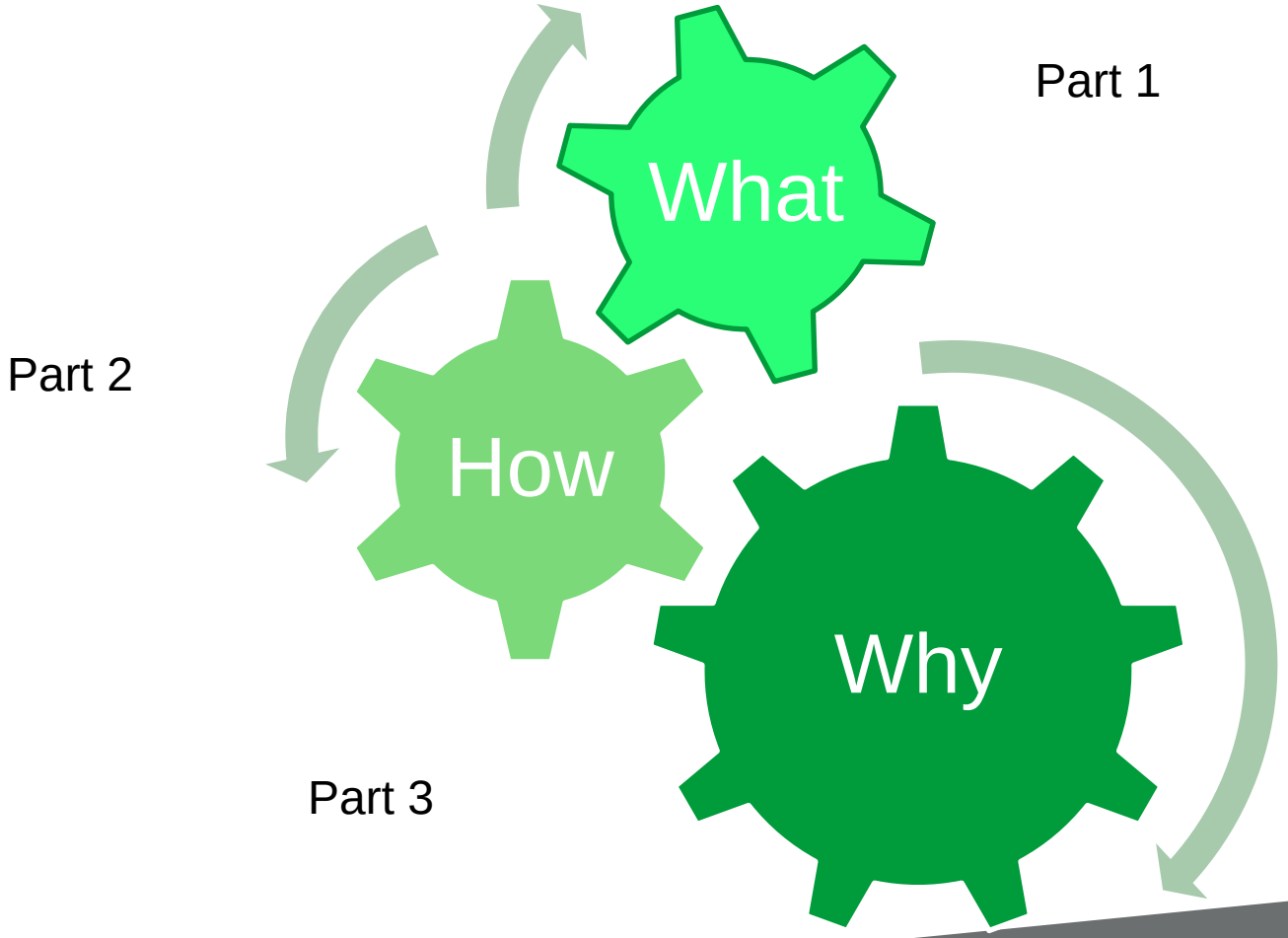
PEER TO PEER ANALYSIS
PART 3

Dr. Maria Johar MBA
Physician Advisor

THE PEOPLE, PROCEDURE, AND PROCESS



EXPERTS OPINE

- RAC monitor
- **https://www.racmonitor.com/are-peer-to-peers-worth-it-physician-reaction**

- Peer review and appeal: flawed but trusted? - The Lancet
- https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(03)14218-3/fulltext

- So you've been rejected, now what? On appeals in peer-reviewed ...
- https://hub.wiley.com/.../so-youve-been-rejected-now-what-on-appeals-in-peer-review...

