AETNA BETTER HEALTH® of Illinois
Policy

Policy Name:	Peer-to-Peer Review	Page:	1 of 6
Department:	Medical Management	Policy Number:	7000.65
Subsection:	Utilization Management	Effective Date:	12/01/2020
Applies to:	■ Medicaid Health Plans		

PURPOSE:

To define the Aetna Better Health peer-to-peer review process through which a treating practitioner makes a request to discuss a utilization issue with an Aetna Better Health medical director. This process applies to Aetna Better Health Medical Management (medical and behavioral health) and Long-Term Care Services and Supports (LTSS) coverage determinations.

This process does not apply to LTSS enhanced benefits. LTSS enhanced benefits do not require medical director review (enhanced services as listed in the managed care organization (MCO) contract Chapter II – Program Description, Exhibit F, Section 3.2.2. For example, adult day services, personal emergency response system, home-delivered meals, Money Follow the Person services).

STATEMENT OF OBJECTIVE:

To facilitate a discussion between a requesting practitioner and a medical director concerning a utilization issue. A peer-to-peer consultation may address a potential request for services, requests under review, ongoing patient care, or a denial.

DEFINITIONS:

Concurrent Review	A request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if Aetna Better Health did not previously approve the earlier care. All inpatient concurrent requests are considered urgent. Concurrent reviews are typically associated with inpatient care, residential behavioral care, intensive outpatient behavioral health care and ongoing ambulatory care.
Denial, Reduction, or Termination of Financial Responsibility	The non-authorization of care or service at the level requested based on either medical appropriateness or benefit coverage. Partial approvals (modifications) and decisions to discontinue authorization when the practitioner or member does not agree are also denials.
Medically Necessary/Medical Necessity	Services that, when recommended by a provider for a member are: for the purpose of preventing, diagnosing, or treating an illness, injury, disease or its symptoms; to assist in the member's ability to attain, maintain, or regain functional capacity; for the opportunity for

	a member receiving LTSS to have access to the benefits of community living, to achieve person centered goals, and live and work in the setting of the member's choice; or, for a member to achieve age-appropriate growth and development. Medically Necessary services are requested in accordance with applicable policies and procedures, and provided in a manner that is: (1) in accordance with generally accepted standards of good medical practice in the medical community; (2) consistent with nationally recognized evidence-based guidelines; (3) clinically appropriate, in terms of type, frequency, extent, site, and duration; and (4) not primarily for the economic benefit of Aetna Better Health or for the convenience of the member or provider.[1]
Peer-to-Peer Consultation	A discussion between a requesting practitioner and a medical director/physician reviewer concerning intent to render an adverse determination based on medical necessity review. Adverse determinations are made by the medical director and communicated to practitioners/providers. A peer-to-peer review is optional for a requesting provider and is not part of a prerequisite for an appeal.
Practitioner	A licensed or certified professional who provides medical or behavioral healthcare services.
Prior Authorization	Prior assessment that proposed services (such as hospitalization) are appropriate for a particular patient and will be covered by Aetna Better Health. Payment for services depends on whether the patient and the category of service are covered by the member's benefit plan.
Provider	A person or organization enrolled with the state regulatory agency to provide covered services to a member.[2]
Retrospective Review	Any review for care or services that have already been received. A request for coverage of care that was provided.

[1] DHFS Contract 2018-24-401 Section1.1.127
[2] DHFS Contract 2018-24-401 Section1.1.160

LEGAL/CONTRACT REFERENCE:

- Department of Healthcare and Family Services Contract 2018-24-401
- National Committee for Quality Assurance (NCQA) Standards and Guidelines for the Accreditation of Health Plans
- Code of Federal Regulations (CFR) Title 42 Part 422, Subpart M
- Centers for Medicare & Medicaid Services (CMS) Medicare Managed Care Manual Chapter 13, Section 30

FOCUS/DISPOSITION:

The peer-to-peer review is the presentation of the reviewing medical director's thought process in reviewing all available information submitted to support the demonstration of medical necessity for the requested service(s).

