AAVBC

AMERICAN ACADEMY OF VALUE BASED CARE

Follow-Up After ED Visit

Quick Reference Guide

2026

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MEASURE SNAPSHOT

CMS Part C Star Measure: C21 – Follow-up after ED Visit for People with Multiple High-Risk Chronic Conditions

CMS Definition: This rating measures the percent of patients **18 and older** with **2 or more high-risk chronic conditions** who got follow-up care within **7 days** after they had an emergency department (ED) visit.[1] Depending on the person's needs this might be a visit with a healthcare provider, an appointment with a case manager, or a home visit.[1]

FIELD	ENTRY
CMS measure name	Follow-up after ED Visit for People with Multiple High-Risk Chronic Conditions, FMC
Domain	Managing Chronic (Long Term) Conditions
CMS weighting category	Process Measure
Weight	**1, standard-weighted**
Primary data source	HEDIS, administrative claims
Unit of measurement	CMS contract-level measure; individual clinicians and practices do not receive a C21 Star Rating
Trend direction	**Higher is better**
Case-mix adjusted	No[1]
Measurement period	01/01/2024 – 12/31/2024, two years before reporting year[1]
Star measure credit	A qualifying **follow-up service** billed within the measurement period in selected settings: office or outpatient visit, telehealth or telephone contact, e-visit, home visit, case management, or transitional/complex care management per the specification. This measure is scored from administrative claims: **there is no chart-review fallback**, so a documented visit whose claim never carries a qualifying code does not count[1,2]
Unit of measurement	**The ED visit**. Each qualifying ED visit opens its own **7-day window.** Patients with three qualifying visits generate three separately scored episodes[1,2]
Statistical method	Clustering. Cut points are recalculated **each year** from the distribution of health plan scores and are not fixed targets[1]
Not reported for	Prescription Drug Plans[1]

ABBREVIATIONS: CMS = Centers for Medicare & Medicaid Services; ED = emergency department; FMC = Follow-up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (HEDIS label)

How The Years Line Up

Care Delivered
Qualifying ED visits and their **7-day follow-up** windows across calendar year 2024, with eligible ED visits effectively ending in late December so each window can close inside the year[1,2]

↓

Data Reported
HEDIS reporting from claims during 2025, through the health plan's certified HEDIS submission

↓

Published Rating
Reported in the 2026 Star Ratings, published October 2025[1]

↓

Payment Year
Contributes to the Star Rating used for 2027 Medicare Advantage quality bonus determinations

The 2026 Star Rating reflects windows that closed in 2024. An ED visit managed well in the current measurement period is 2026 measurement-year care and will appear in the **2028 Star Ratings**. The window never changes: seven days, restarting with every qualifying visit.[1,2]

In One Sentence

For every ED visit by a patient **18 or older** carrying **two or more high-risk chronic conditions**, this measure asks one question: did a qualifying follow-up service (in person, by phone, by video, or through care management) happen and get documented within 7 days?

CMS Cut Points

These are the CMS base-group cut-point ranges used for the 2026 Star Ratings. Final measure-level Star assignment also incorporates CMS statistical significance testing; the cut points from the 2024 measurement year can be used as a directional benchmark but should not be interpreted as guaranteed prospective thresholds.[1]

PLAN TYPE	1 STAR	2 STAR	3 STAR	4 STAR	5 STAR
MA/MA-PD	<50%	≥50% to <59%	≥59% to <67%	≥67% to <78%	≥78%

ABBREVIATIONS: MA = Medicare Advantage; MA-PD = Medicare Advantage Prescription Drug

2026 Industry Performance

National numeric average: 61 percent. This numeric average corresponds to an average rating of 2.8 Stars in the 2026 Star Ratings. C21 ranks among the **lower-performing measures** in the Part C set. The primary drivers of performance (ED discharge alerts, reserved follow-up slots, and flexible visit modalities) are operational and fall directly within practice control.[1]

Broader MA market context: roughly **64%** of MA-PD enrollees are in health plans rated four or more stars for 2026, and 18 MA-PD health plans earned an overall 5-star rating.[3]

WHAT THE MEASURE IS ASKING

AAVBC PERSPECTIVE — HOW THIS MEASURE WORKS

This measure is triggered when a patient visits the emergency department. **The clock starts at discharge.** The follow-up must happen **within 7 days** and be **billed with a qualifying code**. To close this measure, the practice must identify that the visit occurred, reach the patient, and complete billing, all within 7 days of discharge.

In Plain Language

This measure evaluates whether a patient with two or more high-risk chronic conditions received follow-up care within 7 days of an ED visit. The purpose of the 7-day window is to **reduce the risk of rehospitalization following the visit**. The follow-up can be delivered by telephone, in person, or by virtual visit, but it must be performed by a physician or a qualified mid-level practitioner (nurse practitioner or physician assistant). The follow-up does not need to address the diagnosis from the ED visit. **The 7-day clock starts at the time of the ED discharge.**[1,2]

Who can Close this Measure?