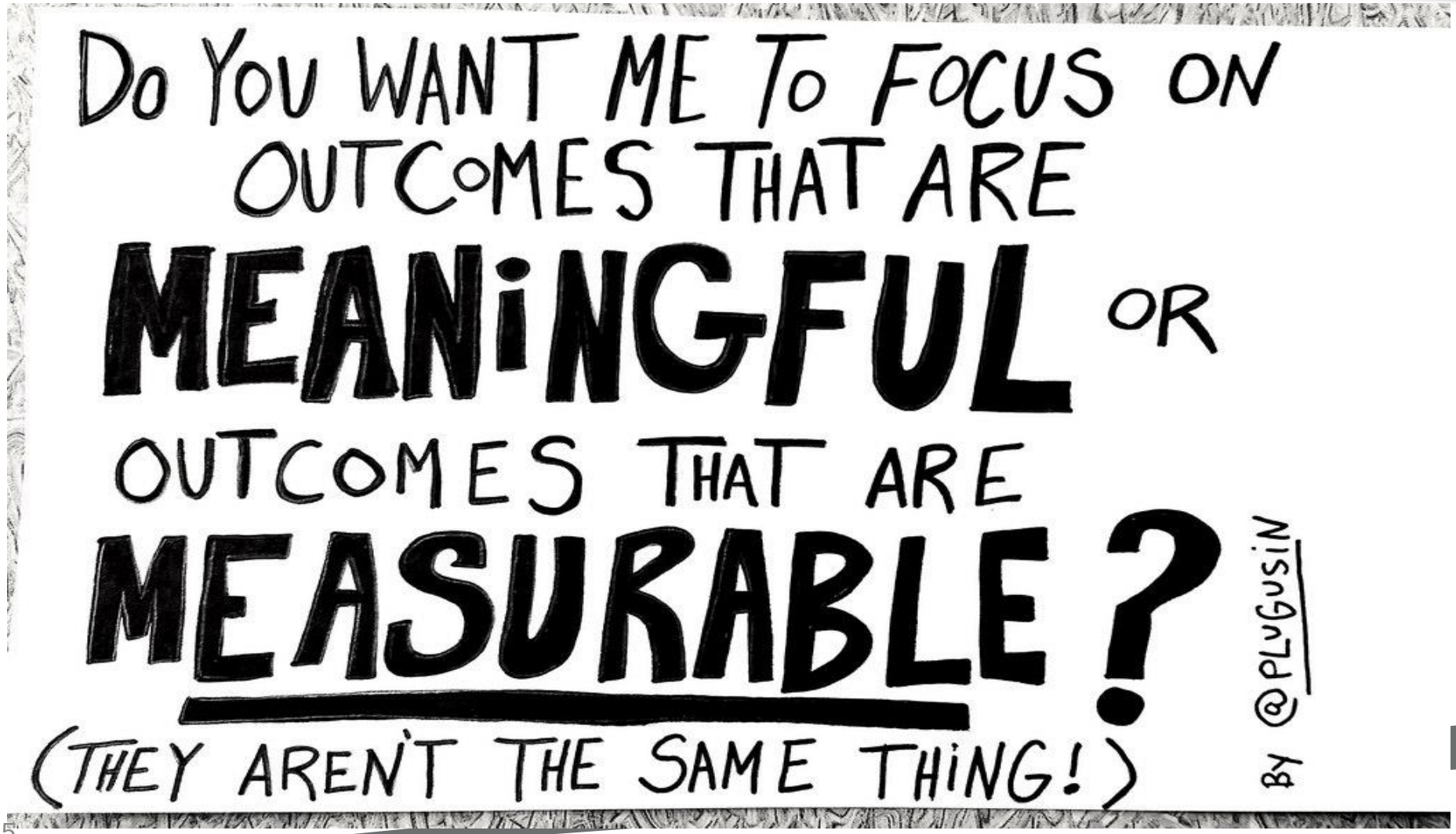
- When Insurance Gets Turned Down: Appeals Explained | diaTribe
- https://diatribe.org/when-insurance-gets-turned-down-appeals-explained

Why Change??

If you always do what you've always done, you'll always get what you've always got.

