

Exchange and Evaluation of Clinical Information Among Providers

Policy Number: **M080101699**
Effective Date: **1/1/2008**
Sponsoring Department: **Clinical Quality / EXT**
Impacted Department(s): **Clinical Services, Practice Management, Medical Resource Management**

Type of Policy: Internal External

Applies to (Line of Business):

- Corporate (All)
- State Products, if yes which plan(s): MediSource Child Health Plus
- Medicare, if yes, which plan(s): MAPD; PDP/EGWP
- Commercial, if yes, which type: Large Group; Small Group; Individual

Excluded Products within the Selected Lines of Business (LOB)

This section is intended to list specific LOB products that are excluded from adhering to this policy (due to differences in law/regulations). If not applicable, please indicate N/A.

Applicable to Vendors? Yes No

Purpose and Applicability:

To identify the requirements related to the exchange of information and communications between practitioners (inclusive of behavioral health and other ancillary providers) and other care settings in order to provide continuity and coordination of care between the primary care physician (PCP) and specialists, and other settings.

Policy:

Exchange of Information:

The appropriate, timely and confidential exchange of pertinent member clinical information among all practitioners, regardless of referral method or lack of, is required:

- After the initial consult/evaluation; and
- If the member has been seen on an ongoing basis 12 months or greater; and
- If the member has had significant changes in clinical presentation or treatment.

The following are accepted forms of communication which represent flow of information and promote continuity and coordination of care:

- Primary **care physician (PCP)**, when aware a member is seeing a specialist, is required to provide specialists with pertinent medical information in the form of a letter, office notes, or a summary including any diagnostic reports as needed in a timely manner.
- Specialist is required to send information to the member's PCP in the form of a letter, progress note, or documented phone call. Information shared should include the diagnosis and treatment plan or overall summary reports including any diagnostic reports.
- Facility [hospital (inpatient and/or ER), skilled nursing facility, rehabilitation unit, ambulatory surgery center, infusion therapy center, urgent care center, home care agency, etc.] is required to provide to the PCP a discharge summary, including diagnostic reports or such ongoing care management reports as the member's condition requires.
- Behavioral **Health Specialist**: Independent Health encourages the sharing of clinical information between primary care physicians and behavioral health specialists as a means to facilitate effective coordination of care. The sharing of such clinical information requires that a valid, member-signed, HIPAA consent form, be in place authorizing the provider to release such information.

Documentation Requirements:

Specialists are required to have evidence of the date that the report was sent to the PCP. The PCP's office copy is required to have the date that the report was received by the PCP. The report must also demonstrate verification that it was reviewed by the PCP.

Evaluating Continuity and Coordination of Care:

- Independent Health's Clinical Quality department monitors the continuity and coordination of care through annual data collection of members' medical care for all specialists across settings or transitions in care.
- Medical records for audit are identified through member complaints, internal concerns, HEDIS medical record review and a random sampling of members who have seen specialists during the previous calendar year.
- The annual audit of specialists requires verification of notification to the primary care physician of results of the initial visit/evaluation or changes in condition or treatment.
- The threshold for compliance is 90%. Specialists who score below the 90% are required to submit a plan to improve their compliance. The Clinical Quality department evaluates the practitioner for compliance 6 months after acceptance of plan.
- Practitioners scoring below the 90% threshold will have continued follow up every six months until compliance is demonstrated.

Quantitative and causal analysis is utilized to identify areas for improvement. An annual summary that includes analysis of the data, as well as identified interventions and issues, is completed and presented to the Clinical Quality committee and Health Care Quality committee for review and recommendations.

Additional Evaluation Requirements for Behavioral Health:

For behavioral health continuity and coordination of care, a summary of findings is also reviewed by the Behavioral Health Clinical Advisory committee, which is composed of practicing primary care and behavioral health professionals from the provider panel.

Independent Health monitors continuity and coordination of care across settings or transitions in care, and between behavioral health and medical care to require:

- The exchange of information between medical/primary care specialties and behavioral health practitioners.
- The appropriate diagnosis, treatment, and referral of behavioral health disorders commonly seen in primary care.
- The appropriate use of psychopharmacological medications including interactions with other medications the member is taking.
- Management of members with co-existing medical and behavioral health disorders.
- Programs of primary or secondary preventative behavioral health.

Continuous Access:

For more information on continuous access and transition to other care, please refer to Continuous Access to Practitioners Policy # M970201238

Definitions

Continuity and coordination of care is the communication between a member’s primary care physician and specialists or facilities rendering care to ensure quality of care.

Healthcare Effectiveness Data and Information Set (HEDIS) is the most widely used set of health care performance measures in the United States to assess, report on and improve the quality of health care.

Timely exchange of information: For purposes of this policy, the timely exchange of pertinent patient information is 7 days for routine, non-urgent visits and 1 business day for urgent or emergent visits.

References

Related Policies, Processes and Other Documents

Regulatory References

- Health Information Portability and Accountability Act, 45 CFR Part 160 and 164
- 10 NYCRR Part 98 - §98-1.13(g)(3)
- NYS Public Health Law §4403(1)(f) and (6)
- Medicare Managed Care Manual Chapter 4, Section 110.2
- NCQA Standards for Accreditation QI 10 Care and Coordination of Medical Care.
- NCQA Standards for Accreditation QI 11 Continuity and Coordination Between Medical and Behavioral Health Care.

Version Control

Sponsored By:

Name sponsor: Thomas Foels

Title of sponsor: Chief Medical Officer

Signature of sponsor:

Revision Date	Owner	Notes
1/6/2009	Ann Mathias	Reviewed
1/5/2010	Ann Mathias	Reviewed
4/1/2011	Ann Mathias	Revised
4/1/2012	Ann Mathias	Revised
4/1/2013	Ann Mathias	Revised
4/1/2014	Ann Mathias	Revised
4/1/2015	Ann Mathias	Reviewed
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