Discover the “Do’s and Don’ts” to Maximize Success in Peer-To-Peer Conversations

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Does anyone understand how sick my patient is ? Really?? What criteria???

OBJECTIVES

- Examine what your next steps are when you are denied a peer-to-peer review
- Impact of Peer to Peer appeals
- Building a comprehensive physician orientation system
- Techniques for managing peer-to-peer reviews when discussing with Medical Directors of commercial payers and Medicare Advantage plans
- Tackle the increasing overturn rate for managed care denials

The Denial?

Typical Denial

The Infinity Wars: No one wins here

Metrics

HOW MANY DAY/WEEK/ MONTH YEAR?

HOW MANY BY PAYOR?

HOW MANY BY DIAGNOSIS?

HOW MUCH IN DOLLARS?

HOW MANY BY PHYSICIAN?

Reasons

- Administrative
- Technical
- DRG Downgrade
- Medical Necessity
- Discharge Disposition

Why

- The reason for the disputed claim.
- Options for an expedited resolution.
- Submit Any additional information if possible.
- Denial letter needs to be reviewed and all possibilities exhausted.

WHO

Review your contracts

Find out **who** can do a P 2 P

- Attending or Physician Advisor

Prior Experience

Possible time constraints

Desired Resolutions

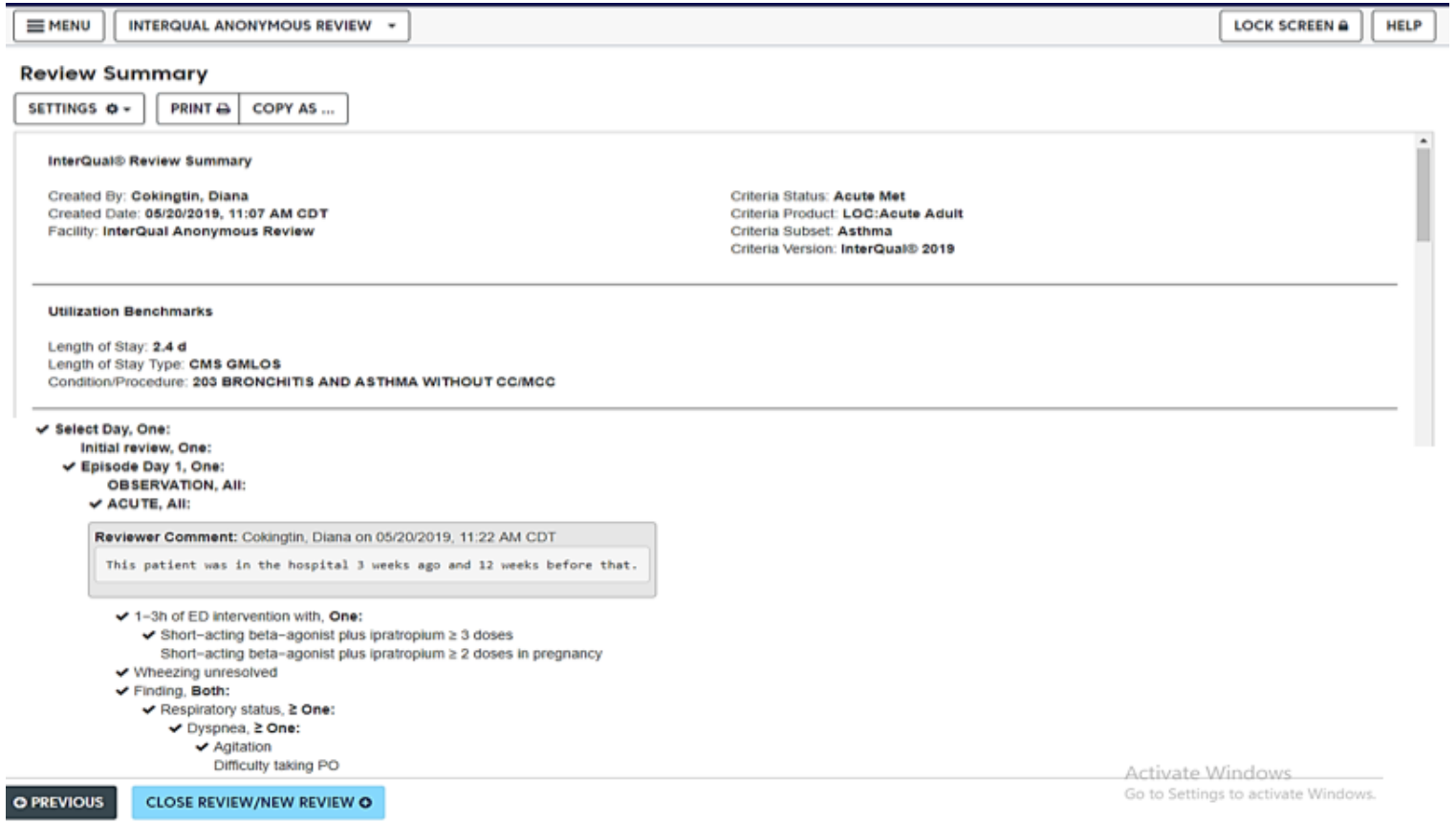
What

- The Response
- Medical Criteria
- Medical Literature
- Medical Picture
- Expert Testimony

HOW

- Team Approach
- Prep
- Documentation
- Contracts
- Education

The Prep: Review Summary



Peer to Peer Form

To be completed by UR Nurse/ Payer Specialist:

Hospital:_____ **Tax ID:**_____ **NPI:**_____

Name: _____ **Age**_____ **DOB:**_____

Insurance Plan:_____ **Policy ID:**_____ _____ **Ref no:**_____

Admission: ( ) Emergency ( ) Elective **Admission Date:**_____

Level Of Care: ( ) Med Surg ( ) Intermediate ( ) ICU

Insurance Physician No:	**Timeframe: ( ) 24 hrs ( ) 48 hrs**

Peer to Peer Form