The qualifying follow-up service must be billed by a **physician** (MD or DO) or by one of the **non-physician practitioners** CMS recognizes as eligible billing practitioners for these services: a nurse practitioner (NP), physician assistant (PA), clinical nurse specialist (CNS), or certified nurse-midwife (CNM). Each of these titles requires state licensure in that role, and NPs, PAs, CNSs, and CNMs must additionally hold the national certification required for their license. This applies to office visits, outpatient visits, telehealth visits, e-visits, transitional care management **(99496)**, and chronic/complex care management **(99487, 99489, 99490)**.

Why it Exists

In patients with **multiple chronic conditions**, a flare in one condition can affect the others. The days following an ED visit are when these effects are **identified and addressed**, or progress if unaddressed. Roughly **one in five patients** experiences an **adverse event** in the weeks after leaving acute care, most commonly medication-related.[4] **Timely outpatient follow-up within 7**

days after the emergency room visit discharge is associated with substantially **lower readmission risk** in the populations for this measure.[5] However, this risk is not limited to patients who happen to meet this measure's denominator criteria. Any patient discharged from the ED can experience a similar destabilization, which is why **timely follow-up** should be **standard practice for all ED visits** across your patient population, not only the patients in this measure.

QUALITY OUTCOME — WHAT THIS MEASURE PROTECTS

Timely outpatient follow-up after acute care episodes is associated with roughly **21% lower 30-day readmission risk** in pooled analyses across heart failure, COPD, myocardial infarction and stroke.[5] Additionally, medicare transitional care management billing is independently associated with lower readmissions and mortality.[6] The 7-day window corresponds to the **period of highest clinical risk after discharge**.

What a Care Team Actually Controls

Star Ratings are calculated at the CMS contract level, not for individual clinicians or practices. Care teams nevertheless influence the clinical experiences and workflows that contribute to measure performance. What follows is the part of this measure a care team can influence directly.

DIRECTLY WITHIN THE PRACTICE	INFLUENCED, SHARED WITH OTHERS	OUTSIDE THE PRACTICE
• Working the **ED discharge** feed **daily** • Tiering and reaching patients within **48 hours** • Delivering the 7-day visit by whichever modality the patient can actually use (televisit, virtual, or in person) by a **physician or mid-level** • **Reconciling the ED medication changes** • Documenting the service with a **qualifying code the same week**	• Whether the hospital's ADT feed covers the EDs patients **actually use** • Automations or information exchange from ED, imbed **health information exchange** to provide triggers that patient has been in ER • Plan claims processing • Caregiver availability for the contact	• **Who** visits which ED and **when** • The **eight qualifying condition categories** and episode logic • Cut points, clustering, and the **Categorical Adjustment Index** • The exclusion of visits that convert to admissions

ABBREVIATIONS: ADT = admission, discharge, transfer; ED = emergency department

CLINICAL PEARL — WHEN THE CLOCK STARTS

For the FMC (Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions) measure, the 7-day follow-up window begins on **the date the patient is discharged from the emergency department**. **The discharge date counts as day 0**, so a follow-up visit completed **on the same calendar day as the ED discharge is fully compliant** with the window.

For most ED visits, the discharge date and the arrival date fall on the same calendar day, so this distinction rarely changes anything in practice. **It matters for a patient who is boarded in the ED overnight or held longer**, where discharge can land on a different calendar day than arrival. In that situation, **the discharge date, not the arrival date, is what starts the 7-day window**.

AAVBC PERSPECTIVE — AN EVENT-BASED MEASURE

Most measures are satisfied **once per patient per year**. This measure resets with **every qualifying ED visit**; a patient can pass in March but fail in August, and each episode scores separately. **AAVBC advocates tight control of chronic diseases to avoid unnecessary ER visits.**

MEASURE SPECIFICATION

HEDIS Episode-Based Measure

The unit of measurement is the ED visit. Eligibility is decided by the patient's pre-existing condition history; completion of the measure is decided by the claims that follow the visit.

ELEMENT	SPECIFICATION
Denominator	ED visits during the measurement year for patients **18 or older** with **two or more** of the eight high-risk chronic condition categories, established from diagnosis history before the ED visit.[1,2] Eligible visits effectively end in **late December** so each 7-day window closes inside the measurement year[2]

ELEMENT	SPECIFICATION
The eight condition categories[2]	1. Acute myocardial infarction (including history of MI) 2. Alzheimer's disease and related disorders 3. Atrial fibrillation 4. Chronic kidney disease 5. COPD and asthma (grouped as a single category) 6. Depression 7. Heart failure 8. Stroke and transient ischemic attack
Numerator	Whether the patient received a qualifying follow-up service within **7 days of the ED discharge**, counted as the discharge date plus the 7 days that follow (8 days total)[2]
Diagnosis matching	The follow-up does not need to carry the ED diagnosis or a qualifying-condition diagnosis to count. The service itself qualifies[2]
Exclusions	**ED visits that result in an inpatient stay**, and **ED visits followed by admission to an acute or nonacute inpatient setting** on the day of the visit or within 7 days after, regardless of diagnosis. Admission may prevent outpatient follow-up, so those episodes leave the measure. Hospice and death exclusions, and contract-level small-plan rules, also apply[1]
Data collection	Administrative claims only. There is no hybrid medical-record fallback: a follow-up that happened but was never billed with a qualifying code is invisible to this measure[2]
Measurement window	January 1 – December 31, 2024 for the 2026 Star Ratings[1]

