005, 11006, 15734, 15920, 15931, 15933, 15940, 15950, 19306, 20100, 20101, 20102, 21811, 21812, 21813, 22904, 22905, 27080, 35221, 35251, 35281, 35840, 36565, 36566, 37617, 38100, 38115, 38120, 38530, 38531, 38564, 38765, 39501, 39540, 39541, 39560, 43122, 43279, 43281, 43282, 43286, 43287, 43288, 43325, 43327, 43330, 43332, 43333, 43336, 43337, 43340, 43500, 43501, 43502, 43510, 43520, 43605, 43610, 43611, 43620, 43621, 43622, 43631, 43632, 43633, 43634, 43640, 43641, 43644, 43645, 43651, 43652, 43653, 43772, 43773, 43774, 43775, 43800, 43810, 43820, 43825, 43830, 43831, 43832, 43840, 43843, 43845, 43846, 43847, 43848, 43850, 43860, 43865, 43870, 43880, 44005, 44010, 44020, 44021, 44025, 44050, 44055, 44110, 44111, 44120, 44125, 44126, 44127, 44130, 44140, 44141, 44143, 44144, 44145, 44146, 44147, 44150, 44151, 44155, 44156, 44157, 44158, 44160, 44180, 44186, 44187, 44188, 44202, 44204, 44205, 44206, 44207, 44208, 44210, 44211, 44212, 44227, 44300, 44310, 44312, 44314, 44316, 44320, 44322, 44340, 44345, 44346, 44602, 44603, 44604, 44605, 44615, 44620, 44625, 44626, 44640, 44650, 44660, 44661, 44680, 44700, 44800, 44820, 44850, 44900, 44950, 44960, 44970, 45000, 45020, 45110, 45111, 45112, 45113, 45114, 45116, 45119, 45120, 45121, 45123, 45126, 45130, 45135, 45136, 45395, 45397, 45400, 45402, 45540, 45550, 45562, 45563, 45800, 45805, 47010, 47015, 47100, 47120, 47122, 47125, 47130, 47300, 47350, 47360, 47361, 47362, 47370, 47380, 47400, 47420, 47425, 47460, 47480, 47564, 47570,

47600, 47605, 47610, 47612, 47620, 47711, 47712, 47715, 47720, 47721, 47740, 47741, 47760, 47765, 47780, 47785, 47800, 47801, 47900, 48000, 48001, 48020, 48100, 48105, 48120, 48140, 48145, 48146, 48148, 48150, 48152, 48153, 48154, 48155, 48500, 48510, 48520, 48540, 48545, 48547, 48548, 49000, 49002, 49010, 49020, 49040, 49060, 49062, 49084, 49203, 49204, 49205, 49215, 49255, 49320, 49322, 49323, 49402, 49425, 49429, 49553, 49557, 49561, 49565, 49566, 49900, 50205, 50500, 50740, 57305, 57307, 60200, 60254, 60270, 60540, 60545, 60650

NUMERATOR:

Inpatient readmission to the same hospital for any reason or an outside hospital (if known to the surgeon), within 30 days of the principal surgical procedure

Numerator Instructions:

INVERSE MEASURE - A lower calculated performance rate for this measure indicates better clinical care or control. The “Performance Not Met” numerator option for this measure is the representation of the better clinical quality or control. Submitting that numerator option will produce a performance rate that trends closer to 0%, as quality increases. For inverse measures, a rate of 100% means all of the denominator eligible patients did not receive the appropriate care or were not in proper control.

Numerator Options:

Performance Met:

Unplanned hospital readmission within 30 days of principal procedure (**G9310**)

OR

Performance Not Met:

No unplanned hospital readmission within 30 days of principal procedure (**G9309**)

RATIONALE:

