Peer-to-peer insurance reviews

What are the "rules" that apply to peer-to-peer reviews?

Peer-to-peer reviews may have specific requirements specified by state law and regulations, federal law, and regulations, insurance company "code of conduct," "Code of Ethics" [specified by??], accreditation agencies, insurance policies, and otherwise. There may be meaningful variability in these requirements, even within any given payer (e.g., across specific employer plans).

Below are common expectations for the proper conduct of peer-to-peer reviews that may be helpful.[1]

1. Peer reviewer must have appropriate clinical competence:
   - Accreditation agencies (e.g., NCQA, URAC) specify that the peer reviewer have training and experience suited to clinical treatment requirements under discussion, including potential complications (from treatment or lack of treatment) and determinations of medical necessity
   - Certain requirements from other sources may specify years of clinical practice, specialty-based board certification, years in current practice or other qualifying credentials for a peer reviewer.

2. Peer reviewer must be timely available to the treating clinician based on patient requirements:
   - Peer-to-peer discussions may be specified in connection with prior authorization, at check-points in treatment, or as part of quality reviews.
   - A treating clinician may request a peer-to-peer review for the benefit of their patient and all reasonable efforts must be made by an insurer in providing access to these reviews.

3. Peer reviewer must comply with the insurer/payer's Code of Conduct and the health insurance plan of the patient; specific requirements may include the following:
   - Written documentation of medical necessity and other insurance coverage determinations, including reference to patient documents reviewed, medical necessity standards applied (whether proprietary to the insurer or published by clinical associations), clinical/scientific basis for determinations (with reference documents made available upon request, as appropriate), [what else?]
   - Review of all relevant patient information, including any reasonably appropriate consultation with the treating clinician
   - No less than comparable training as the treating physician or clinician
   - Timely responses to requests from the treating clinician for documentation of claims determinations;
   - Specific Plan provisions reviewed that would appropriately support the right to treatment and authorization requirements.

4. Authorization by a peer reviewer of an adverse determination (i.e., denial of coverage) without sufficient review and consideration of medical records is not permitted.

5. Peer-to-peer review transcripts and supporting documents are to be included in the patient claims file for potential reference in appeals or other dispute resolution processes.

6. Usual HIPAA patient consents are required ahead of disclosures such as in peer-to-peer discussions.

[1] Cover My Mental Health does not provide legal or medical counsel of any kind, and we encourage you to consult a competent expert for specific guidance.