Henry Ford

MEANINGFUL OR MEASURABLE???



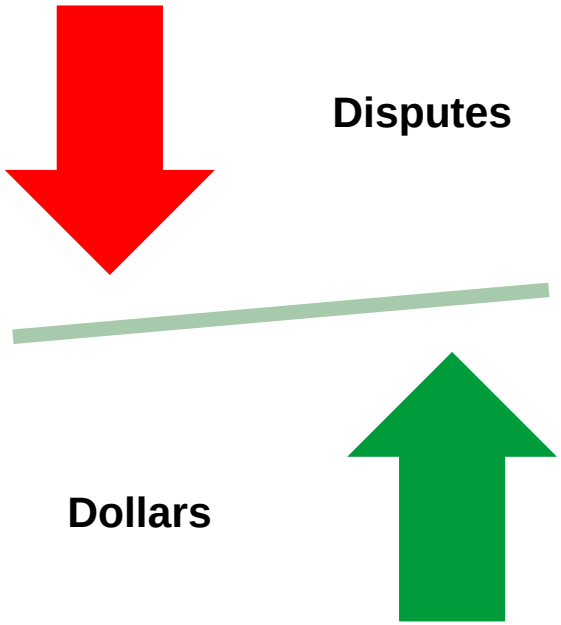
VALUE OF PEER TO PEER DIALOGUE

- Outcomes
  - Reduction of Denials
  - Improvement of AR
  - Denial Prevention
  - Education
  - Metrics that drive change

"It's so fun to catch up! Now what were we supposed to be covering again?"

VALUE FOR STAKEHOLDERS

- Patients
- Case Management
- Physicians
- Physician Advisors
- Denial Team
- Revenue Cycle



LONG TERM GOALS

- Patient satisfaction improved
- Physician education provided
- Payor communication improved

ANTHEM 2015

Medicare Advantage
Outreach and Education Bulletin

Anthem BlueCross BlueShield

Anthem Blue Cross and Blue Shield

Peer to Peer Process

Effective November 1, 2014 Anthem Blue Cross and Blue Shield (Anthem) will change our Peer to Peer process. This change expedites reviews of adverse determinations.

The changes are outlined below:

- Providers can call and request a Peer to Peer discussion at any time; however once the denial letter is sent our medical directors cannot overturn an adverse determination.
- You will have until 5:00 p.m. the following business day, after a verbal denial notification is given, to request a Peer to Peer conversation before the letter is sent.
- Anthem will accept a Peer to Peer discussion from one of the following:
  - The attending physician or the last treating physician
  - The physician's nurse practitioner
  - The Chief Advisor of the facility (i.e. facility medical director)
  - Physician Advisor (i.e. MD overseeing the UM or CM department at the facility)
- Anthem will delay sending the denial letter up to 2 business days, if a Peer to Peer discussion has been requested. This will allow time for the discussion to take place.
- If the Peer to Peer discussion takes place after the letter has been sent, the only option would be a formal appeal or a written reopen request per CMS guidelines.

If you have any questions, please contact your local Network Relations Consultant.

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ANTHEM 2018

Peer to Peer Review Process

Upon the Providers request from an attending, treating or ordering physician, Anthem provides a medical peer-to-peer review process where our internal peer clinical reviewers re-examine cases when an adverse medical necessity determination will be made or has been made regarding health care services for Covered Individuals. The attending, treating or ordering physician may offer additional information and/or further discuss his/her cases with our peer clinical reviewers who made the initial adverse determination.

Initiating a Peer-to-Peer Request: Providers can initiate a peer-to-peer request **IF** he/she is the attending, treating or ordering physician, Nurse Practitioner, or Physician Assistant who provides the care for which any adverse medical necessity determination is made. In compliance with nationally recognized guidelines from the National Committee for Quality Assurance (NCQA) and URAC, Provider or his/her designee may request the peer-to- peer review. Others such as hospital representatives, employers and vendors are not permitted to do so.