This is an adverse surgical outcome, which is often a preventable cause of harm, thus it is important to measure and report. It is feasible to collect the data and produces reliable and valid results about the quality of care. It is useful and understandable to stakeholders. As highlighted earlier, this measure was developed in a collaborative effort by the American College of Surgeons and the American Board of Surgery. This measure addresses the National Quality Strategy Priorities, and was identified by an expert panel of physician providers to be a critical outcome for this procedure. This measure addresses a high-impact condition as it is one of the most common procedures performed in the U.S. The measure aligns well with the intended use. The care settings include Acute Care Facilities/Hospitals. Data are being collected in a clinical registry that has been in existence for over 5 years, with over 4000 current users. Thus, we are requesting consideration of this measure in the MIPS CQM reporting option. The level of analysis is the clinician/individual. All populations are included, except children. The measure allows measurement across the person-centered episode of care out to 30 days after the procedure whether an inpatient, outpatient, or readmitted. The measure addresses disparities in care. The risk adjustment is performed with a parsimonious dataset and aims to allow efficient data collection resources and data reporting. Measures have been harmonized when possible.

CLINICAL RECOMMENDATION STATEMENTS:

A modified-Delphi methodology using an expert panel of surgeons who are Directors of the American Board of Surgery identified this to be a critical outcome for this surgical procedure (Surgeon Specific Registry Report on Project for ABS MOC Part IV. Unpublished study by the American College of Surgeons in conjunction with the American Board of Surgery, 2011).

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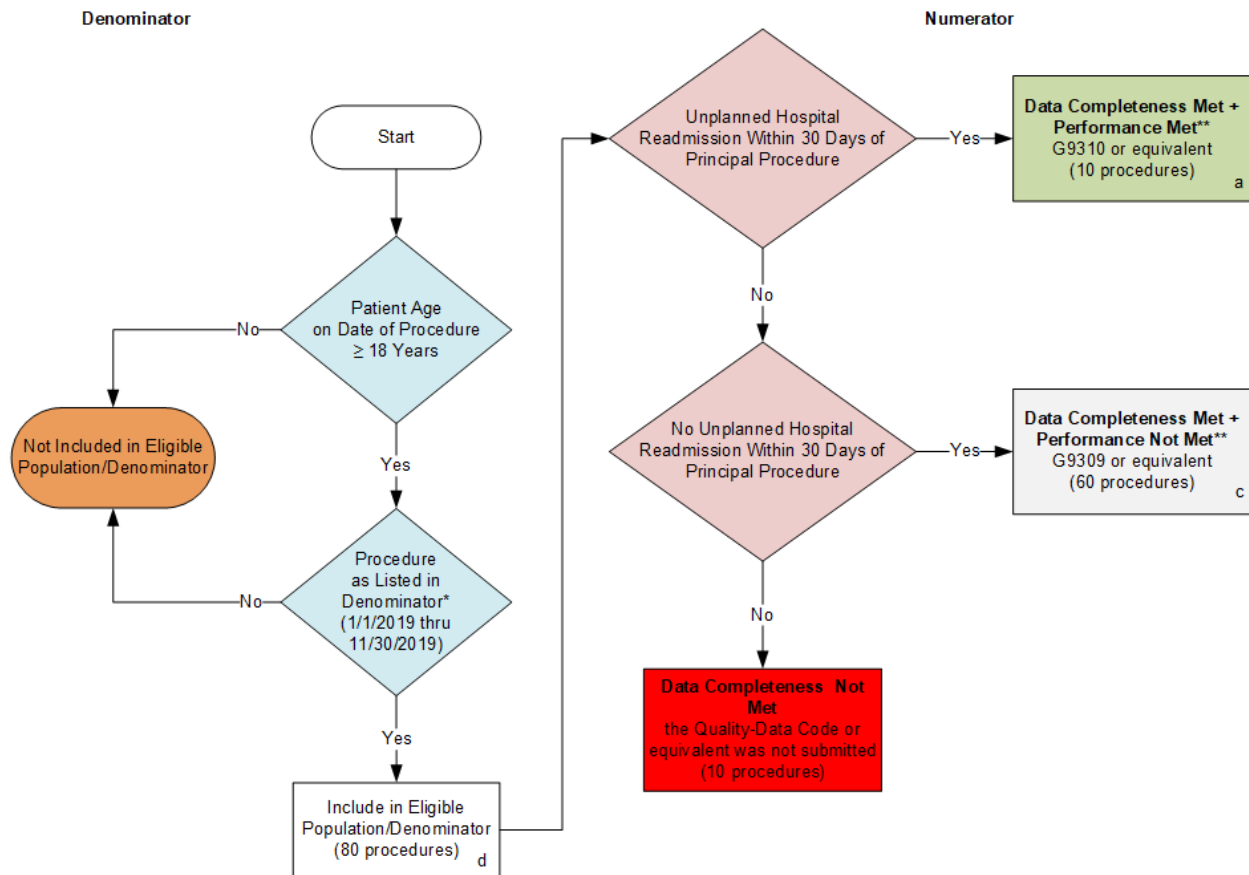
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2019 Clinical Quality Measure Flow for Quality ID #356: Unplanned Hospital Readmission within 30 Days of Principal Procedure