ABBREVIATIONS: COPD = chronic obstructive pulmonary disease; ED = emergency department; MI = myocardial infarction

⚠ RED FLAG — INTERPRETING ADMISSION EXCLUSIONS

An **ED visit episode** is removed from this measure when the patient is admitted within 7 days of that visit. As a result, a health plan's FMC rate can appear strong even when its highest-risk patients are being admitted rather than successfully followed up. An admission-driven exclusion **should not be interpreted as a successful episode**. Depending on the specifics, that admission may be captured by other inpatient or readmission-related measures, such as **Plan All-Cause Readmissions**.

Commonly Misunderstood

- Teams assume the follow-up must be an office visit → **telephone, e-visits, virtual check-ins, home visits by a physician or mid-level practitioner all qualify**

- A documented but unbilled contact is often assumed to count → **claims are the only pathway** for this measure. For example, a nurse call that is not billed with a qualifying code **does not count towards the measure**, regardless of the clinical work performed

CLINICAL PEARL — MEASURE ELIGIBILITY IS NOT A CLINICAL THRESHOLD

This measure only counts ED visits for patients with **two or more** of the eight high-risk chronic condition categories, but that does not relieve the care team's duty for **timely follow-up with their patients**. A patient with a single chronic condition, or one who does not meet the denominator criteria at all, can still experience a medication-related complication after an ED visit, so timely follow-up remains **standard of care** regardless of whether the visit is included in this measure.

HOW PERFORMANCE IS MEASURED

From ED Visit to Credit

CMS scores episodes using **administrative billing records**. The ED visit and the condition history define the denominator event, and a billing record with a qualifying service code inside the 7-day window **satisfies the numerator**. Because there is no record review, this measure is closed **through an administrative CPT code**. The most commonly billed qualifying codes include established office visits delivered in person or by telehealth (**99213–99215**, billed with modifier **95** for audio-video or modifier **93** for audio-only, and **POS 10 (Place Of Service)** for the patient's home or **POS 02** for another location), e-visits and virtual check-ins (**99421–99423, 98016**), home visits (**99347–99350**), transitional care management (**99496**), case management (**T1016**), and complex care management (**99487, 99489, 99490**).[1,2]

CMS assigns measure stars performance by clustering, it includes the measure in the **Part C Improvement Measure (correlation 0.463)** and the Categorical Adjustment Index, and applies no case-mix adjustment.[1]

CLINICAL PEARL — EARLY FOLLOW-UP

The measure allows **7 days** for follow-up, but the period of highest clinical risk occurs earlier. Post-ED decompensation in heart failure, COPD, and advanced kidney disease is concentrated in the **first 48 to 72 hours** (while the steroid taper is still active and a new diuretic dose has not yet stabilized).
Scheduling follow-up at **day 2 or 3** addresses this risk period and allows time to reschedule if the appointment is cancelled. Scheduling at day 7 satisfies the measure's requirement but **does not address the period of highest clinical risk**. Early follow-up, **within 24 to 48 hours** where feasible, connects the patient with the right treatment at the right time.[5]

Internal Performance is not the Official Star Result

Internal dashboards can support care improvement, but they should be distinguished from the official CMS result because the populations, denominators and data pathways differ.

CALL IT THIS	WHICH MEANS
Official result	The contract-level result calculated and published by CMS using its **own data and methodology**
Internal proxy	An **organization's internal estimate** based on its own patient population and available records. Useful for improvement work, but **not equivalent** to the official result
Documentation completeness	How **consistently** the care delivered is documented in structured fields
Patient understanding	Whether patients leave encounters with a **clear understanding** of what care they received, supported by an accessible record

ABBREVIATIONS: CMS = Centers for Medicare & Medicaid Services
**Internal estimates should be labeled clearly and interpreted separately from the official CMS contract-level result because the populations, denominators, and measurement pathways differ

Adjustment and Comparability

This measure is not case-mix adjusted.[1] Plans with more dual-eligible, rural, or cognitively impaired patients may score lower on the unadjusted rate, since these patients often face more barriers to getting a follow-up visit within 7 days. Utilize different modalities to ensure patients receive timely and the best standard of care for their situation.

