

## **BACKGROUND**

These Rules of Exchange are intended to be appropriate for all laboratory results transmissions among providers, health plans, and purchasers. Importantly, prior to the establishment of the CALINX Laboratory Work Group, lab results have not been traded among laboratories, providers, or health plans. Readers should be aware that if there are conflicts between the CALINX Rules of Exchange and the rules and regulations established by the federal government for Medicare and Medicaid transactions, the federal regulations should supercede the CALINX Rules of Exchange.

## **CONTENT**

- All data transmission will comply with any federal government regulations and will meet CALINX data format and content standards.
  - Data Format: HL7
  - Test Code Format: LOINC

## **FREQUENCY**

- Frequency of lab results data transmission:
  - Agreed to laboratory results will be sent electronically from laboratories to provider organizations and from provider organizations to health plans on a 30-day cycle.
    - Lab to treating physician: immediate
    - Lab to physician organization: 30 days or less
    - Physician organization to plan: 30 days or less from receipt - not to exceed 60 days from the date of service.

## **ACCURACY AND COMPLETENESS**

- Provider organizations will provide the results of HEDIS and selected laboratory tests in a standardized, electronic format to health plans.

## **APPROPRIATE USE**

- Individually identifiable data are not provided to employers; however, individually identifiable data may be provided to 3rd parties to be merged with employer records for aggregate reporting and analysis – while adhering to confidentiality requirements
- Individually identifiable patient data may not be sold to third-party vendors by plans or providers without prior written patient consent.

## LABORATORY RULES OF OF EXCHANGE (cont.)

- Plans directly contacting patients using information obtained from laboratory results data will follow an approved policy procedure, which will include advance written notice with applicable information to the provider organization or individual clinician (See Appendix: Laboratory).
  - The purpose is to establish a consistent method of communicating Health Management Programs (HMPs) to PMGs, allowing the PMGs the opportunity to refuse HMPs because of their own existing programs, and documenting that the PMGs HMPs meet or exceed NCQA standards.
- Plans directly contacting patients using information obtained from laboratory results data will give 45-days advanced written notice to the provider organization or individual clinician, as appropriate.<sup>1</sup>
  - The intent of this rule is to coordinate the accuracy of patient communication, and to ensure a coordinated approach to the care of the patient.
  - Every provider organization will designate a recipient for the HMO communication process. This recipient is responsible for 1) verifying communication accuracy, 2) notifying or communicating with all involved individual physicians.
  - Any communication using lab result data must be specific regarding the exact information being sent to an individual member (i.e. suggesting a Pap Smear deficiency must include specific patient identifier).
  - The provider organization may object to the notice within the 45-day timeframe if it finds the specific data on specific patients inaccurate. The provider organization will notify the HMO of its findings and mutually create an accurate notice to specific patients.
  - No written objection by the provider organization within the 45-day timeframe (defined as from date of receipt by designated individual) is evidence of full approval.

<sup>1</sup> Appropriate should be considered as either the contracted entity – i.e., IPA or Medical Group – or the directly contracted clinician.