



MEDICAL COVERAGE POLICY

SERVICE: Peer-to-Peer Opportunity

Policy Number: 244

Effective Date: 10/01/2021

Last Review: 08/26/2021

Next Review Date: 08/26/2022

Important note:

Unless otherwise indicated, this policy will apply to all lines of business.

Even though this policy may indicate that a particular service or supply may be considered medically necessary and thus covered, this conclusion is not based upon the terms of your particular benefit plan. Each benefit plan contains its own specific provisions for coverage and exclusions. Not all benefits that are determined to be medically necessary will be covered benefits under the terms of your benefit plan. You need to consult the Evidence of Coverage (EOC) or Summary Plan Description (SPD) to determine if there are any exclusions or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and your plan of benefits, the provisions of your benefits plan will govern. However, applicable state mandates will take precedence with respect to fully insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, Federal mandates will apply to all plans. With respect to Medicare-linked plan members, this policy will apply unless there are Medicare policies that provide differing coverage rules, in which case Medicare coverage rules supersede guidelines in this policy. Medicare-linked plan policies will only apply to benefits paid for under Medicare rules, and not to any other health benefit plan benefits. CMS's Coverage Issues Manual can be found on the CMS website. Similarly, for Medicaid-linked plans, the Texas Medicaid Provider Procedures Manual (TMPPM) supersedes coverage guidelines in this policy where applicable.

SERVICE: Peer-to-Peer Opportunity. Also known as “Peer-to-Peer Call” or “P2P”

PRIOR AUTHORIZATION: Not applicable

POLICY: Please review the plan’s EOC (Evidence of Coverage) for details.

For Medicare plans, please refer to appropriate Medicare LCD (Local Coverage Determination). If there is no applicable NCD or LCD, use the information set forth below.

For Medicaid plans, please refer to the Texas Medicaid TMPPM for peer-to-peer details.

BSWHP will afford the provider of record a reasonable opportunity to discuss the plan of treatment for the enrollee with a physician prior to the issuance of an adverse determination consistent with Texas Administrative Code and Texas Insurance Code regarding adverse determinations.

BSWHP will continue to make the Peer-to-Peer Opportunity offered prior to the issuance of the Adverse Determination available up to the issuance of the adverse determination letter. Once the denial letter has been issued, the provider will need to initiate an appeal if they request reconsideration.

Timelines within TAC and TIC for Peer-to-Peer Opportunity and Notice of Adverse Determinations from receipt of request at Health Plan or Insurance Company:

Type of Adverse Determination	P2P Timeline Prior To Denial	Denial Notification Timeline
Prospective / Prior Authorization	No less than one working day	Within 3 working days, written Medicaid – within 2 working days
Retrospective	No less than five working days	Not later than 30 days, written
Concurrent	Up to 4 hours	Within one working day – telephonic or electronic
Post Emergency Stabilization	Up to 1 hour	Not later than one hour

Note: Medicaid prior authorization processing timeframes still must be met in accordance to HHSC guidelines. All peer-to-peer considerations must be arranged within these timeframes.

The Medicaid turnaround times for pre-authorization/ prior authorization requests are noted below (Approvals and Denials):



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- Urgent = Written notification within 3 business/working days
- Routine = Written notification within 3 business/working days

If the allotted peer-to-peer time has not expired, but the processing timeframe is approaching due, plan's decision / notification requirements must be made based on the available information at that time within the processing timeframes.

In order for providers to understand the reason for an adverse determination, they can speak informally about the denial with the reviewing Medical director, if available. Doing so may help the provider decide whether to file an appeal on behalf of the Member. Remember that after the adverse determination letter has been issued, the opportunity for a formal P2P has closed, and only an appeal can change the adverse determination.

OVERVIEW:

Texas Administrative Code and Texas Insurance Code have specified that health plans and insurance companies will offer a reasonable opportunity to discuss the plan of treatment for an enrollee with a physician prior to the issuance of an adverse determination. Reasonable timelines for this opportunity are defined.

Also, within these Codes are defined timelines for the completion of a request for services where an adverse determination applies, and these defined timelines may conflict with the reasonable timelines for peer-to-peer opportunities. When a request for service is received, all the information necessary to make a determination may not be present initially, albeit the timeline for making the determination and notification of that determination has already begun. The defined timelines for completion of the adverse determination will take precedence over Peer-to-Peer Opportunity timelines.

MANDATES:

Texas Administrative Code and Texas Insurance Code apply for this service regarding Peer-to-Peer Opportunity and Adverse Determination Time of Notice Requirements.

SUPPORTING DATA: See Text following "References" below.

CMS: Not applicable.

