Peer-to-peer insurance reviews

Best practices for clinicians' preparation and documentation of peer reviews

These best practices[1] may help mental health and substance use disorder clinicians prepare for and conduct peer reviews in support of their patients' care and insurance coverage.

Clinicians treating patients with mental health and/or substance use disorders may encounter required discussions with health insurer "peers" in connection with (a) prior authorizations, (b) progress check-ins, (c) medical necessity determinations, and (d) similar "reviews," quality oversight, or appeals.

Such clinical reviews can be challenging, especially when the assigned peer reviewer has insufficient clinical training and/or applies potentially inappropriate standards for evaluation of necessary patient care, or the treating clinician is unprepared for the discussion.

The guidance and "best practices" provided here support better preparation and conduct of peer-to-peer reviews to optimize achieving insurance coverage of medically necessary care.

Clinician	Former Insurance Executive
"Peer reviews of clinical care can add value if based on a patient-centric, informed dialogue." Psychiatrist in private practice	"Clinicians are well-advised to focus with the insurer 'peers' on their patient's 'quality of care' needs. Reaching alignment on what a patient needs ***first*** will best inform the question of whether that care is covered by the patient's insurance." Former behavioral health unit director; multiple health insurers
Mental Health Executive	**Consumer Insurance Advocate**
"I've trained hundreds of clinicians to approach peer reviews as ***their*** call, not the peer's. The best results follow a script of (a) 'Thanks for taking my call,' (b) overview of [patient] condition and treatment plan, and (c) new information on condition." Community mental health practitioner	"Understanding health insurer decisions about coverage starts with understanding who is deciding and on what basis. Preparing for a peer review is a critical part of clinician advocacy for patients." Patient and Healthcare Provider Insurance Advocate

Summary of guidance and documentation support provided here

The specific guidance below includes:

- Potential "agenda" for the call, plus specific talking points and questions
- Preparation for clinical discussion
- Documentation of the discussion
- After the call: potential follow-ups and next steps

[1] Cover My Mental Health NFP provides education and guidance with respect to dealing with denied health insurance claims and other obstacles to receiving mental health care. Cover My Mental Health does not provide legal services or legal advice with respect to those or any other matters.

The accompanying worksheets support your inquiries and documentation of the discussion, including:

- Patient and clinician information
- Peer background and clinical competence
- Basis of peer assessment
- Documentation requests made of the peer reviewer

Potential "agenda" for the call, plus specific talking points and helpful questions

The reasonable goals for a peer-to-peer review for a treating clinician are:

- Alignment with the peer reviewer regarding the treatment plan, including level of care;
- Clarity/specificity regarding the peer reviewer's competence, preparedness, and basis of assessment for coverage; and
- Go-forward plan for documentation of coverage or path to resolution of coverage

With these goals in mind, below is the outline for an "agenda" and potential talking points for a peer-to-peer discussion. The documentation resources accompanying this guidance support your note-taking for future reference.

A. **Summarize case**, including patient age, gender, demographics, and new clinical information
   - ► *"In considering the appropriate care for my patient, I would like to provide you with current facts of the case."*

B. **Required treatment and level of care for [patient]** – the primary goal of the treating clinician for the peer-to-peer discussion is articulated at the start, such as:

   - ► *"I am prepared to discuss the treatment plan for [patient], including level of care and recent developments with an eye toward helping this patient achieve recovery [not mere crisis stabilization]. This is essential for our conversation before discussing coverage of care as specified in the patient's insurance plan."*

C. **Peer background and competence** – what clinical training and practice does the clinical reviewer have in support of this review?

   The independent accreditation organizations who oversee health insurers' practices require that peer reviews are conducted by a clinician who is trained and experienced in the evidence-based guidelines specific to the treatment under review.

   - ► *"I have a few questions to help with my discussion of [patient], specifically, I'd like to learn about your training, board certifications, clinical practice, and review of patient-specific documents and preparation to better guide my discussion."*

D. **Basis of peer reviewer assessment** – understanding peer review's clinical standard of care as applied to this review

   - ► *"In considering the appropriate care for my patient, ~~I~~ would like to understand the clinical standard of care applied by the payer."*

E. **Coverage status, clarifications, path to a determination** – is the patient's condition and the treating clinician's plan understood?; what possible next steps?