Insurance Physician No:	Timeframe: ( ) 24 hrs ( ) 48 hrs	
Length of Stay	Anticipated Dc Date:	No of Denied Days

Reason for Denial: _____

UR Comments:

_____

Diagnosis: _____

UR Nurse:_____ph no_____ Date:_____

To be completed with Physician Input	YES	NO
1. Does the pt's condition require an INPT stay?	( )	( )
2. Are treatments and services being rendered that can only be provided in an INPT setting?	( )	( )
3. Is discharge planning in progress?	( )	( )
4. Could services be provided more efficiently as suggested by the payor?	( )	( )

Peer to Peer Form

5. Can Physician documentation justify an INPT stay? ( ) ( )
6. Are you willing to do a P2P to get the Inpt stay approved? ( ) ( )
7. Reason to Appeal:

_____

8. Called at: date /__/___time _____ Am/Pm Call returned at _____Am/ Pm Spoke to: Dr_____
9. Outcome of call ( ) Approved by payor ( ) Denied by payor as INPT ( ) will Accept OBS and facilitate Dc Asap
10. Reasons for Denial/ Approval:

_____

_____

11. If still Denied, which options will you recommend? ( ) Consider a written Appeal ( ) Refer to Physician Advisor

12. Peer to Peer done by Physician : _____Date: _____

Please return form to UM Nurse at fax no: - Or email UM----------

Or call UM Nurse at ----------

Peer to Peer

UR Nurse: Please fill the top half with all pertinent information.

Please inform the Physician why the denial occurred, and what documented options can be considered to justify the inpt stay.

The physician may need a little assistance for the first few calls. Contact your Physician Advisor or Manager if you need any support.

Peer to Peer

Physicians: You are seeking **INPATIENT CARE!** You know their clinical issues the best!
Inpatient status covers them financially and it is up to **YOU to Fight For Your Patient's Best Interests**!

*** Before Calling the Payor, discuss the case with the UM nurse to prep for the call, understand the reason, and prepare your clinical justification.

