

## Quality ID #356: Unplanned Hospital Readmission within 30 Days of Principal Procedure

### 2026 COLLECTION TYPE:

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) CLINICAL QUALITY MEASURE (CQM)

### MEASURE TYPE:

Outcome – High Priority

- ***INVERSE MEASURE: LOWER SCORE – BETTER***

### DESCRIPTION:

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

### INSTRUCTIONS:

#### Reporting Frequency:

This measure is to be submitted each time a denominator eligible procedure as defined in the denominator criteria is performed.

#### Intent and Clinician Applicability:

This measure is intended to reflect the quality of services provided for patients who undergo an operative procedure. 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 Strata and Performance Rates:

This measure contains one strata defined by a single submission criteria.

This measure produces a single performance rate.

#### Implementation Considerations:

For the purposes of MIPS implementation, this procedure measure is submitted each time a procedure is performed for the performance period. There is no diagnosis associated with this measure.

Include only patients that have procedures through **November 30th** of the performance period. This will allow the evaluation of at least 30 days after the surgical procedure within the performance period.

This is an inverse measure which means 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.

#### Telehealth:

**NOT TELEHEALTH ELIGIBLE:** This measure is not appropriate for nor applicable to the telehealth setting. This measure is procedure based and therefore doesn't allow for the denominator criteria to be conducted via telehealth. It would be appropriate to remove these patients from the denominator eligible patient population. Telehealth eligibility is at the measure level for inclusion within the denominator eligible patient population and based on the measure specification definitions which are independent of changes to coding and/or billing practices.

#### Measure Submission:

The quality data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third party intermediaries that utilize this collection type for submissions; however, these codes may be submitted for those third party intermediaries that

utilize Medicare Part B claims data. The coding provided to identify the measure criteria: Denominator or Numerator, may be an example of coding that could be used to identify patients that meet the intent of this clinical topic. When implementing this measure, please refer to the 'Reference Coding' section to determine if other codes or code languages that meet the intent of the criteria may also be used within the medical record to identify and/or assess patients. 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, 15778, 15920, 15931, 15933, 15940, 15950, 19306, 20100, 20101, 20102, 21601, 21602, 21603, 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, 43497, 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, 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, 49013, 49014, 49020, 49040, 49060, 49062, 49084, 49186, 49187, 49188, 49189, 49190, 49215, 49255, 49320, 49322, 49323, 49402, 49425, 49429, 49553, 49557, 49596, 49616, 49617, 49618, 49621, 49622, 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** – see Implementation Considerations.

**Numerator Options:**

**Performance Not Met:**

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

**OR**

**Performance Met:**

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

**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 produce reliable and valid results about the quality of care. It is useful and understandable to stakeholders. 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 10 years, with over 5500 current, active 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. The measure has 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).

**REFERENCES:**

There are no sources in the current document.