HIGH-YIELD INTERVENTIONS

Meeting the 7-day window depends on three factors: identifying the ED visit **the same day it occurs**; contacting patients **in order of clinical risk**; and completing a **billed, qualifying service** for that contact.[2]

ACTION	WHEN/WHO	WHY IT MATTERS FOR THIS MEASURE
Review the ED discharge feed each morning and assign each qualifying discharge to a named owner	**Daily**, 15 minutes · care team	Claims data arrive weeks after the window closes while the **ADT/HIE feed is available the same day**.[7] Screen all patients daily and flag those meeting the two-or-more-condition criteria

ACTION	WHEN/WHO	WHY IT MATTERS FOR THIS MEASURE
Prioritize the day's discharges by clinical risk	**Daily** · care team	Address **organ-failure flares** (heart failure, COPD, advanced CKD) and polypharmacy transitions first, followed by socially vulnerable patients, with all remaining patients contacted **within the week**[8]
Reserve one or two same-day transition slots each day, in person or virtual, for post-ED patients, and offer open-access scheduling	**Standing schedule policy** · Practice leadership	Reserved capacity converts an alert into an appointment[9]
Send a previsit outreach questionnaire: **Complete the pharmacist hand-off before the visit, secure the ED discharge summary and medication list, confirm fills with pharmacy, flag duplicates** **Ask the patient to bring their discharge paperwork and current medications**	**Days 1–2** · Clinical pharmacist or RN	ED prescribing occurs without a complete medication history. Pre-visit reconciliation gives the clinician an **accurate list before the visit**, supporting a complete clinical picture and helping to **prevent drug interactions**. Post-discharge pharmacist contact is associated with **reduced downstream acute care use**[10]
Deliver the qualifying contact, by a physician or mid-level practitioner, using a modality the patient can access. **Transportation should not be the reason a window closes**	**By day 3 target, day 7 limit** · Clinician or care manager	**Telephone, video, e-visits, home visits and case management** all qualify.[2] This directly supports frail, rural and caregiver-dependent patients
Focus the visit on the transition: ED summary reviewed, medications reconciled, red-flag thresholds	**The visit** · Clinician	The ED team treats the case without your **complete picture** of the patient's medications, chronic disease management, or social and financial situation. As the clinician who manages the patient longitudinally, this contact is where **drug interactions**, unsustainable treatment changes, or findings requiring **specialist referral** are identified

ACTION	WHEN/WHO	WHY IT MATTERS FOR THIS MEASURE
Bill the service the same week using the code the modality warrants, and audit documentation against claims weekly	**Same week** · Billing and Quality Staff	This measure is scored from administrative data only; **an uncoded contact does not count**. TCM (99496) requires TCM's own discharge and timing criteria; **an ED discharge alone is not TCM-eligible**. **Confirm eligibility with coding and compliance before billing.** Otherwise, use the code matching the service provided[6]

ABBREVIATIONS: ADT = admission, discharge, transfer; CKD = chronic kidney disease; ED = emergency department; MA = medical assistant; RN = registered nurse; TCM = Transitional Care Management

AAVBC PERSPECTIVE — AVOIDING ER VISITS

Preventing an ED visit in the first place is just as **valuable as managing** it after it occurs. Patients who have a **consistent primary care relationship** with same-day/open access scheduling, and extended office hours, are less likely to default to the ED for a non-emergent issue, especially when they are told directly to **call the practice first before going to the ED**. This is a **preventative strategy** and falls outside the FMC measure specification, but it reduces the number of qualifying ED visits the practice has to manage under this workflow and exemplifies quality value based care practice.

Risk Stratification — Who to Reach First

This measure is specifically designed for the **most at risk patients** in the population. Patients with 2 or more core chronic diseases should be **prioritized** and **seen as soon as possible**.

TIER	CRITERIA	RESPONSE
Urgent: same day	**Organ-failure flare** (heart failure, COPD or severe asthma, CKD stage 4–5 or ESRD) **stacked with a risk multiplier**: significant cognitive impairment, severe behavioral health condition, or substance use disorder	**Care manager assigned immediately**; pharmacist reconciliation call same day; **visit (telehealth acceptable)** booked within **48 hours**; caregiver of record contacted directly where a cognitive or behavioral multiplier is present
Priority: within 24–48 hours	**Single organ-failure flare**, or a **polypharmacy transition** (multiple medications changed at the ED visit, or a heavy maintenance regimen)	Scheduled within **48 hours**; pharmacist secures the actual ED discharge list and confirms pickup; visit inside the window with TCM timing where appropriate[6]

TIER	CRITERIA	RESPONSE

ABBREVIATIONS: CKD = chronic kidney disease; COPD = chronic obstructive pulmonary disease; ED = emergency department; ESRD = end-stage renal disease; TCM = Transitional Care Management

QUALITY OUTCOME — CLINICAL BENEFIT OF TIMELY FOLLOW UP

Timely transitional care management is associated with **lower 30- and 90-day readmissions** and **lower mortality**[6] The same first-week contact required by this measure is also where **duplicate therapy and missed prescription refills** are identified.[10]