Prior Authorization

A peer-to-peer review may be offered prior to the final determination for services that have not yet begun. If the practitioner's request for a peer-to-peer review is received prior to the date the denial of coverage determination was faxed to the practitioner, the Aetna Better Health staff member:

- Advises the practitioner to submit a new precertification request with all existing and any new or additional information, or
- Advises the practitioner of the availability of the Aetna Better Health member appeal process
- For services that have already begun or have been completed, the request is handled in accordance with the Aetna Better Health provider appeals process
- If the practitioner specifically requests an appeal, then the request is handled in accordance with the Aetna Better Health member appeals process if the service has not yet been rendered or the Aetna Better Health provider appeals process if the service has been provided

Concurrent Review

The request for a peer-to-peer review must be:

- Received prior to the issuance of the final determination, otherwise the Aetna Better Health staff member will advise the requesting practitioner of the availability of the Aetna Better Health provider appeals process.

The peer-to-peer review is conducted by the medical director responsible for the initial determination to deny coverage; if not available, the treating practitioner is referred to an available medical director for the peer-to-peer review.

Peer-to-peer consultations occur between the treating practitioner and an Aetna Better Health medical director. Peer-to-peer consultation occurs timely in accordance with the member's clinical need. Someone other than the treating practitioner can call to schedule the peer-to-peer consultation at the request of the treating practitioner.

Retrospective Review

For retrospective review peer-to-peer requests, the Aetna Better Health staff advise the requesting provider/practitioner of the Aetna Better Health provider appeals process.

Vendor Services

If Aetna Better Health delegates prior authorization or concurrent review to an outside entity, that outside entity is responsible for the peer-to-peer review process. Aetna Better Health remains responsible for all appeals.

Notification[3]

Aetna Better Health notifies the requesting practitioner about the opportunity to discuss a medical necessity denial either in the denial notification (NOA/Adverse Benefit Determination), by telephone or in materials disseminated to the treating practitioner informing him/her of the opportunity to discuss a denial with a reviewer. Aetna Better Health includes the time and date of the denial notification and that the practitioner was notified that a physician or other reviewer is available to discuss the denial.

Decision Making

The Aetna Better Health medical director considers all available information when conducting a peer-to-peer review and the resultant decision is based upon the application of clinical

[3] NCQA HP 2019/2020 UM7 A and D

criteria/guidelines and the clinical information presented both prior to and during the peer-to-peer consultation. The results of a peer-to-peer review are conveyed at the time of the consultation.

If the peer-to-peer consultation does not result in a change of decision, the Aetna Better Health medical director refers the treating practitioner to the denial of coverage appeal provisions provided in the written determination letter, and as appropriate, describes the expedited appeal process.

If there is a change in the determination as a result of the peer-to-peer consultation, in addition to the verbal conveyance of the decision to the practitioner, a written notification of the final determination is sent to the member for pre-service request with a copy to the practitioner.

Required Documentation

Documentation of the peer-to-peer review or attempts to complete the peer-to-peer review is captured within the Aetna Better Health business application system episode notes in the authorization.

OPERATING PROTOCOL:

Systems

- Aetna Better Health business operating systems

Measurement

- Pre-service request:
  - Percentage of peer-to-peer consultations that result in a change of decision
- Concurrent review request:
  - Percentage of peer- to-peer consultations that result in a change of decision
- Retrospective review request:
  - Percentage of peer- to-peer consultations that result in a change of decision

Reporting

- Monthly or as necessary to meet state and regulatory contractual mandated requirements

INTER-/INTRA-DEPENDENCIES:

Internal

- Aetna Medicaid
- Concurrent Review
- Coordination of Benefits
- Finance
- Medical Management
- Member Services
- Network Management
- Prior Authorization
- Provider Relations
- Quality Management

External

- Delegated vendors
- Practitioners

Aetna Better Health