*** Here are some tips we have gathered to optimize your experience.

1. **Be cordial**. (The Dr on the other end is just doing his job)
2. **Know** / ask for the specialty of the Dr you are speaking with.
3. **Know** your case, why they are denying and have a clinical justification ready.
4. **Have** all the facts and reasons handy.
5. **Ask them** what information they have regarding your pt, fill in the gaps.
   (Usually this will be enough to overturn your case)

Peer to Peer

6. **Share** any outpatient failed treatments and why observation is not appropriate.
7. **Ask for potential options to keep the pt safe and decrease readmissions and morbidity.**
8. **Do Not Discuss** different kinds of criteria, only individual clinical care!
9. **Always remain Professional and Calm.**
10. **Any** contractual issues should be referred back to the Physician Advisor or UM nurse.
11. **Please end with a clear decision. Inpt or not inpt?**
12. **You** will not win all, however we learn from **all!**
13. **Please contact you UM nurse and she will help you fill out the other side of the form.**

Appeal Submission

- You can submit appeals through our Provider Portal or using the Provider Appeal Form. The Provider Portal is the most efficient method of submitting appeals.
- Include the following required documentation:
  - Progress notes including symptoms and their duration, physical exam findings, conservative treatment that the member has completed, preliminary procedures already completed and the reason service is being requested
  - Any documentation of specialists' reports or evaluations, any pertinent previous diagnostic reports and therapy notes
  - If the service has already been provided, a copy of the original remittance advice and/or the denied claim
  - If filing an appeal on behalf of a member or for pre-service issues, the member's written consent, which must be specific to the service being appealed, is only valid for that appeal and must be signed by the member (**Please note:** You can use the Consent for Provider to File an Appeal on Patient/Member's Behalf form to record this consent.

CareSource Appeals

Expediting Clinical Appeals

- If you feel that your patient's life or health is at risk if a decision about care is not made in a timely manner, you may ask us to expedite a clinical appeal.
- Call us at **1-800-488-0134** to expedite a clinical appeal.

Notification of Resolution

- CareSource will decide whether to expedite an appeal within 24 hours. We will make reasonable efforts to provide prompt verbal notification to the member of the decision to expedite or not expedite the appeal; the attempt will be made by phone. If the member is in a facility, the provider or facility will be notified on the same business day of the decision.
- Expedited appeals will be resolved and verbal notification will be made within 72 hours of receipt of the appeal or as expeditiously as the medical condition requires unless the resolution time frame is extended. CareSource will send written notification to both the provider and the member on the same business day of the decision.

CareSource Appeals

Denied Expedited Appeals

- If CareSource decides not to expedite the clinical appeal, we will send written notification **within two calendar days** of receipt of the appeal to both the member and the provider. This notification will include the determination to process the appeal as a standard appeal and any **additional appeal rights** the member may have related to our decision. The appeal will be resolved within 15 calendar days from the date the appeal was received and follow the standard CareSource appeal process.

Extending an Appeal

- **Members may verbally** request that CareSource extend the time frame to resolve any **medically necessity appeal request up to 14 days**. CareSource may also request an extension. CareSource must submit documentation that the extension is in the member's best interest to the Ohio Department of Medicaid (ODM) for prior approval.
- If ODM approves the extension, CareSource will notify the member in writing of the extension reason and new timeframe.

- **Initiating a Peer-to-Peer Review Request:** Providers can initiate a peer-to-peer review 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.

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.

HUMANA

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.

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

- **Commercial Appeals Definitions of Terms:**
- **Adverse Determination:** A denial, reduction, termination of, or failure to provide **a service** or make payment:
  - In whole or part for a benefit (Example: Applying the Plan provisions and paying less than the total amount of expense submitted for a deductible, coinsurance or copayment)
  - For Group Plans: Based on eligibility to participate in the Plan (when a claim or appeal is made)
  - For Individual Plans: Based on eligibility to participate in the Plan
  - Based on rescission of coverage
  - **Expedited/Urgent Appeal:** a verbal or written request for a fast or rush appeal from a Member, representative, or physician to appeal a service denial, termination of care, or a reduction in the level
    of care. An appeal will be expedited when the determination, if processed according to the standard appeal time frames, could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function, or would cause the member to have severe pain that cannot be adequately managed without the requested care or treatment.

