Peer to Peer Review Illinois

Peer-to-peer review is the process through which a treating practitioner or a clinician on behalf of the treating practitioner discusses a clinical denial of coverage determination with a peer reviewer in the same or similar specialty as a physician who typically manages the condition or disease. Peer-to-peer is not an additional level of review or an appeal. It is a focused discussion between these practitioners or a physician assistant/nurse practitioner and the peer reviewer.

- The peer reviewer confirms that the facility physician is initiating the peer-to-peer review on behalf of the treating practitioner prior to conducting a peer-to-peer review with this physician.
- Only one peer-to-peer review is available for each coverage denial determination.
    - Staff refers all subsequent peer-to-peer review requests to the appeal process. This includes treating practitioners that initiate a peer-to-peer review request after the facility physician conducts a peer-to-peer review on behalf of the treating practitioner.
- The health plan may conduct the peer-to-peer review prior to the denial determination or up to 10 calendar days from the date of the denial of coverage letter.
- The health plan does not conduct peer-to-peer reviews after the receipt of an appeal request

The peer reviewer or designee refers the treating practitioner to the appeal language in the denial of coverage letter when the practitioner requests a pre-service peer-to-peer review more than 10 calendar days from the date of the letter. A health plan staff member contacts the practitioner within one business day of receipt of the request to schedule or conduct the peer-to-peer review. The peer-to-peer review occurs as quickly as possible dependent on the urgency of the case but not more than 3 business days from the receipt of the practitioner request unless otherwise agreed to by the MCO and provider.

- The medical director attempts to contact the practitioner at the appointment time to complete the peer-to-peer review. If the provider is not available at the appointment time, the medical director makes one additional attempt within a reasonable timeframe to contact the treating practitioner and complete the peer-to-peer review.

D. Decision Making:

The peer reviewer or behavioral health consultant psychiatrist/psychologist/BCBA-D considers all available information when conducting a peer-to-peer review. The peer reviewer or behavioral health consultant psychiatrist/psychologist/BCBA-D reviews the applicable clinical criteria/guidelines, the clinical information that is present before and during the peer-to-peer discussion and uses clinical judgment to make a decision.

- The peer reviewer communicates the results of the peer-to-peer review to the treating practitioner/ physician on behalf of a facility at the time of the discussion.
- Staff generates a new determination letter within one business day of the peer-to-peer review if the peer reviewer or behavioral health medical director changes the initial coverage decision after the generation of a coverage denial letter.
- The peer reviewer refers the treating practitioner to the appeal process and provides expedited appeal information (upon request or as appropriate) if the peer-to-peer discussion does not result in a change of decision.

- The behavioral health medical director/psychologist/BCBA-D maintains responsibility for all behavioral health initial coverage determinations including those that include a peer-to-peer review prior to the issuance of the coverage decision.

Review/Revision History	
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