COMMON PITFALLS AND PRACTICAL FIXES

FAILURE MODE	WHY IT HAPPENS	WHAT PREVENTS IT
Learning about the ED visit from the claim	Claims are typically posted **weeks after the visit**, often after the 7-day window has already closed. Out-of-network and out-of-area ED visits are the **most common gaps in awareness**	**Daily monitoring** of ADT and HIE feeds, with **quarterly audits** confirming which facilities' visits reach the queue[7]
Chronological outreach	Contacting patients in discharge order spends time on stable patients first, **delaying outreach to higher-risk patients**	**Risk-based tiering** during morning review, prioritizing organ-failure and polypharmacy cases first[8]
Insufficient same-week capacity	When no same-week capacity exists, the follow-up is scheduled **beyond day 7**, and the window closes without a completed visit	**Reserved daily transition slots**, and a policy allowing telephone visits when in-person capacity is unavailable, since telephone contact **still qualifies**[9]
Care delivered without a claim	The qualifying visit is documented in the EHR but **never billed**, so it is not documented by this administrative-only measure	Assign a **billing disposition** to every post-ED contact the same week, and **reconcile documented contacts against submitted claims weekly** to identify gaps[2]

FAILURE MODE	WHY IT HAPPENS	WHAT PREVENTS IT
Psychological health gap	Depression is a qualifying category, but the ED discharge typically defaults to a physical-health referral	**Collaborative care integration** so a single contact addresses both physical and psychological needs, supported by trained staff available for **timely case management**[12]
Fragmented specialist care	A patient may have several specialist visits within days of the ED visit, none of which include a structured transition contact, so the **episode does not meet the measure** despite frequent contact with the health system	Assign **one accountable owner per episode** to consolidate the transition into a single qualifying encounter and route specialist input through that contact

ABBREVIATIONS: ADT = admission, discharge, transfer; ED = emergency department; EHR = electronic health record; HIE = health information exchange

Common Pitfalls

This measure requires structured, timely care: a qualifying follow-up contact **within 7 days satisfies the measure**. Achieving this requires **coordinated communication across the care team** and health information exchange channels updated in real time. Also, the **clinical content of the encounter matters as much as when it occurs**. A superficial contact can miss the underlying reason for the ED visit, **increasing the likelihood of a return visit**. The following situations do not represent successful follow-up:

- A contact with **no record of what was reviewed or discussed**. **Proof of contact is not the same as proof of care**
- **Billing a transitional-care management code without doing the medication and care-plan review**
- **Reconciling medications using only the discharge summary, without speaking to the patient.** Discharge paperwork is often incomplete, so this step can miss concerns (duplicate drugs, dangerous combinations, drugs the patient never actually filled) that talking to the patient would catch
- **Marking a follow-up as complete when the patient was never reached.** If no real contact happened, there is no follow-up to credit, regardless of how the attempt is documented

CLINICAL PEARL — THE 7-DAY WINDOW IS A CRITICAL

The 7-day follow-up window in these measures corresponds to the period of **highest post-discharge risk**.

Most post-discharge deterioration and medication errors occur within the **first few days after a hospital or ED visit**. Common causes include incorrect use of new medications, interactions between old and new medications, and early signs of worsening conditions that go unnoticed without follow-up contact.

The window is set based on this risk period. Contact made within 7 days has a higher likelihood of identifying a problem before it results in a repeat ED visit or readmission. Contact made after this window is less likely to prevent an adverse outcome that may have already occurred.

BARRIERS AND EVIDENCE-BASED SOLUTIONS

Patient-side

BARRIER	HOW IT SHOWS UP	WHAT HELPS
Medication friction after the ED	New prescriptions may require **prior authorization** or involve **copays**, leading the patient to **postpone follow-up** until medication issues are resolved	Pharmacist hand-off clears authorizations and confirms pickup **before** the visit[10]
Cognitive impairment	Discharge instructions assume the patient can **recall information and self-schedule**, which patients with dementia often cannot do. Follow-up is **at risk without an engaged caregiver**[3]	**Assign a dedicated and qualified case management team**, with appropriate case management encounter and correct code/documentation; **all notes and reminders** should be routed to the caregiver of record, not only the patient[13]
Transportation barriers	Transport gaps and inflexible work **schedules** can make an in-person visit within 7 days unreachable	**Transportation interventions cut missed appointments by roughly a third**.[12] Switching to telephone, video or home visit removes the need for travel

BARRIER	HOW IT SHOWS UP	WHAT HELPS
Uncertainty about warning signs	Patients discharged quickly after an ED visit **may not know what symptoms warrant a call** versus a return visit, and may default to waiting or returning to the ED	Provide **specific, numeric red-flag thresholds** (weight, glucose, breathing changes) at the contact, along with **one phone number to call**

ABBREVIATIONS: ED = emergency department

CLINICAL PEARL — MEDICATION RECONCILIATION IN THE POST-ED CALL

Medication reconciliation should be one of the first questions in the post-ED call, alongside confirming the reason for the visit and whether follow-up care is already scheduled.
Begin with a direct question to the patient:
"Were you given any new prescriptions, and have you picked them up?"
If there are: **“What are they? Let’s review them.”**[10]