CODES: Not applicable

POLICY HISTORY:

Status	Date	Action
New Policy	01/30/2018	New policy
Review	05/22/2019	No changes
Review	07/30/2020	Corrected Medicaid turnaround time. Added explanatory paragraph.
Review	08/26/2021	Minor corrections

REFERENCES:

The following references were utilized in the formulation of this medical policy. BSWHP will continue to review references and evidence related to this policy and may modify it at a later date based upon the evolution of the published Administrative Code from the State of Texas. Should additional information become available and this Peer-to-Peer Opportunity



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information is not included in the list, please forward the reference(s) to BSWHP so the information can be reviewed by the Medical Directors/ Medical Coverage Policy (MCPC) and the Quality Improvement Committee (QIC) to determine if a modification of the policy is in order.

1. Texas Administrative Code. Title 28. Insurance, Part 1. Texas Department of Insurance, Chapter 19 Agents' Licensing, Subchapter R. Utilization Reviews for Health Care Provided under a Health Benefit Plan or Health Insurance Policy, Rule 19.1710. Requirements Prior to Issuing Adverse Determination. [http://texreg.sos.state.tx.us/public/readtac\\$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=28&pt=1&ch=19&rl=1710](http://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=28&pt=1&ch=19&rl=1710)
2. Texas Administrative Code. Title 28. Insurance, Part 1. Texas Department of Insurance, Chapter 19 Agents' Licensing, Subchapter R. Utilization Reviews for Health Care Provided under a Health Benefit Plan or Health Insurance Policy, Rule §19.1703 Definitions [http://texreg.sos.state.tx.us/public/readtac\\$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=28&pt=1&ch=19&rl=1703](http://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=28&pt=1&ch=19&rl=1703)
3. Texas Insurance Code. Title 14. Utilization Review and Independent Review, Chapter 4201. Utilization Review Agents. Subchapter E. Utilization Review: Relations with Patients and Health Care Providers, Sec. 4201.206. Opportunity to Discuss Treatment Before Adverse Determination. <http://www.statutes.legis.state.tx.us/Docs/IN/htm/IN.4201.htm>
4. Texas Insurance Code. Title 14. Utilization Review and Independent Review, Chapter 4201. Utilization Review Agents. Subchapter G. Notice of Determinations, Sec. 4201.304. Time for Notice of Adverse Determination. <http://www.statutes.legis.state.tx.us/Docs/IN/htm/IN.4201.htm>

Text from TAC - Requirements Prior to Issuing Adverse Determination

In any instance in which the URA is questioning the medical necessity or appropriateness, or the experimental or investigational nature, of the health care services prior to the issuance of an adverse determination, the URA must afford the provider of record a reasonable opportunity to discuss the plan of treatment for the enrollee with a physician. The discussion must include, at a minimum, the clinical basis for the URA's decision and a description of documentation or evidence, if any, that can be submitted by the provider of record that, on appeal, might lead to a different utilization review decision.

(1) The URA must provide the URA's telephone number so that the provider of record may contact the URA to discuss the pending adverse determination.

(2) The URA must maintain, and submit to TDI on request, documentation that details the discussion opportunity provided to the provider of record, including the date and time the URA offered the opportunity to discuss the adverse determination, the date and time that the discussion, if any, took place, and the discussion outcome.

Source Note: The provisions of this §19.1710 adopted to be effective February 20, 2013, 38 TexReg 892

Text from TAC – Definitions, Reasonable Opportunity

(a) The words and terms defined in Insurance Code Chapter 4201 have the same meaning when used in this subchapter, except as otherwise provided by this subchapter, unless the context clearly indicates otherwise.

(b) The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise.



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(26) Reasonable opportunity--At least one documented good faith attempt to contact the provider of record that provides an opportunity for the provider of record to discuss the services under review with the URA during normal business hours prior to issuing a prospective, concurrent, or retrospective utilization review adverse determination:

- (A) no less than one working day prior to issuing a prospective utilization review adverse determination;
- (B) no less than five working days prior to issuing a retrospective utilization review adverse determination;
- or
- (C) prior to issuing a concurrent or post-stabilization review adverse determination.

Text from Texas Insurance Code – Opportunity to Discuss Treatment before Adverse Determination

Sec. 4201.206. OPPORTUNITY TO DISCUSS TREATMENT BEFORE ADVERSE DETERMINATION. Subject to the notice requirements of Subchapter G, before an adverse determination is issued by a utilization review agent who questions the medical necessity or appropriateness, or the experimental or investigational nature, of a health care service, the agent shall provide the health care provider who ordered the service a reasonable opportunity to discuss with a physician the patient's treatment plan and the clinical basis for the agent's determination.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Amended by: Acts 2009, 81st Leg., R.S., Ch. 1330 (H.B. 4290), Sec. 9, eff. September 1, 2009.

