TRC and FMC Provider Checklist

Follow required timelines and documentation standards to ensure compliant reporting

This checklist is a reference tool only and does not close care gaps for the Transitions of Care (TRC) and Follow-Up After Emergency Department Visit (FMC) HEDIS[1] measures. A qualifying visit must be completed, documented and submitted to be counted.

Timeline quick reference

Measure	Timing	Key requirement
TRC – Patient engagement	Within 30 days	After discharge (discharge date does not count); no face-to-face required.
TRC – Medication reconciliation	Within 30 days	After discharge (discharge date does count); no face-to-face required.
TRC – Notification of Inpatient Admission (NIA)	Within 3 days	Document notification (day of admission + 2 days).
TRC – Receipt of Discharge Information (RDI)	Within 3 days	Document receipt (day of discharge + 2 days).
FMC – Follow-up visit	Within 7 days	Applies only to members fully discharged from the emergency department (ED).

What providers must do

Schedule follow-up promptly	
	Contact patient as soon as admission, discharge and transfer (ADT)/discharge notification is received (can use Cozeva®).
	Maintain appointment availability for post-discharge and post-ED visits.

During the visit – assess and document	
	Review discharge summary and confirm patient understanding.
	Verify prescriptions were filled.
	Perform medication reconciliation.
	Document: • Current medication list • Assessment and plan • Physical exam findings

TRC requirements

Complete a qualifying clinical interaction within 30 days of discharge:

- Must be a clinical interaction (not scheduling or outreach only).
- Caregiver interaction is acceptable when the patient cannot communicate.

Required documentation:	
	Date interaction.
	Visit type (office, telehealth, phone, home, TCM, etc.).
	Physician or practitioner name and credential.
	Evidence the interaction was completed.

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[1]HEDIS: Healthcare Effectiveness Data and Information Set.

Medication reconciliation

- No face-to-face visit required.
- Must be completed by MD, DO, PA, clinical pharmacist, or RN.

Required documentation:	
	Date completed.
	Phyisican or practitioner signature and credential.
	Current medication list.
	Confirmation that discharge medications were reviewed and reconciled.

Billing codes

Description	Code
Medication reconciliation encounter	CPT: 99483, 99495, 99496
Medication reconciliation intervention	CPT II: 1111F

NIA and RDI requirements

Document receipt and integration into the outpatient record within required timeframes.

Notification of inpatient admission

Document within 3 days of admission.

Include:	
	Date notification received (ADT alert, call, fax, secure message).
	Documentation available in the outpatient record within timeframe.
	Evidence of physician or practitioner involvement (e.g., communication, orders, pre-admission exam).

Note: Referral to the ED alone does not meet criteria.

Receipt of discharge information

Document within 3 days of admission.

Include:			
	Treating physician or practitioner		Medication list
	Procedures/treatments		Test results or pending tests
	Discharge diagnoses		Post-discharge instructions

Documentation guidance (compliance focus)

- Record the date discharge information was received.
- Confirm when information became available in the electronic health record (EHR).
- If the primary care physician (PCP) is the discharging provider, documentation must still occur within the 3-day requirement. If discharge information is integrated and accessible within the timeframe, a separate notation is not required.

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FMC requirements

Complete a follow-up visit within 7 days of an ED discharge.

- Applies only to patients fully discharged from the ED.
- Observation or inpatient stays do not qualify.

Accepted visit types

- Outpatient or behavioral health visits.
- Phone or transitional care management.
- Virtual visits (video, e-visit or virtual check-in).

Required documentation:	
	Visit date and type
	Physician or practitioner name and credential
	At least 2 qualifying chronic conditions (diagnosed prior to ED visit).
	Exam findings, assessment and plan.

Qualifying chronic conditions

- Chronic obstructive pulmonary disease (COPD) or asthma
- Alzheimer's disease and related disorders
- Chronic kidney disease
- Depression
- Heart failure
- Acute myocardial infarction
- Stroke or transient ischemic attack
- Atrial fibrillation

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