System and Workflow

BARRIER	HOW IT SHOWS UP	WHAT HELPS
ADT/HIE coverage gaps	The feed may cover the primary hospital visit but **miss standalone or out-of-area EDs**. As a result, the practice's denominator can be **larger than what the alert queue identifies**	Use **HIE-level connection** rather than **hospital-by-hospital feeds** where available, and reconcile claims-identified ED visits against the alert queue **monthly** to identify gaps[7]
Patient-initiated scheduling	Discharge paperwork instructs the patient to follow up within 7 days, **placing responsibility for scheduling on the patient** rather than the practice	The practice **initiates outreach and books the appointment directly**, rather than relying on the patient to schedule independently. **Appointment modality is confirmed at the time of booking**
Incomplete coding	Telehealth contacts missing modifiers, telephone visits never coded, case management delivered but **not billed**	A **concise qualifying-code reference** for the billing team, modality-specific documentation templates, and the weekly documentation-to-claims audit[2]

BARRIER	HOW IT SHOWS UP	WHAT HELPS

ABBREVIATIONS: ADT = admission, discharge, transfer; ED = emergency department; HIE = health information exchange

Disparity Gaps Requiring Targeted Action

The contract-level rate **does not show which populations are being missed**, and this measure is not case-mix adjusted.[1] The populations listed below are **over-represented in the denominator**, since multimorbidity is more common among disadvantaged populations, and **under-represented in the numerator** due to barriers that modality flexibility is intended to address. **Track completion rates by dual-eligible status, cognitive impairment, rurality, and behavioral health comorbidity**.

POPULATION SEGMENT	PATIENT IMPACT	INTERVENTIONS
Patients with cognitive impairment and dementia	Self-managed follow-up is **often not feasible**. Without an engaged caregiver, the follow-up window **may close without any contact occurring**	Use **case management as the default pathway**, with instructions and reminders directed to the **caregiver**. Dementia case management has been shown to **improve coordination and reduce unmet needs** in systematic review[2,13]
Dual-eligible and low-income patients	**Transportation limitations, hourly work schedules, and unstable housing** can prevent attendance. Practices serving these patients often have the **least outreach staffing**	**Transport benefits arranged at booking**,[12] evening and same-day capacity, community health worker outreach, and the **telephone visit as the first option** when applicable[2]
Rural patients	Distance can make a 7-day in-person visit **impractical**, and internet connectivity may not be reliable	Use **audio-only telephone contact** as the primary rural pathway, with **home visits and community health worker support** as additional options[2]
Patients with severe behavioral health conditions and SUD	**Care fragmentation, stigma, and impaired executive function** contribute to both the ED visits and the missed follow-ups. The **qualifying depression diagnosis is frequently left unaddressed**	Use **collaborative care within 7 days** and **behavioral health case management** as qualifying contacts, and **address the behavioral barrier first**[12]

ABBREVIATIONS: ED = emergency department; SUD = substance use disorder

DOCUMENTATION REMINDER — CORRECT DOCUMENTATION FOR THE ED FOLLOW-UP VISIT

The note should document the **ED visit date and facility**, confirmation that the **discharge summary was reviewed**, and which **qualifying conditions the patient carries**. If a post-ED contact is documented as a routine chronic-care note instead, the **connection to the ED episode is lost**, even when the claim itself is correct.

CLINICAL CONTEXTS AND APPLICATIONS

Clinical Contexts

CONDITION OR SITUATION	WHY THIS MEASURE MATTERS HERE	WHAT TO WATCH FOR
Heart failure	**Diuretic changes at ED discharge** can **improve or worsen** heart failure status within days[5]	**Contact by day 2–3**, weight and symptom check with a numeric action threshold, and the fluid-relevant medication changes verified against the pharmacy fill
COPD and severe asthma	**Flare resolution** occurs over the steroid taper, not at discharge. Relapse risk remains elevated throughout the follow-up window	Taper adherence, inhaler technique and device changes at the contact; **escalation criteria documented clearly**
Advanced chronic kidney disease	**New medications** started at the ED visit can affect renal function or potassium levels	**Early labs** where indicated, an **NSAID check** by name, and **renal dosing review** of everything the ED added
The multimorbid intersection	In patients with heart failure, CKD, and diabetes, a **single ED medication change** can affect all three conditions within the follow-up window	**Urgent-tier handling** regardless of how routine the ED diagnosis looked, and the pharmacist hand-off treated as mandatory

ABBREVIATIONS: CKD = chronic kidney disease; COPD = chronic obstructive pulmonary disease; ED = emergency department; NSAID = nonsteroidal anti-inflammatory drug

