Plan All-Cause Readmissions (PCR)

MEASURE DESCRIPTION

For persons 18 years of age and older, the risk-adjusted ratio of observed-to-expected unplanned acute readmissions for any diagnosis within 30 days of an acute hospitalization (index hospital stay or IHS). Acute hospitalizations and readmissions only include inpatient and observation stays. Multiple data elements may be calculated for various age and socioeconomic (SES) populations in this measure, including:

- Estimated Readmission Risk: Sum of all risk adjustment weights (observation stay, presence of surgery, principal discharge diagnosis, comorbidities, COVID-19 discharge, age and gender) associated with every IHS
- Expected 30-Day Readmissions: Sum of the estimated readmission risk for all IHS within 30 days of initial discharge
- Expected Readmissions Rate: Count of expected 30-day readmissions divided by the count of IHS
- Observed Readmission Rate: Count of observed 30-day readmissions divided by the count of IHS
- Observed-to-Expected (O/E) Ratio: Count of observed 30-day readmissions divided by the count of expected 30-day readmissions
    - O/E Ratio < 1.0 means that there were fewer unplanned readmissions than expected given the readmission risk of the population, indicating strong post-discharge and transitions of care
    - O/E Ratio = 1.0 means that the observed readmission rate matched the risk-adjusted expected rate of the population, indicating average performance
    - O/E Ratio > 1.0 means there were more unplanned readmissions than expected given the readmission risk of the population, indicating potential areas for improvement in post-discharge and transitions of care[1]

EXCLUSIONS

Persons, discharges, and readmissions are excluded if the following apply:

Exclusion	Time frame

Persons
• Hospice or use of hospice services
Acute inpatient or observation stay discharges
• Death during the inpatient stay
• Principal diagnosis of pregnancy or a condition originating in the perinatal period on the discharge claim
Acute readmissions for any diagnosis within 30 days of initial discharge
• Principal diagnosis of pregnancy or a condition originating in the perinatal period on the discharge claim
• Planned hospital stays with the following criteria on the discharge claim:
  ○ Principal diagnosis of maintenance chemotherapy
  ○ Principal diagnosis of rehabilitation
  ○ Organ transplant
• Potentially planned procedure without a principal acute diagnosis
	Any time during the measurement period

CODING[2]

For exclusions, use the appropriate code:

Pregnancy	
ICD10CM[3]	[Codes not individually listed due to high volume]
Perinatal conditions	
ICD10CM	[Codes not individually listed due to high volume]
Chemotherapy	
ICD10CM	Z51.0, Z51.11, Z51.12
Rehabilitation	
ICD10CM	Z44.001, Z44.002, Z44.009, Z44.011, Z44.012, Z44.019, Z44.021, Z44.022, Z44.029, Z44.101, Z44.102, Z44.109, Z44.111, Z44.112, Z44.119, Z44.121, Z44.122, Z44.129, Z44.30, Z44.31, Z44.32, Z44.8, Z44.9, Z45.1, Z45.31, Z45.320, Z45.321, Z45.328, Z45.41, Z45.42, Z45.49, Z45.811, Z45.812, Z45.819, Z46.82, Z46.89, Z46.9
Kidney transplant	
CPT® [4]	50360, 50365, 50380
HCPCS[5]	S2065
ICD10CM	0TY00Z0, 0TY00Z1, 0TY00Z2, 0TY10Z0, 0TY10Z1, 0TY10Z2
Bone marrow transplant	
ICD10CM	30230AZ, 30230C0, 30230G0, 30230G2, 30230G3, 30230G4, 30230U2, 30230U3, 30230U4, 30230X0, 30230X2, 30230X3, 30230X4, 30230Y0, 30230Y2, 30230Y3, 30230Y4, 30233AZ, 30233C0, 30233G0, 30233G2, 30233G3, 30233G4, 30233U2, 30233U3, 30233U4, 30233X0, 30233X2, 30233X3, 30233X4, 30233Y0, 30233Y2, 30233Y3, 30233Y4, 30240AZ, 30240C0, 30240G0, 30240G2, 30240G3, 30240G4, 30240U2, 30240U3, 30240U4, 30240X0, 30240X2, 30240X3, 30240X4, 30240Y0, 30240Y2, 30240Y3, 30240Y4, 30243AZ, 30243C0, 30243G0, 30243G2, 30243G3, 30243G4, 30243U2, 30243U3, 30243U4, 30243X0, 30243X2, 30243X3, 30243X4, 30243Y0, 30243Y2, 30243Y3, 30243Y4

TIPS FOR SUCCESS

Before or during acute inpatient/observation stay

- Connect with an Admission, Discharge, and Transfer (ADT) system as well as health plan ADT alerts; include ED visits, inpatient admissions/discharges, and facility transfers (SNF, IRF)
- Deploy transition care managers to support inpatient care and transition planning (e.g., reinforce care plan, coordinate post-discharge follow-up scheduling), especially for patients who are at high risk for readmissions
- Ask patients about issues that may have contributed to hospitalization and discuss how to prevent them
- Ask patients if they completed or scheduled prescribed outpatient workups or other services. This could include physical therapy, home health care visits, or obtaining durable medical equipment
- Develop a patient action plan for warning signs that their condition is worsening and how to respond
- Schedule a follow-up PCP or post-acute home visit appointment, as appropriate. Keep a few open appointments available so patients can be seen within 7 days of discharge

After acute inpatient/observation stay

- Implement a multi-disciplinary post-discharge process to track, monitor, and follow-up with patients
    - Review ADT reports at office opening, midday, and at end of day
    - Include a multi-disciplinary team (health coach, pharmacy, social work, behavioral health)
    - Stratify the population based on risk (e.g., readmission history, polypharmacy, social determinants of health, presence, or absence of family and social support), and re-stratify as needed after team review
- Outreach patients based on high risk (same day), medium risk (24-48 hours) and low risk (3 days)

- Discuss the discharge summary with patients and ask if they understand the instructions and medication list.; document and date the medication reconciliation in the patient's medical record and submit a claim with CPT II code 1111F or appropriate transitional care management code
- Obtain test results from when the patient was discharged and track tests that are still pending
- Conduct multi-disciplinary retrospective readmission reviews to understand opportunities for improvement

Note: Tip sheets are regularly reviewed and revised with pertinent technical specification updates from NCQA.

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[1] National Committee for Quality Assurance. HEDIS® Measurement Year 2026 Volume 2 Technical Specifications for Health Plans (2026), 388-404.
[2] This information is not intended as billing or legal guidance or for creating EMR extract files. These codes are proprietary and do not guarantee payment. Not all codes are included, and coding requirements may change. Each code should be used based on medical necessity and supported by proper documentation in the member record.
[3] ICD-10 created by the National Center for Health Statistics (NCHS), under authorization by the World Health Organization (WHO). Copyright WHO.
[4] CPT® is a registered trademark of the American Medical Association (AMA).
[5] HCPCS codes and descriptors are approved and maintained jointly by the alpha-numeric editorial panel (consisting of Centers for Medicare & Medicaid Services, America's Health Insurance Plans, and the Blue Cross Blue Shield Association).