Text from Texas Insurance Code – Time for Notice of Adverse Determination.

Sec. 4201.304. TIME FOR NOTICE OF ADVERSE DETERMINATION. (a) Subject to Subsection (b), a utilization review agent shall provide notice of an adverse determination required by this subchapter as follows:

- (1) with respect to a patient who is hospitalized at the time of the adverse determination, within one working day by either telephone or electronic transmission to the provider of record, followed by a letter within three working days notifying the patient and the provider of record of the adverse determination;
- (2) with respect to a patient who is not hospitalized at the time of the adverse determination, within three working days in writing to the provider of record and the patient; or
- (3) within the time appropriate to the circumstances relating to the delivery of the services to the patient and to the patient's condition, provided that when denying post-stabilization care subsequent to emergency treatment as requested by a treating physician or other health care provider, the agent shall provide the notice to the treating physician or other health care provider not later than one hour after the time of the request.

b) A utilization review agent shall provide notice of an adverse determination for a concurrent review of the provision of prescription drugs or intravenous infusions for which the patient is receiving health benefits under the health insurance policy not later than the 30th day before the date on which the provision of prescription drugs or intravenous infusions will be discontinued.

Added by Acts 2005, 79th Leg., Ch. 727 (H.B. 2017), Sec. 4, eff. April 1, 2007.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1037 (H.B. 1621), Sec. 4, eff. September 1, 2015.



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Sec. 4201.305. NOTICE OF ADVERSE DETERMINATION FOR RETROSPECTIVE UTILIZATION REVIEW.

(a) Notwithstanding Sections 4201.302 and 4201.304, if a retrospective utilization review is conducted, the utilization review agent shall provide notice of an adverse determination under the retrospective utilization review in writing to the provider of record and the patient within a reasonable period, but not later than 30 days after the date on which the claim is received.

(b) The period under Subsection (a) may be extended once by the utilization review agent for a period not to exceed 15 days, if the utilization review agent:

(1) determines that an extension is necessary due to matters beyond the utilization review agent's control; and

(2) notifies the provider of record and the patient before the expiration of the initial 30-day period of the circumstances requiring the extension and the date by which the utilization review agent expects to make a determination.

(c) If the extension under Subsection (b) is required because of the failure of the provider of record or the patient to submit information necessary to reach a determination on the request, the notice of extension must:

(1) specifically describe the required information necessary to complete the request; and

(2) give the provider of record and the patient at least 45 days from the date of receipt of the notice of extension to provide the specified information.

(d) If the period for making the determination under this section is extended because of the failure of the provider of record or the patient to submit the information necessary to make the determination, the period for making the determination is tolled from the date on which the utilization review agent sends the notification of the extension to the provider of record or the patient until the earlier of:

(1) the date on which the provider of record or the patient responds to the request for additional information; or

(2) the date by which the specified information was to have been submitted.

(e) If the periods for retrospective utilization review provided by this section conflict with the time limits concerning or related to payment of claims established under Subchapter J, Chapter 843, the time limits established under Subchapter J, Chapter 843, control.

(f) If the periods for retrospective utilization review provided by this section conflict with the time limits concerning or related to payment of claims established under Subchapters C and C-1, Chapter 1301, the time limits established under Subchapters C and C-1, Chapter 1301, control.

(g) If the periods for retrospective utilization review provided by this section conflict with the time limits concerning or related to payment of claims established under Section 408.027, Labor Code, the time limits established under Section 408.027, Labor Code, control.

Added by Acts 2009, 81st Leg., R.S., Ch. 1330 (H.B. 4290), Sec. 10, eff. September 1, 2009.



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Note: Health Maintenance Organization (HMO) products are offered through Scott and White Health Plan dba Baylor Scott & White Health Plan, and Scott & White Care Plans dba Baylor Scott & White Care Plan. Insured PPO and EPO products are offered through Baylor Scott & White Insurance Company. Scott and White Health Plan dba Baylor Scott & White Health Plan serves as a third-party administrator for self-funded employer-sponsored plans. Baylor Scott & White Care Plan and Baylor Scott & White Insurance Company are wholly owned subsidiaries of Scott and White Health Plan. These companies are referred to collectively in this document as Baylor Scott & White Health Plans.

RightCare STAR Medicaid plans are offered through Scott and White Health Plan in the Central Managed Care Service Area (MRSA) and STAR and CHIP plans are offered through SHA LLC dba FirstCare Health Plans (FirstCare) in the Lubbock and West MRSA's. Individual HMO plans are offered through FirstCare in West Texas.