Patient Journey

BEAT	CONTENT
Presents as	A woman in her **late sixties** with **heart failure, stage 3b kidney disease** and **depression** presents to the ED with acute dyspnea and is discharged the same day with an increased diuretic dose. **No admission**
What happens	The ADT alert is reviewed the following morning. Two qualifying conditions put the visit in the denominator, and the heart-failure flare puts her in the **urgent tier**. The pharmacist reconciles the new diuretic dose against her home list and pharmacy fills the same day; the practice books a telehealth visit for day 3
Outcome	At the day 3 video visit the clinician reviews the ED summary, confirms the diuretic change is tolerated, sets a numeric weight threshold with her daughter on the call, and, because her PHQ-9 has drifted up, adjusts the depression plan. **The visit is billed with the telehealth-appropriate code the same week**

ABBREVIATIONS: ADT = admission, discharge, transfer; ED = emergency department; PHQ-9 = Patient Health Questionnaire-9
Note: Case is illustrative and is not a reported individual case

Companion Guides – Making Connections

GUIDE	WHEN TO REACH FOR IT
Transitions of Care QRG (C20)	Applies the same measurement approach used in this guide to hospital discharges, using **four components** instead of one
Reducing All-Cause Readmissions QRG (C18)	Describes where some excluded episodes may be identified. An **ED visit that converts to an admission within 7 days** exits this measure and, depending on its specifications, may be identified by this related measure instead
Medication Reconciliation Post-Discharge QRG (C17)	Describes the **medication reconciliation** process referenced in this measure's **pharmacist hand-off**

ABBREVIATIONS: ED = emergency department; QRG = Quick Reference Guide; TRC = Transitions of Care

DOCUMENTATION THAT SUPPORTS CARE

Documentation that Reflects the Care

- This measure is scored from claims, **accurate documentation is essential**. The claim **satisfies the numerator**, while the clinical note supports **audit review**, continuity of care, and the **documentation that connects the contact to the episode**[2]
- **Connect every post-ED note to the event** by including the ED visit date and facility, confirmation that the **discharge summary was reviewed**, and each **qualifying chronic condition assessed individually by name**

What Belongs in the Record

ELEMENT	WHAT TO RECORD
The episode identification	ED visit date, facility, presenting problem, and explicit note that the discharge paperwork was reviewed, connecting this contact to the denominator event
The qualifying conditions	**Each high-risk condition** assessed **individually** and **by name**
The reconciliation	ED changes compared **against the home regimen**, duplicates and stop-list resolved by name, pickup confirmed, and who performed it
The modality and the code	**How the contact happened** (office, video, telephone, home, case management) matching the code the claim will carry[2]
The action plan	**Condition-specific numeric thresholds**, who to call, and the escalation line between clinic call and emergency return
Relevant Codes*	Code billed matched to modality: office visit, in person or telehealth (**99213–99215**, with modifier **95** for audio-video or modifier **93** for audio-only), e-visit/virtual check-in **(99421–99423, 98016)**, home visit **(99347–99350)**, TCM **(99496)**, case management **(T1016)**, complex care management **(99487, 99489, 99490)**. Confirm the correct code before billing

ABBREVIATIONS: CKD = chronic kidney disease; COPD = chronic obstructive pulmonary disease; ED = emergency department *Confirm the correct code before billing

Billing Codes Reference

CODE*	DESCRIPTION
99213–99215	Established patient office/outpatient visit (levels 3–5)
Modifier 93	Audio-only synchronous telehealth service, appended to an E/M code
Modifier 95	Audio-video synchronous telehealth service, appended to an E/M code
99421–99423	Online digital evaluation and management service (e-visit)
98016	Brief communication technology-based service (virtual check-in)
99347–99350	Home visit, established patient
99496	Transitional care management, high complexity
T1016	Case management, per 15 minutes
99487	Complex chronic care management, first 60 minutes
99489	Complex chronic care management, each additional 30 minutes
99490	Chronic care management, first 20 minutes

*Confirm the correct code before billing

Clinical Documentation Optimization – SOAP

S — Subjective

Post-ED follow-up by synchronous video, **day 3 after an ED visit** at [facility] on [date] for acute dyspnea; no admission. Reports breathing improved on the increased diuretic dose; no chest pain or orthopnea. Daughter present on the call. Mood: reports worsening low mood over recent weeks; PHQ-9 completed remotely: **12, up from 6**.

O — Objective

ED discharge summary and labs reviewed. Home weight log: **down 1.5 lb since discharge**. Speaking in full sentences, no visible respiratory distress on video. Pharmacy fill history confirms the new diuretic dose dispensed; no duplicate diuretic at home per reconciliation call.

A — Assessment

Heart failure exacerbation, improving on the adjusted regimen. Stage 3b CKD, stable, no nephrotoxic additions from the ED visit. Depression, moderate symptom recurrence identified at this contact.

P — Plan

Diuretic change continued; ED medication list reconciled against the home regimen with the daughter, no discrepancies outstanding. Action thresholds set and repeated by teach-back: call the clinic for weight gain over **3 lb in 24 hours** or **5 lb in a week**; emergency services for severe dyspnea or chest pain. Depression plan adjusted [detail]; behavioral health care manager to call

within one week. Renal panel ordered for next week. Billed as a synchronous **telehealth visit** with the applicable modifier this week.[2]

Documentation caution: The note **identifies the episode**, works **each qualifying condition** by name, and **matches the claim that closes the measure**. It also shows why the diagnosis-matching flexibility matters: the most consequential finding at this contact was the depression the ED visit had nothing to do with.

