Select Health Quality Provider Program

Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)

2026 Quality Measure Reference Guide

What's Inside

Related Quick Links

- Adult/Pediatric Primary Care Measures Quick Guide
- Report Hub Instructions: Basic User
- Formatting a Gaps List in Excel
- Demographic Allowable Corrections
- Quality Data Correction (QDC) Tool: Submitting Corrections

Select Health

This measure is included in the Primary Care Quality Provider Program.

Measure Description

Description	The percentage of emergency department (ED) visits for Select Health members 18 years of age and older with multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit
Denominator	The eligible population for this measure includes Medicare members 18 years old and older with multiple, high-risk chronic conditions who visit an ED on or between January 1 and December 24 of the measurement year. **Note that:** • Included events are those where patients are diagnosed with 2 or more of these conditions (determined by ICD 10 codes in claims data) during the prior or current measurement year.* • Each condition listed below is an eligible chronic condition. **NOTE**: Chronic obstructive pulmonary disease (COPD) and asthma are considered the same chronic condition: — Chronic respiratory conditions (e.g., COPD, asthma, or emphysema) — Depression — Alzheimer's disease and other dementia-related disorders — Heart failure • Diagnoses must be documented on 2 different dates of service. Visits must be for the same eligible chronic condition during the measurement year or the year prior to the measurement year, but prior to the ED visit.
Numerator	Members in the denominator must have a follow-up service on or within 7 days of the ED visit (8 total days) via: • A case management visit • Monitored electroconvulsive therapy in an outpatient, ambulatory surgical, community mental health, or partial hospitalization setting • Transitional care management services • An outpatient, telephone, or telehealth visit, including those for behavioral health services in a clinic, at home, or at a community mental health center • Complex care management services • An intensive outpatient encounter or partial hospitalization, including observation visits • An e-visit or virtual check-in • Initiation and engagement of alcohol and other drug abuse or dependence treatment (IET) stand-alone visits **NOTE**: FMC is an event-based measure. For each ED visit, there will be a care opportunity that needs to be addressed.
Intake/Measurement Periods	**January 1** through **December 31** of the measurement year

Continued on page 3...

Measure Description, Continued

Exclusions	• Any ED visit resulting in an inpatient admission on the day of, or within 7 days following, the ED visit regardless of the principal diagnosis for admission • ED visits occurring within the same 8-day period (e.g., an ED visit on April 1 is in scope, but subsequent visits occurring April 2–8 are not. If the same patient visits an ED on April 9, this would be a new event requiring follow up).
Allowable Corrections	Unaccounted for follow-up service. Transitional care management, case management, and complex care management visits must include detailed evidence of patient interaction. Documentation of visit must include some or all of the following: • Thorough and diagnosis-appropriate mental health assessment • Review of medication list and medication side effects • Physical exam findings • Compliance with documentation and prescribed treatment • Discharge summary review, verifying understanding of instructions and that all new prescriptions were filled • Questions/concerns the member or caregiver may have **NOTE**: Documentation example, "...contacted patient after ED visit, no questions," will not meet criteria.

* Access the online **FMC Coding Reference** for more information.

Allowable Corrections

General Guidance

- Include a copy of EHR note, progress note, or screen print signed by MA/RN/MD including member name, DOB, and provider.
- Submit corrections using **this online tool**.
- Wait 6 weeks from the date of service to enter corrections to allow for claim lag.
- Don't attach multiple patient records to a single correction.
- Each date of service requires separate correction entries, except for kidney health evaluation and the immunization measures.

FOLLOW UP AFTER ED VISIT FOR PEOPLE WITH MULTIPLE HIGH-RISK CHRONIC CONDITIONS (FMC)				
Allowable Correction	**Submission Correction Process**			
	Category	**Measure**	**Component**	**Correction Type(s)**
Unaccounted for follow-up service	Care Coordination	FMC Follow Up After ED w/ Multiple High-Risk Chronic Conditions	FMC Numerator	• Case management • Complex care management • Telephone visit • Substance use disorder services
Additional Required Documentation (see "General Guidance" for standard requirements)			**Notes for Entering Corrections**	
Visit documentation must include date of follow-up service and some/all the following:* • Thorough and diagnosis-appropriate mental health assessment • Review of medication list and medication side effects • Physical exam findings • Compliance with documentation and prescribed treatment • Review discharge summary; verify understanding of instructions and that all new prescriptions were filled. • Questions/concerns the member or caregiver may have, etc.			Follow-up services can be completed by: • Outpatient, phone, or virtual check-in • Transitional care management, care management, or complex care management services • Behavioral health visit as outpatient or via telehealth • Substance use disorder service or substance abuse counseling and surveillance	

* Documentation example that will not meet criteria: "Contacted patient after ED visit; no questions."