Anthem BlueCross BlueShield

CARESOURCE THEN

CareSource

Provider Clinical / Claim Appeal form

Include supporting documentation • Incomplete submission will be returned for additional information • Applicable timely filing limits apply

Member Name_____	Date of Service_____
Member ID Number_____	Code / Service not covered_____
	Place of Service_____

Provider Name_____ Please indicate the following provider information: Provider NPI Number_____	CareSource Claim	Provider	ID_____ Number_____
Provider Telephone Number (_____)_____	Requestor Name_____		

Select the most appropriate appeal type:	Required Documentation:
❑ **Claims Appeal** — An adverse decision regarding payment for a submitted claim or a denied claim for services rendered to a CareSource member.	• Appeal Form • Supporting Documentation • Original Remittance Advice The provider / Facility rendering services has 365 days from the date of service to file a claim appeal.
❑ **Clinical Appeal** — A request to review a determination not to certify an admission, extension or stay, or other health care service conducted by a peer review who was not involved in any previous adverse determination / non-certification decision pertaining to the same episode or care.	• Appeal Form • Records supporting medical necessity • Original Remittance Advice The provider / facility rendering services has 180 days from the date of service to file a clinical appeal.
❑ **Corrected Claim** — Any correction of the date of service, procedure / diagnosis code, incorrect unit count, location code and / or modifier to a previously processed claim. ▪ Resubmit the entire claim with updated information as a **Corrected Claim**. If you disagree with the amount paid on a claim line, you will need to submit an appeal.	**Please send Corrected Claims to:** STOP CareSource ATTN: Claims Dept. P.O. Box 8730 Dayton, OH 45401-8730

Reason for appeal request:

Claims Appeals Department **P.O. Box 2008** **Dayton, OH 45401-2008**	**Clinical Appeals Department** **P.O. Box 1947** **Dayton, OH 45401-1947**	**Fax to: Provider Claims Appeal Coordinator** **Fax Number: 937-531-2398**

OH-P-1165

CARESOURCE NOW

MEDICAL NECESSITY CRITERIA

CareSource utilizes nationally recognized criteria to determine medical necessity and appropriateness of inpatient hospital, rehabilitation and skilled nursing facility admissions. These criteria are designed to assist health care partners in identifying the most efficient quality care practices in use today. They are not intended to serve as a set of rules or as a replacement for a physician's medical judgment about individual patients. CareSource defaults to all applicable state and federal guidelines regarding criteria for authorization of covered services. CareSource also has policies developed to supplement nationally recognized criteria. If a patient's clinical information does not meet the criteria, the case is forwarded to a CareSource Medical Director for further review and determination. Physician reviewers from CareSource are available to discuss individual cases with attending physicians upon request.

Utilization review determinations are based only on appropriateness of care and service and existence of coverage. CareSource does not reward health care partners or our own staff for denying coverage or services. There are no financial incentives for our staff members that encourage them to make decisions that result in underutilization.

Our members' health is always our number one priority. Upon request, CareSource will provide the clinical rationale or criteria used in making medical necessity determinations. You may request the information by calling faxing the CareSource Medical Management department. If you would like to discuss an adverse decision with CareSource's physician reviewer, please call the Medical Management department at **1-800-488-0134** within five business days of the determination.