Humana

- Humana will provide a full and fair review of the appeal. All appeal reviews will be conducted by a reviewer possessing the following characteristics:
  - Did not participate in the initial decision; and
  - Is not a subordinate of the individual who made the initial decision
  - In addition to the above requirements, appeal reviews for medical necessity, experimental, and investigational will include a specialty review by a reviewer who is from the same or similar specialty, who typically treats the medical condition or provides the treatment in question, and holds an active, unrestricted medical license.
  - Appeals should be submitted within 180 days of the date that Member receives the adverse determination (see Note 1 below). Member may provide Humana with additional information that relates to the adverse determination and Member may request copies of information that Humana has that pertains to the appeal. Humana will notify Member of its decision within 72 hours for expedited appeals or within 30–60 days for standard appeal of receiving the request (see Note 2 below).

Medicare Appeals

Medicare Appeals – Definition of Terms:

Authorized Representative - an individual either appointed by a Member or authorized under state or other applicable law to act on behalf of the Member in obtaining an organization/coverage determination, or grievance or appeal determination.

Coverage Determination (Part D Plan) - any decision made by or on behalf of a Part D Plan regarding payment or benefits to which a Member believes he or she is entitled.

Expedited/Urgent Appeal - A verbal or written request for a fast appeal review of a preservice denial, termination of care, or a reduction in the level of care if the time frame for a standard appeal could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function, or care or treatment that if not rendered could subject the Member to severe pain that cannot be adequately managed, based on the opinion of a practitioner with knowledge of the Member's medical condition. Expedited appeals exclude requests for payments for services already provided.

Independent Review Entity ("IRE") - an independent entity contracted by CMS to provide an independent review of a Plan's appeal decision.

Organization Determination (MA Plan) - any determination made by a Medicare health Plan with respect to any of the following:

- Payment for temporarily out-of-the-area renal dialysis services, emergency services, post-stabilization care, or urgently needed services;
- Payment for any other health services furnished by a Provider other than the Medicare health Plan that the Member believes are covered under Medicare, or, if not covered under Medicare, should have been furnished, arranged for or reimbursed by the Medicare health Plan;
- The Medicare health Plan's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the Member believes should be furnished or arranged by the Medicare health Plan;
- Reduction, or premature discontinuation of a previously authorized ongoing course of treatment;
- Failure of the Medicare health Plan to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the Member with timely notice of an adverse determination, such that a delay would adversely affect the health of the Member; or
- Medicare Savings Accounts (MSA) only: decisions regarding whether expenses paid for with money

Reconsideration (MA appeal) - the first step in the appeal process after an adverse organization determination; A Medicare health Plan or independent review entity may reevaluate an adverse organization determination, the findings upon which it was based, and any other evidence submitted or obtained.

Redetermination (PDP appeal) - the first level of the appeal process which involves a Part D Plan reevaluating an adverse coverage determination, the findings upon which it was based, and any other evidence submitted or obtained.

Specialty Review - a review conducted by a health care provider that typically manages the medical condition, procedure, or treatment under review for clinical appeals.

Medicare Appeals Process:

Humana will accept and process any oral PDP or written PDP or Medicare Advantage appeal from a Member or an authorized representative expressing dissatisfaction with Humana's adverse determination. In addition, Humana will accept and process any additional evidence or allegations of law and fact related to the disputed issue.

Expedited appeals exclude requests for payments of services already provided, but may include:

- medical necessity (service) denials;
- benefit denials;
- termination or reduction of care or benefits; or
- delays in providing or approving an expedited coverage or service request when a delay would adversely affect the Member's health

Standard appeals may include:

- medical necessity denials;
- benefit denials;
- claim denials that affect the member's payment of a deductible, coinsurance or copayment;
- termination or reduction of care or benefits; or
- delays in providing or approving coverage or services when a delay would adversely affect the member's health

Humana will identify and remove any communication barriers that may impede Members or representatives from effectively making appeals. Humana will facilitate the request to file an appeal for

The Denial

The right way

Glad to have chatted with you

- Thanks for approving the stay.
- Could I please have the approval number ?
- Have a nice day Dr. Perfect.

Thank you

Suggestions or Comments, Please feel free to reach out to us.

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