Access guidance for general corrections to demographics.

Frequently Asked Questions

The percentage of emergency (ED) visits for members 18 years of age and older who have multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit. There are 8 days total to include visits that occurred on the day of the ED visit.

Q: Why does this measure matter?

A: Timely follow-up after ED visits for this population:

- Improves cross-continuum provider collaboration
- Mitigates communication lapses between the ED and outpatient providers
- Helps assess the reasons for emergency care, the outcome of the visit, and any changes to the treatment plan

Q: What is Select Health doing to help?

A: Select Health promotes this follow up by:

- Providing care management services to help members manage chronic health conditions, such as COPD, heart failure, and atrial fibrillation. Members can self-refer to the program in addition to provider referrals. Contact care management at **800-442-5305**.
- Publishing an article in Provider Insight newsletter highlighting the measure specifics.
- Educating members via the Medicare member newsletter about the FMC measure and responding to frequently asked questions.

Q: What are best practices for this measure?

A: Best practices include:

- Contact members upon receipt of the ED discharge notification and schedule a post-ED follow-up visit within 2–5 days after discharge. The follow-up visit can be on the same day as the ED visit. Be sure to:
  - Develop outreach internal team and/or assign care/case managers to members to ensure they keep follow-up appointments or reschedule missed appointments.
  - Set flags, if available in the electronic health record (EHR), or develop a patient tracking method for those who may need screenings and follow-up visits.
- Discuss the discharge summary; verify understanding of instructions and if all new prescriptions were filled.
- Complete a thorough medication reconciliation with the members and/or caregiver.
- Educate members on the importance of regular follow up with their primary health care provider to manage their chronic condition(s).

Continued on page 6...

ELIGIBLE CHRONIC CONDITION DIAGNOSES

Members aged 18 or older on the date of the ED visit who:

- Have 2 or more eligible chronic conditions (as listed below) that were diagnosed prior to the visit
  - COPD, asthma, unspecified bronchitis (NOTE: COPD and asthma are considered the same chronic condition)
  - Alzheimer's disease and related disorders
  - Chronic kidney disease
  - Depression
  - Heart failure (chronic heart failure; heart failure diagnosis).
  - Acute myocardial infarction (MI value set; old myocardial infarction).
  - Atrial fibrillation
  - Stroke and transient ischemic attack (visit with a principal diagnosis of encounter for other specified aftercare not included)
- Visited the ED on or between January 1 and December 24 of the measurement year

Frequently Asked Questions , Continued

- Submit claims in a timely manner, and include the appropriate codes for diagnoses, health conditions, and the services provided.
- Keep open appointments so that patients with an ED visit can be seen within 7 days of their discharge. (In addition to an office visit, follow up could be provided via a telehealth, telephone, e-visit or virtual visit.)
- Encourage patients to call primary care physician's (PCP's) office/after-hours line when condition changes (e.g., weight gain, medication changes, high/low blood sugar readings).

Q: What types of visits meet criteria for follow-up?

A: Visit types that meet criteria include:

- An outpatient visit, telephone visit, e-visit or virtual check-in
- Transitional care management services
- Case management visits
- Complex care management services
- An outpatient or telehealth behavioral health visit with outpatient point of service (POS)
- An outpatient or telehealth behavioral health visit
- An intensive outpatient encounter or partial hospitalization with Partial Hospitalization POS
- An intensive outpatient encounter or partial hospitalization
- A community mental health center visit with community mental health center POS
- Electroconvulsive therapy with ambulatory surgical center, community mental health center POS, outpatient POS, or partial hospitalization POS
- A telehealth visit with telehealth POS
- A substance use disorder service or substance abuse counseling and surveillance

Working Your Open Gaps List

STEP 1
Create a current gaps-in-care list: 1. Open your "Gaps-in-Care for Download" report: **QPP Report Hub.** 2. Apply these filters: — **Super clinic:** Choose your clinic. — **Measure:** Click on "F/U After ED Visit for People with High-Risk Chronic Conditions (FMC)" — **Status:** Unclick "Compliant" box; this will filter for only the achievable and non-compliant members. 3. In the drop-down menu on the top right side of the page, change the view from "**Member**" to "**Download.**" 4. Follow the instructions on the screen to export the data to Excel. 5. Refer to **Report Hub Instructions: Basic User.**
STEP 2
Format your Excel export. (Refer to **Formatting a Gaps List in Excel**.)
STEP 3
Review tips for working your gaps-in-care list (**page 8**).