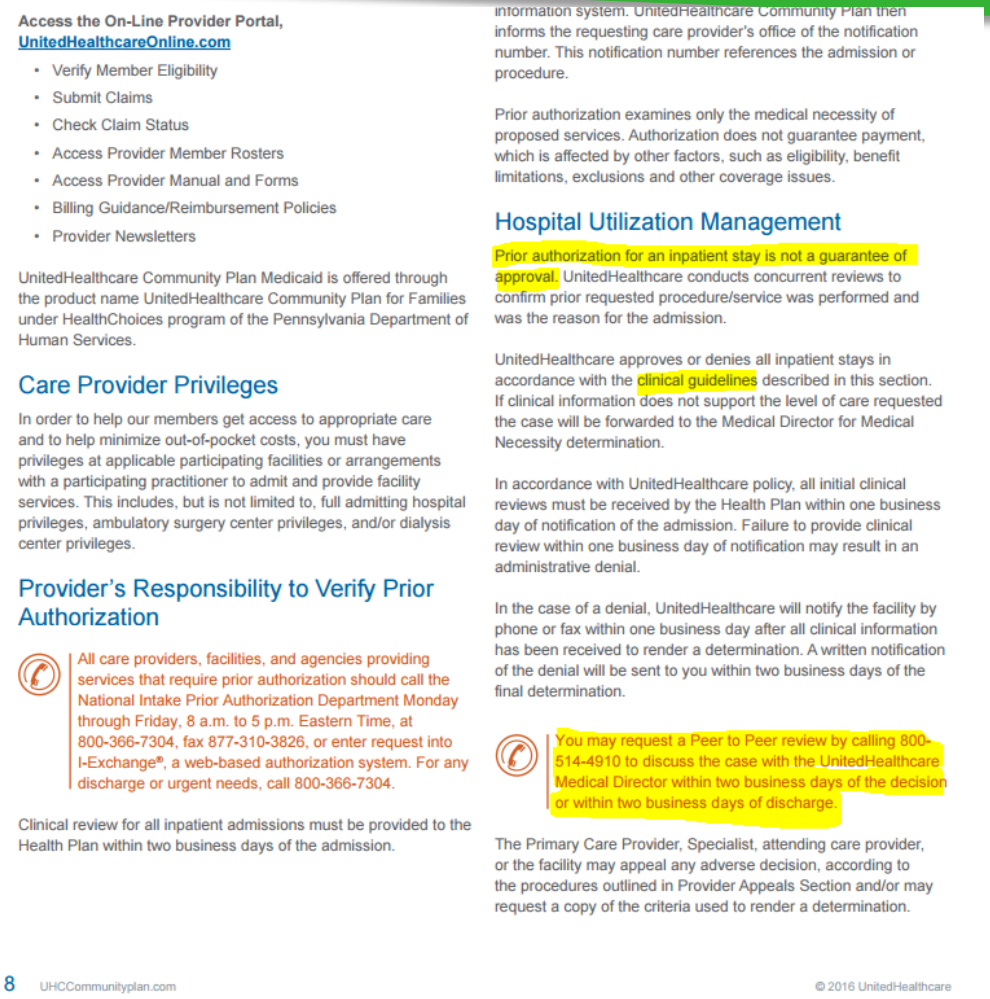
ACCESS TO STAFF

Health partners may call our toll free number at **1-800-488-0134** to contact Medical Management staff with any UM questions.

- Staff members are available from 8 a.m. to 5 p.m. Eastern Standard Time (EST), Monday through Friday, for inbound calls regarding UM issues.
- Staff members can receive inbound communication regarding UM issues after normal business hours.
- Health partners may leave voice mail messages on these telephone lines after business hours, 24 hours a day, seven days a week.
- A dedicated fax line, email and the PROVIDER PORTAL can be used for medical necessity determination requests 24 hours a day, seven days a week.
- Staff members can send outbound communication regarding UM inquiries during normal business hours, unless otherwise agreed upon.
- Staff members are identified by name, title and organization name when initiating or returning calls regarding UM issues.
- Staff members are available to accept collect calls regarding UM issues.
- Staff members are accessible to callers who have questions about the UM process.

For the best interest of our members and to promote their positive health care outcomes, CareSource supports and encourages continuity of care and coordination of care between medical care health partners as well as between behavioral health care health partners.

UNITED HEALTH CARE



Access the On-Line Provider Portal, UnitedHealthcareOnline.com

- Verify Member Eligibility
- Submit Claims
- Check Claim Status
- Access Provider Member Rosters
- Access Provider Manual and Forms
- Billing Guidance/Reimbursement Policies
- Provider Newsletters

UnitedHealthcare Community Plan Medicaid is offered through the product name UnitedHealthcare Community Plan for Families under HealthChoices program of the Pennsylvania Department of Human Services.

Care Provider Privileges

In order to help our members get access to appropriate care and to help minimize out-of-pocket costs, you must have privileges at applicable participating facilities or arrangements with a participating practitioner to admit and provide facility services. This includes, but is not limited to, full admitting hospital privileges, ambulatory surgery center privileges, and/or dialysis center privileges.

Provider's Responsibility to Verify Prior Authorization

All care providers, facilities, and agencies providing services that require prior authorization should call the National Intake Prior Authorization Department Monday through Friday, 8 a.m. to 5 p.m. Eastern Time, at 800-366-7304, fax 877-310-3826, or enter request into I-Exchange®, a web-based authorization system. For any discharge or urgent needs, call 800-366-7304.

Clinical review for all inpatient admissions must be provided to the Health Plan within two business days of the admission.

information system. UnitedHealthcare Community Plan then informs the requesting care provider's office of the notification number. This notification number references the admission or procedure.

