Information Exchange Policy for Primary Care/Specialists/Facilities

BlueShield of Northeastern New York

Last Reviewed: June 20, 2018

Last Revised: June 15, 2017

Policy:

This information exchange policy ensures practitioners and facilities have the needed health care information to provide coordinated, quality health care services to BlueShield of Northeastern New York members. All practitioners, including behavioral health and facilities providing health and behavioral care services to members, must ensure timely exchange of pertinent medical information. (Consent may be addressed with member by the office privacy policy or by separate consent to share information.)

Timeframes for information exchange shall be the following:

- **Within thirty (30) calendar days of initial assessment**
- **Annually if concurrent care continues for more than twelve (12) months, or more frequently if the member's clinical condition or treatment changes significantly,**
- **Within seven (7) calendar days of medication change.**

The below guidelines are supported by Section 33.13 of the New York State Mental Health Law (NYSMHL), 42 CFR Part 2, Section 17 and Article 27-F of the New York State Public Health Law, standards promulgated by the Centers for Medicare & Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA), and HIPAA regulations. The guidelines are as follows:

Procedures:

Those affected by the policy are primary care practitioners, specialists and pertinent ancillary practitioners, health care and home care facilities, surgical, laboratory, and diagnostic centers.

Minimum information to be exchanged:

1. **Primary Care:** The primary care practitioner is required to provide the specialist with pertinent medical information, including, but not limited to:
    - Office notes
    - Discharge summaries
    - A formal letter summarizing medical history
    - Diagnostic test reports
    - Other pertinent consult reports and information

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2. **Specialist:** The specialist is required to provide the member's pertinent medical information to the primary care practitioner in order to promote optimal coordination of care, regardless of the member's referral method. This includes, but is not limited to:
    - Diagnosis
    - Consultation report or treatment notes
    - Diagnostic reports
    - Plan of treatment
    - Medications prescribed or medication changes
    - Other pertinent consult reports and information
    - Concurrent care management reports, when applicable
3. **Facility (including urgent care centers):** Facilities involved in the member's care are required to provide the primary care practitioner with the following:
    - Discharge summaries
    - Diagnostic reports
    - Emergency room summaries/reports/notes
    - Concurrent care management reports, when applicable (home care, skilled, rehab, etc.)
4. **Behavioral health specialists:** Exchange of information may be to another behavioral health practitioner and/or the member's primary care practitioner with an appropriate signed consent from the member.
    - Diagnosis
    - Medications prescribed or medication changes
    - Any significant risk status or issues
    - Stress-related factors
    - Treatment recommendations
    - Frequency of treatment
    - Significant coordination of care issues/medical compliance issues