Measure Information

Studies show that communication challenges and adverse health outcomes persist because hospitals, including ED providers, fail to send medical records to patients' outpatient providers upon admission and following discharge.[1,2]

NOTE: Examples used in this document are for instructional purposes only; the dates that appear are only representative of what a user might see.

Timely follow-up visits are important for assessing the reasons for emergency care, the outcome of the visit, and any changes to the treatment plan.

This measure assesses the percentage of emergency department (ED) visits between January 1 and December 24 of the measurement year for patients ages 18 and older who have multiple high-risk chronic conditions and who had a follow-up service within 7 days of the ED visit (8 days total).

For this measure:

- The "Qualified Date" (date of ED visit) is when the measurement period begins.
- The measurement end date is 7 days from discharge date, which is noted in the "Compliance Date" and "Status Detail" (indicated by "To Be Complete") columns as noted in the sample screen shot at right.
- Any visit occurring before or after these dates will NOT count as compliance for this measure.

Measure Name	Qualified Date	Compliance Date	Status	Measure Instructions
F/U After ED Visit for People with High-Risk Multiple Chronic Conditions (FMC)	MM/DD/YYYY	MM/DD/YYYY	Compliant	Member completed follow-up visit.
F/U After ED Visit for People with High-Risk Multiple Chronic Conditions (FMC)	MM/DD/YYYY	MM/DD/YYYY	Compliant	Member completed follow-up visit.
F/U After ED Visit for People with High-Risk Multiple Chronic Conditions (FMC)	MM/DD/YYYY		Missed	Member did not complete follow-up visit by MM/DD/YYYY
F/U After ED Visit for People with High-Risk Multiple Chronic Conditions (FMC)	MM/DD/YYYY		Missed	Member did not complete follow-up visit by MM/DD/YYYY
F/U After ED Visit for People with High-Risk Multiple Chronic Conditions (FMC)	MM/DD/YYYY	MM/DD/YYYY	Compliant	Member completed follow-up visit.

Continued on page 8...

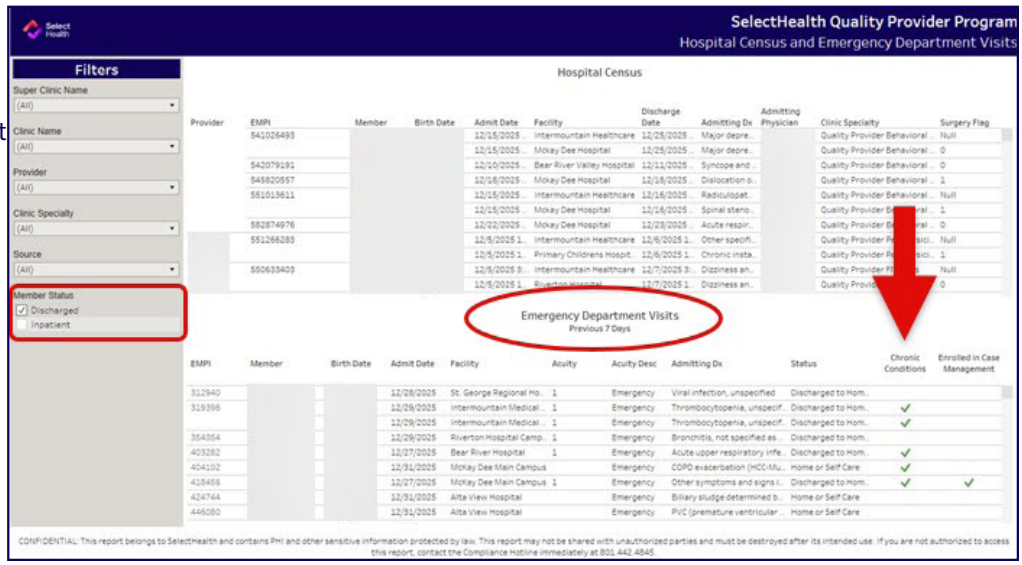
Working Open Gaps List, Continued

Tips for Working your Gaps-in-Care List

1. **Filter your list to display only achievable. Note that:**
   - **If follow-up visits are NOT scheduled** and if they are still within compliance time frame for the 7-day follow-up visits, schedule the FMC visit before the measure end date.
   - **If remaining visits are NOT scheduled** and will fall out of measure compliance, please still follow your clinic's process to schedule the FMC visit for best patient care practice.
   - **If the status states, "Missed,"** and a member did not complete a follow-up visit within the 7-day time frame, review and identify which barriers were present and work with clinic teams to identify process improvement opportunities.