Prior authorization examines only the medical necessity of proposed services. Authorization does not guarantee payment, which is affected by other factors, such as eligibility, benefit limitations, exclusions and other coverage issues.

Hospital Utilization Management

Prior authorization for an inpatient stay is not a guarantee of approval. UnitedHealthcare conducts concurrent reviews to confirm prior requested procedure/service was performed and was the reason for the admission.

UnitedHealthcare approves or denies all inpatient stays in accordance with the clinical guidelines described in this section. If clinical information does not support the level of care requested the case will be forwarded to the Medical Director for Medical Necessity determination.

In accordance with UnitedHealthcare policy, all initial clinical reviews must be received by the Health Plan within one business day of notification of the admission. Failure to provide clinical review within one business day of notification may result in an administrative denial.

In the case of a denial, UnitedHealthcare will notify the facility by phone or fax within one business day after all clinical information has been received to render a determination. A written notification of the denial will be sent to you within two business days of the final determination.

You may request a Peer to Peer review by calling 800-514-4910 to discuss the case with the UnitedHealthcare Medical Director within two business days of the decision or within two business days of discharge.

The Primary Care Provider, Specialist, attending care provider, or the facility may appeal any adverse decision, according to the procedures outlined in Provider Appeals Section and/or may request a copy of the criteria used to render a determination.

8 UHCCommunityplan.com

Facility Denial Process

When the medical group/IPA is delegated for authorization and concurrent review, we expect them to issue a facility denial letter to the contracted facility when the facility's medical record or claim fails to support the level of care or services rendered. This may be determined through concurrent or retrospective review.

There are three types of facility denial letters:

- Delay in inpatient services
- Delay in change of level of care within the same facility
- Delay in facility discharge

The delegated medical group/IPA must comply with our protocols, policies and procedures for denials, including turn-around times for issuing, delivering and submitting facility denial letters to UnitedHealthcare. Facility denials are not sent to the member and specifically exclude them from liability for the denied level of care and/ or services.

https://www.uhcprovider.com/content/provider/en/viewer.html?file=https%3A%2F%2Fwww.uhcprovider.com%2Fcontent%2Fdam%2Fprovider%2Fdocs%2Fpublic%2Fadmin-guides%2FUnitedHealthcare_Administrative_Guide_2017.pdf

HUMANA THEN

Peer-to-Peer Review: Prior to or at the time an adverse determination is communicated, the Provider ordering services is given an opportunity to discuss the plan of treatment for the Member and the clinical basis for treatment with a health Plan medical director. **Note:** Contact Humana Customer Service (1-800-4HUMANA) with any questions.

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Inpatient Coordination of Care: In the event coverage guidelines for an inpatient stay are not met and/or the Member's certificate does not provide the benefit, a licensed, medical professional will consult with the PCP and/or attending physician. If necessary, the licensed, medical professional will refer the case to a health Plan medical director for review and possible consultation with the attending physician. If the health Plan medical director determines that coverage guidelines for continued hospitalization are no longer validated, the Member, attending physician, hospital, and the Member's primary care office will be notified in writing that benefits will not be payable if the Member remains in the hospital on and after the effective date of the nonapproval.

HUMANA NOW

Peer-to-peer Review Process Changing for Humana Medicare Advantage (MA) Products

Humana is implementing changes to the peer-to-peer review process for its Medicare Advantage health plans.

Effective Aug. 1, 2018, Humana's time frame for completing a peer-to-peer review is changing. The process then will be:

- Prior to issuing a medical necessity denial in response to an authorization request for medical service, a Humana representative will call the treating healthcare provider and offer to schedule a peer-to-peer review. The review must take place prior to Humana's issuance of the denial. Humana will no longer offer peer-to-peer reviews after the denial.
- Additional clinical information may be submitted at any time prior to the peer-to-peer conversation.

To ensure a timely and effective review of authorization requests for medical services for patients, healthcare providers need to be sure to:

- Submit all relevant medical records and pertinent information to support the authorization reques
- Respond promptly to requests for additional information so a timely and effective review can be completed.

Note: The current peer-to-peer review process will remain in place for commercial and Medicaid plans.

For more information, contact Humana Customer Service at 1-800-448-6262 (1-800-4HUMANA).

SYSTEM SOLUTIONS

- Regular Education for all
- Tip sheets created
- EMR templates
- Informed UM Staff
- Do’s and Don’t ‘s shared

THANK YOU