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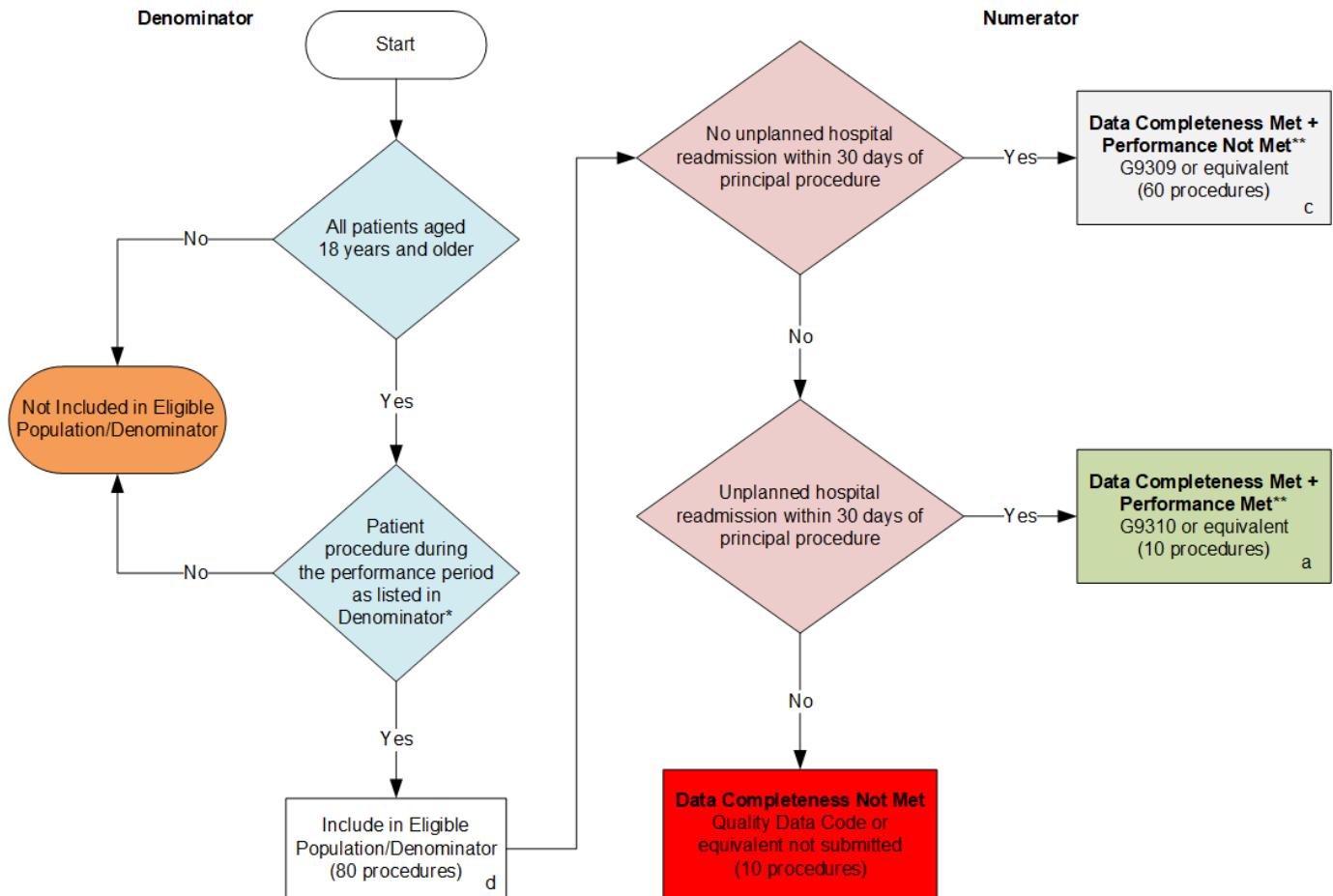
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**2026 Clinical Quality Measure Flow for Quality ID #356:  
Unplanned Hospital Readmission within 30 Days of Principal Procedure**  
**INVERSE MEASURE: LOWER SCORE - BETTER**

**Disclaimer:** Refer to the measure specification for specific coding and instructions to submit this measure.



**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.

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**2026 Clinical Quality Measure Flow Narrative for Quality ID #356:**  
**Unplanned Hospital Readmission within 30 Days of Principal Procedure**  
**INVERSE MEASURE: LOWER SCORE - BETTER**

***Disclaimer:** Refer to the measure specification for specific coding and instructions to submit this measure.*

1. Start with Denominator
2. Check *All patients aged 18 years and older*:
  - a. If *All patients aged 18 years and older* equals No, do not include in Eligible Population/Denominator. Stop processing.
  - b. If *All patients aged 18 years and older* equals Yes, proceed to check *Patient procedure during the performance period as listed in Denominator\**.
3. Check *Patient procedure during the performance period as listed in Denominator\**:
  - a. If *Patient procedure during the performance period as listed in Denominator\** equals No, do not include in Eligible Population/Denominator. Stop processing.
  - b. If *Patient procedure during the performance period as listed in Denominator\** equals Yes, include in Eligible Population/Denominator.
4. Denominator Population:
  - 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 *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\*\**.
    - *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.
  - b. If *No unplanned hospital readmission within 30 days of principal procedure* equals No, proceed to check *Unplanned hospital readmission within 30 days of principal procedure*.
7. 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\*\**.
    - *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.
  - b. If *Unplanned hospital readmission within 30 days of principal procedure* equals No, proceed to check *Data Completeness Not Met*.

8. Check *Data Completeness Not Met*:

- 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 equals Performance Met (a equals 10 procedures) plus Performance Not Met (c equals 60 procedures) divided by Eligible Population / Denominator (d equals 80 procedures). All equals 70 procedures divided by 80 procedures. All equals 87.50 percent.

Performance Rate\*\* equals Performance Met (a equals 10 procedures) divided by Data Completeness Numerator (70 procedures). All equals 10 procedures divided by 70 procedures. All equals 14.29 percent.

\*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

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.