Documentation Examples

Complete

"*Post-ED follow-up (ED visit [date], [facility], acute COPD exacerbation; discharge summary reviewed). Conditions assessed: COPD, improving on taper, day 4 of 5; CKD stage 3, no NSAID exposure, renal panel ordered; heart failure, euvolemic, home weights stable. Medications reconciled against ED discharge list: prednisone taper confirmed filled and understood; no duplicates. Action plan: weight gain >3 lb/24 h or increased dyspnea → clinic call; severe breathlessness → 911. Day 14 check assigned to [care manager]. Telephone visit, coded accordingly.*"

Incomplete

"*Follow-up for chronic conditions. Patient doing okay. COPD, CKD and HF stable. Meds reviewed, no changes. Continue current regimen, follow up in 3 months."No ED anchor, no summary review, no reconciliation content, no thresholds, and nothing connecting this visit to the episode. If the claim also went out as a routine visit without a qualifying code, the measure saw nothing at all.*[2,3]

One Status, Clearly Stated

STATUS	WHAT IT MEANS, AND WHAT FOLLOWS FROM IT
ED visit identified	**ADT alert received and date-stamped**; condition history screened; tier assigned. The 7-day clock started at the discharge
Outreach in progress	**Attempts logged with dates and channels**; caregiver of record included where flagged. Unreachable is a barrier documented and followed by another attempt
Contact scheduled	**Modality, date and owner named.** Booked by the practice, inside the window, with transport or technology needs resolved at booking
Contact completed, billed	Qualifying service delivered and the matching code submitted the **same week**
Contact completed, claim pending	This is the gap the **weekly audit is designed to identify**: the contact occurred, but it **has not yet been counted toward the measure** because the claim has not been submitted
Episode excluded, admitted	Inpatient admission within **7 days** removes the episode from this measure and opens the readmission and transitions workflows instead[1]

STATUS	WHAT IT MEANS, AND WHAT FOLLOWS FROM IT
Window closed unmet	**Document the reason** the window closed, such as a **feed gap**, an **unreachable patient**, or **insufficient scheduling capacity**
Monitoring	**Day 14 and day 30** checks owned and dated; the fast-track flag stays on the chart for the next qualifying visit

ABBREVIATIONS: ADT = admission, discharge, transfer; ED = emergency department

KEY TAKEAWAYS

1 Every qualifying ED visit opens its own independent 7-day follow-up window

These windows run continuously throughout the year and can overlap when a patient has more than one qualifying visit.[1,2]

2 Two or more of the eight condition categories define the denominator

COPD and asthma count as one category, not two.[2]

3 The follow-up modality is flexible and does not need to address the ED diagnosis

Telephone, video, e-visits, home visits, and case management all qualify, accommodating for frail, rural, and caregiver-dependent patients.[2]

4 The measure is scored from claims only

A contact that occurred but was never billed with a qualifying code does not count. Assign a billing disposition to every post-ED contact the same week.[2]

5 Aim for day 1, 2 or 3 post discharge, not day 7

The period of highest clinical risk occurs within the first 72 hours, and early scheduling allows time to reschedule if the appointment is cancelled.[5]

6 **Begin the contact by reviewing prescriptions**

An unfilled prescription or duplicate therapy are among the most readily identifiable risks in this episode.[10]

Changes to Monitor

Current as of 2026-08-20

KIND OF CHANGE	GOOD PRACTICE
Measure status and specification	**C21** remains an active Part C process measure using **HEDIS MY2024 FMC**. Confirm the eight condition categories, the eligible service list, and the episode and exclusion logic against the NCQA specification each measurement year[1,2]
Rating-year methodology	**Cut points reset annually through clustering**; revalidate cut points, Categorical Adjustment Index treatment, and Improvement Measure inclusion **(correlation 0.463 for 2026)** each cycle[1]
Rating-year policy	**The CY2027 final rule did not implement the planned health-equity-based reward**; the historical reward factor continues. Confirm reward-factor treatment each Advance Notice cycle[1]
Telehealth and coding	Qualifying telehealth, telephone, e-visit and care-management codes, and their modifier requirements, change with the annual code cycle. Refresh the billing team's qualifying-code reference **before each measurement year**[2]
Data infrastructure	**ADT feed coverage and HIE participation determine the denominator the practice can actually see**; audit feed completeness against claims quarterly, and re-audit whenever a regional facility changes systems
Internal tools	Review **tier criteria, transition-slot policy, outreach scripts** and the **weekly claims audit annually**; do not label retained prior-year cut points as current

ABBREVIATIONS: ADT = admission, discharge, transfer; HIE = health information exchange; NCQA = National Committee for Quality Assurance

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