FMC measures allow for day of discharge visits, giving this measure 8 days to close the gap.

2. **Use the Hospital Census and Emergency Department Visits report** (updated daily) as a resource to assist with scheduling timely appointments after a member is discharged from the ED. On the chart below, note that:
   - Members with a green check mark in the Chronic Conditions section of the ED Visit section are members that fall into the FMC measure.
   - Best practice is to run this report 1–2 times a week, create a list of members to call, and schedule follow-up appointments within the 7-day time frame.
   - Members with a green check mark in the Enrolled in Case Management section are currently receiving and being monitored by the Care Management team through Select Health. It is advised that if a member has multiple high-risk chronic conditions and is not enrolled in CM services, that a referral is made to the SH Care Management team.



To run the Hospital Census and Emergency Department Visits report:*

1. Open your Gaps-in-Care for Download report: QPP Report Hub.
2. Choose "Hospital Census."
3. Apply the super clinic filter (choose your clinic), and click "Apply."

Corrections Pro Tip

Please wait 6 weeks from the date of service before determining if a correction is needed. This allows time for claims to be processed, ultimately ensuring that only needed corrections are submitted.

*The Hospital Census and Emergency Department Visit report is currently unavailable for Nevada and Idaho.

Continued on page 9...

Working Open Gaps List, Continued

Learn More

Refer to the **Quality Data Correction (QDC) Tool: Submitting Corrections** for more information.

References

1 Dhaliwal JS, Dang AK. Reducing Hospital Admissions. [Updated 2024 Jun 7]. In: *StatPearls* [Internet]. Treasure Island (FL): StatPearls Publishing;
2025 Jan. Available from: **https://www.ncbi.nlm.nih.gov/books/NBK606114/**. Accessed January 29, 2026.

2 National Library of Medicine. Methods and effectiveness of communication between hospital allied health and primary care practitioners:
A systematic narrative review. *J Multidiscip Healthc.* 2021 Feb 22;14:493-511.

Resources:

Centers for Medicare and Medicaid Services. *2024 Medicare-Medicaid Plan Performance Data Technical Notes.*
CMS.gov website. [Updated March 2024]. **https://www.cms.gov/files/document/mmpperformancedatatechnotes.pdf**. Accessed January 12, 2026.

Johns Hopkins Medicine: Johns Hopkins Health Plans. *HEDIS®: General Guidelines and Measure Descriptions.* **hopkinsmedicine.org.website**. Updated March 31, 2025. **https://www.hopkinsmedicine.org/johns-hopkins-health-plans/providers-physicians/health-care-performance-measures/hedis/general-guidelines**.
Accessed January 12, 2026.

National Committee for Quality Assurance (NCQA). *HEDIS MY 2025 Measures and Descriptions.* **NCQA.org website**.
https://wpcdn.ncqa.org/www-prod/wp-content/uploads/HEDIS-MY-2025-Measure-Description.pdf.
Accessed January 12, 2026.

Best Practices: Closing Gaps in Care

BEST PRACTICES FOR COMPLIANCE

- The denominator is based on ED visits, not members, between January 1 and December 24 of the measurement year (where member was 18 years of age or older on the date of the visit.)
- Eligible chronic condition diagnoses are identified:
  - On the discharge claim
  - On different dates of service
  - During the measurement year or year prior.
- Visit type need not be the same for the 2 visits, but the visits must be for the same eligible chronic condition. Eligible visits can be (at least) 2:
  - Outpatient visits
  - ED visits
  - Telephone visits
  - E-visits or virtual check-ins
  - Nonacute inpatient encounters
  - Nonacute inpatient discharges
- Visits are identified chronologically. Only 1 visit per 8-day period. If a member has more than one ED visit in an 8-day period, only the first eligible ED visit is included.
- Ensure member has follow-up services within 7 days after the ED visit.

Questions about the Quality Provider Program?
Contact us at QualityProvider@selecthealth.org.