- ► *"Has a determination regarding coverage already been made? If so, what? If not, what steps remain and what information is lacking to finalize?*
- ► *"Given my update on the case, have we fulfilled the necessary criteria for this treatment plan and level of care?"*
- ► *"Is it clear that [patient] ….?" "Did you know that [patient] ….?"*

F. **In case of an adverse determination (e.g., no coverage or delayed resolution)**, potential paths forward:

- ► *"Since we agree on the appropriate course of treatment, though you have declined coverage, what is the path for securing a benefit exception?"*
- ► *"What is your specific proposed alternative to the requested level of care? It is essential to understand that a suggested alternative is feasible from a clinical, timing, and logistical perspective."*
- ► *"Since you support only crisis stabilization, while the generally accepted standard in the field is pursuit of recovery, what next level of review within [insurer] is available for reconsideration?"*
- ► *"Since we disagree on the appropriate course of treatment, what are the specified steps for me to pursue an external review? Or for my providing additional information?"*

G. **Documentation requests** – to request and confirm documentation from the clinical reviewer

- ► *"For my and my patient's future reference, I require documentation of our complete discussions today and your documented assessments including any scientific bases and published articles you have relied on."*

Preparation for clinical discussion

The primary goal of the treating clinician for the peer-to-peer discussion is discussion of the patient's current status, related risk management, and treatment plan for purposes of evaluating quality of care and determining insurance coverage.

Potential reasons for coverage decisions denying or modifying the treating clinician's plan may include:

- Determining medical necessity based on an insurer's proprietary standards, not generally accepted standards
- Coverage of care limited to stabilization, not supporting treatment and recovery
- Treatment plan is deemed experimental by the insurance company

Preparation should specifically anticipate these potential differences.

Ideally, the clinical reviewer would use the same criteria as applied by the treating clinician. As such, asking about the criteria used by the reviewer may be helpful (e.g., ASAM, LOCUS) to effectively challenge their determination.

And, if the criteria used by the peer reviewer are not within generally accepted standards, it may be helpful for the treating clinician to refer to the applicable generally accepted standards and their appropriateness for the patient's specific treatment and recovery.

- Proprietary insurer criteria – Health insurers (and their clinical reviewers) may use assessment criteria such as MCG or InterQual. These criteria may be further modified for individual health plans. Further, the specific guidance provided by MCG or InterQual may not be disclosed.

  These proprietary criteria may limit care to crisis stabilization, though such limitations do not meet generally accepted standards of care.

- The American Medical Association (AMA) "cautions that there is often a vast difference between entities saying their criteria is 'based' on non-profit, professional medical association recommendations versus using the original. If there are any deviations from the integrity of non-profit, professional medical association recommendations/criteria, the AMA is concerned that would adversely affect patients.

  "The AMA urges all payers to use criteria for medical necessity determinations based on the same criteria used by board certified physicians in addiction medicine and psychiatry, as well as child psychiatry. While some payers argue that their own criteria are just fine, other payers have finally started to use criteria that benefit patients."

- Generally accepted standards – Clinicians rely on professional guidelines developed by non-profit, professional associations and referred to as part of "generally accepted standards of care," such as:
  - The American Society of Addiction Medicine (ASAM) criteria;
  - Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS);
  - The Child and Adolescent Level of Care Utilization System and the Child and Adolescent Service Intensity Instrument (CALOCUS-CASII);
  - The Early Childhood Service Intensity Instrument (ECSII).

Documentation:

The accompanying worksheets support your inquiries and documentation of the discussion, including:

- Patient and clinician info
- Peer background and clinical competence
- Basis of peer assessment
- Documentation requests

How could this documentation be helpful to you and your patients?

Cover My Mental Health always recommends documentation of conversations with insurance company representatives about coverage, such as:

- ► Prior authorizations, including initial authorizations, subsequent withdrawals or modifications by the insurer of such authorizations, questions about the scope of authorizations;
- ► Medical necessity determinations, including:
  - Level of care (including transitions to lower levels of care),
  - Determination of the appropriate clinical expertise and availability of a suitable treating clinician,
  - Frequency of care,
  - Rx selection,
  - Imposition of step therapy (or "fail first")
- ► Appeals, including formal appeals filed by the patient, subsequent external reviews; and
- ► Formal insurer complaints, regulatory complaints, and litigation.

Contemporaneous documentation of the clinical discussion, as well as provision of a timely medical necessity letter may also be essential to securing the patient's insurance coverage.

After the call: potential follow-ups and next steps

If coverage is denied	► Provide a medical necessity letter ► Request a benefit exception ► Request an external review ► Inform patient of potential next steps, including benefit exception request, formal insurer complaint, regulatory complaint.
If **urgent** care is denied	► Request an expedited review
If the peer does not have relevant clinical experience	► Request an immediate review with a competent peer ► File a formal complaint with the insurer ► File a grievance with NCQA and URAC (accreditation organizations for health plans)
Document your clinical decisions	► Provide a medical necessity letter
If the peer is unprofessional	► File a formal complaint with the insurer ► File a complaint with the state and/or federal regulator ► File a grievance with NCQA and URAC (accreditation organizations for health plans)