2025 Star Measure Tips


One in a series of tip sheets that look at key Healthcare Effectiveness Data and Information Set measures, commonly referred to as HEDIS® measures.

# Plan All-Cause Readmissions (PCR)

Effectiveness of Care HEDIS® Measure

## Measure description

The percentage of patients that were readmitted to the hospital within 30 days of discharge.

## Measure population (denominator)

Patients 18 years and older who had an acute inpatient or observation stay with a discharge on or between January 1 and December 1 of the measurement year.

- This measure is based on discharges.
- Patients may appear in the denominator more than once.
- Includes acute discharges from any type of facility.

### *Did you know?*

- Unplanned readmissions are associated with increased mortality and higher health care costs.
- Readmissions can be prevented by standardizing and improving coordination of care after discharge and increasing support for patient self-management.

## Measure compliance (numerator)

The number of patients who had an unplanned acute readmission for any diagnosis within 30 days following an acute discharge.

## Exclusions

- Diagnosed with pregnancy or a condition originating in the perinatal period
- Received hospice services anytime during the measurement year
- Deceased during the hospital stay

*continued*

## Helpful HEDIS hints

- Keep open appointments so patients who are discharged from the hospital can be seen within seven days of discharge.
  - If patients have not scheduled their discharge follow-up appointment, reach out and schedule an appointment within seven days of discharge or sooner as needed.
  - Request patients bring all prescriptions, over-the-counter medications and supplements to the post-discharge visit, and complete the medication reconciliation.
- Connect with your state's automated electronic admission, discharge and transfer (ADT) system to receive admission, discharge and transfer notifications for your patients. Michigan Health Information Network (MiHIN). **https://mihin.org/**
- Perform transitional care management for recently discharged patients.
- Consider implementing a post-discharge process to track, monitor and follow up with patients.
  - Obtain and review all discharge summaries.
  - Obtain any test results that were not available when patients were discharged and track tests that are still pending.
  - Discuss the discharge summary with patients and ask if they understand the instructions and filled the new prescriptions.
- Complete a thorough medication reconciliation and ask patients or caregivers to recite the care plan back to you to demonstrate understanding.
- Document and date the medication reconciliation in the outpatient medical record.
- Ask about barriers or issues that might have contributed to patients' hospitalization and discuss how to prevent them in the future
- Ask patients if they completed or scheduled prescribed outpatient workups or other services. This could include physical therapy, home health care visits and obtaining durable medical equipment.
- Develop an action plan for chronic conditions. The plan should include what symptoms would trigger the patient to:
  - Start as-needed or PRN medications
  - Call their doctor (during or after office hours)
  - Go to the emergency room

## Tips for coding

- TCM codes can be billed as early as the date of the face-to-face visit and do not need to be held until the end of the service period to be submitted on a claim.
- Document and date the medication reconciliation in the outpatient medical record.
  - Submit an 1111F claim as soon as the reconciliation is complete. It is not necessary to wait for all components of TCM or care planning services to be met.

## Resources


1. John Hopkins Medicine. 2024. "Hospital Readmissions." **hopkinsmedicine.org/patient-safety/readmissions**
2. Centers for Medicare and Medicaid Services (CMS). 2024. "Hospital Readmissions Reduction Program (HRRP)." **cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program**