

UNDERSTANDING PEER TO PEER CONCURRENT PAYER DISCUSSIONS

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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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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 Provider ID _____ Claim Number _____	
Provider Telephone Number () _____	Requestor Name _____	
Select the most appropriate appeal type:	Required Documentation:	
<input type="checkbox"/> Claims Appeal — An adverse decision regarding payment for a submitted claim or a denied claim for services rendered to a CareSource member.	<ul style="list-style-type: none"> • 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.	
<input type="checkbox"/> Clinical Appeal — A request to review a determination not to certify an admission, extension of 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.	<ul style="list-style-type: none"> • 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.	
<input type="checkbox"/> 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. <ul style="list-style-type: none"> • 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:  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



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.





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.

WHAT ARE THE DELAYS?

- Timing of Denial
- Reason for Denial
- How / who is going to respond?
- When ?
- Response??
- Follow-up ?

THE PEER TO PEER PROCESS



Promedica 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
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P2P 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? | () | () |
| 5. Can physician documentation justify an INPT stay? | () | () |

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 _____



P2P EDUCATION



Promedica Peer to Peer Education



09/2016

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.

P2P EDUCATION



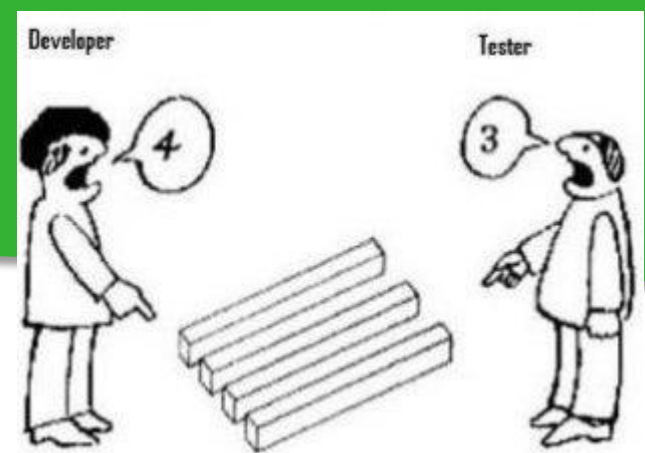
Physicians: You are seeking **INPATIENT CARE!** You know their clinical issues the best!
Inpatient status covers them financially and it is up to **YOU to Fight For Your Patient's Best Interests!**

*** 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)
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.**

P2P EDUCATION



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.**



THANK YOU