SAMPLE CALCULATIONS:

Data Completeness=

$$\frac{\text{Performance Met (a=10 procedures)} + \text{Performance Not Met (c=60 procedures)}}{\text{Eligible Population / Denominator (d=80 procedures)}} = \frac{70 \text{ procedures}}{80 \text{ procedures}} = 87.50\%$$

Performance Rate=**

$$\frac{\text{Performance Met (a=10 procedures)}}{\text{Data Completeness Numerator (70 procedures)}} = \frac{10 \text{ procedures}}{70 \text{ procedures}} = 14.29\%$$

*See the posted Measure Specification for specific coding and instructions to submit this measure.

**A lower calculated performance rate for this measure indicates better clinical care or control.

NOTE: Submission Frequency: Procedure

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The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

**2019 Clinical Quality Measure Flow Narrative for Quality ID #356:
Unplanned Hospital Readmission within 30 Days of Principal Procedure**

Please refer to the specific section of the Measure Specification to identify the denominator and numerator information for use in reporting this Individual Specification.

1. Start with Denominator
2. Check Patient Age:
 - a. If Patient Age is greater than or equal to 18 Years on Date of Procedure equals No during the measurement period, do not include in Eligible Population. Stop Processing.
 - b. If Patient Age is greater than or equal to 18 Years on Date of Procedure equals Yes during the measurement period, proceed to check Procedure Performed.
3. Check Procedure Performed:
 - a. If Procedure as Listed in the Denominator equals No, do not include in Eligible Population. Stop Processing.
 - b. If Procedure as Listed in the Denominator equals Yes, include in Eligible Population.
4. Denominator Population:
 - a. Denominator Population is all Eligible Procedures in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d equals 80 procedures in the Sample Calculation.
5. Start Numerator
6. Check Unplanned Hospital Readmission Within 30 Days of Principal Procedure:
 - a. If Unplanned Hospital Readmission Within 30 Days of Principal Procedure equals Yes, include in Data Completeness Met and Performance Met.
 - b. Data Completeness Met and Performance Met letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a equals 10 procedures in the Sample Calculation.
 - c. If Unplanned Hospital Readmission Within 30 Days of Principal Procedure equals No, proceed to check No Unplanned Hospital Readmission Within 30 Days of Principal Procedure.
7. Check No Unplanned Hospital Readmission Within 30 Days of Principal Procedure:
 - a. If No Unplanned Hospital Readmission Within 30 Days of Principal Procedure equals Yes, include in Data Completeness Met and Performance Not Met.
 - b. Data Completeness Met and Performance Not Met letter is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c equals 60 procedures in the Sample Calculation.
 - c. If No Unplanned Hospital Readmission Within 30 Days of Principal Procedure equals No, proceed to check Data Completeness Not Met.

8. Check Data Completeness Not Met:

- a. If Data Completeness Not Met, the Quality Data Code or equivalent was not submitted. 10 procedures have been subtracted from the Data Completeness Numerator in the Sample Calculation.

SAMPLE CALCULATIONS:

Data Completeness=

$$\frac{\text{Performance Met (a=10 procedures)} + \text{Performance Not Met (c=60 procedures)}}{\text{Eligible Population / Denominator (d=80 procedures)}} = \frac{70 \text{ procedures}}{80 \text{ procedures}} = 87.50\%$$

Performance Rate=**

$$\frac{\text{Performance Met (a=10 procedures)}}{\text{Data Completeness Numerator (70 procedures)}} = \frac{10 \text{ procedures}}{70 \text{ procedures}} = 14.29\%$$