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ACROinsights – Ins-and-Outs of Peer-to-Peer

The goal of this series of articles is to ensure that radiation oncologists are aware of and provided with the knowledge to ensure day-to-day processes are being addressed in a compliant manner. This installment will discuss the ins-and-outs of the peer-to-peer process. The information contained within this ACROinsights article is meant as general guidance and is not intended to replace appropriate legal or authoritative guidance.

One of the greatest challenges to receiving authorization prior to initiation of therapy or reimbursement after denied payment for radiation oncology services is that individual payers have their own definition of medical necessity which are not consistent across the industry. The Centers for Medicare and Medicaid Services (CMS) indicate within the *Medicare Program Integrity Manual,* Chapter 13, "Local Coverage Determinations" the following:

"An item or service may be covered by a contractor LCD if:

- *It is reasonable and necessary under 1862(a)(1)(A) of The Act. Only reasonable and necessary provisions are considered part of the LCD.*

Reasonable and Necessary

Contractors shall determine and describe in the LCD the circumstances under which the item or service is reasonable and necessary under 1862(a)(1)(A). Contractors shall determine if evidence exist to consider an item or service to be reasonable and necessary if the contractor determines that the service is:

- *Safe and effective;*
- *Not experimental or investigational (exception: routine costs of qualifying clinical trial services with dates of service on or after September 19, 2000 which meet the requirements of the Clinical Trials NCD are considered reasonable and necessary); and*
- *Appropriate, including the duration and frequency that is considered appropriate for the item or service, in terms of whether it is:*
    - *Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member;*
    - *Furnished in a setting appropriate to the patient's medical needs and condition;*
    - *Ordered and furnished by qualified personnel;*
    - *One that meets, but does not exceed, the patient's medical need; and*
    - *At least as beneficial as an existing and available medically appropriate alternative."*

That is a definition that many payers utilize to deny services as not "medically necessary." Every payer has a formal appeal process that providers and patients can use to attempt to convince the payer to cover services, but sometimes the most effective course of action is to request a peer-to-peer review or authorization between physicians to have a clinical discussion about the patient. The review usually takes place between the patient's treating physician and the payer's local or regional Medical Director or designated Clinical Staff.

A peer-to-peer review may occur after a pre-authorization has been denied, or following treatment, charges have been denied by the payer. The process can be tedious and time consuming and requires preparation on the part of the provider seeking payer approval. Connecting two physicians directly often involves several staff members from both sides and can take days. This delay should not be a deterrent to initiating the process, but it is important to have realistic expectations regarding time and effort. A frequent source of frustration for providers is the "peer" may not be of their same specialty. Some payers (many times smaller insurers) do not employ or utilize radiation oncologists to provide the peer-to-peer support, while a larger insurer can or does; but this should not be

expected. Some of the "peers" are often medical specialists who have never cared for cancer patients, have no direct experience with cancer therapies, and are reading from corporate developed "scripts."

Most peer-to-peer reviews take place when it is necessary for a patient's physician to justify a specific order, prescription, or inpatient status. The payer will deny the request or status according to its own internal policies and there is a limited amount of time (24 hours) to provide additional justification or the claim for services will be denied. For radiation oncology services many payers require additional justification for any services beyond "conventional" 2-D or 3-D techniques, and many payers have begun to limit the number of fractions they will pay for specific disease sites. Payers seek to provide the lowest cost option and must be convinced of why other therapies would be better for the care of the patient.

Many commercial payers outsource their prior authorization and medical necessity reviews by utilizing third party companies referred to as Radiology Benefit Management companies (RBMs). These companies generally include review of Radiation Oncology services in addition to their diagnostic imaging business line. There are many companies that provide this service with eviCore[1], HealthHelp[2], AIM Specialty Heath[3] and NIA/Magellan[4] as the most frequently encountered in Radiation Oncology. It is critical to review their specific requirements and guidelines prior to any peer-to-peer interaction, as well as any other appeals, prior authorization, etc. For example, HealthHelp's Clinical Guidelines document contains 171 pages of guidance for each cancer type as well as potential exceptions.

Most payers tend to follow a similar process for prior authorization approval. There are defined intake forms that must be completed by the radiation oncologist's staff and the payer will provide an initial clinical review which is generally performed by non-physicians and usually includes:

- Name and office phone number of Radiation Oncologist planning and delivering radiation therapy
- Patient name and ID number
- Disease site being treated
- Stage
- Treatment intent
- Requested radiation therapy modality (initial and/or boost stages) with
    - Ports/angles
    - Total dose
    - Fractions
    - IGRT type
    - Brachytherapy insertions and fractions
- Name of treatment facility where procedures will be performed
- Anticipated treatment start date

If approval is not granted after submission of the initial required documentation, the payer will either indicate such to the provider or escalate internally for physician review. If the request is escalated to a physician, they will either approve, partially approve, or deny the request. Many times, additional information can be submitted by provider staff to justify the approval, but a peer-to-peer discussion is also appropriate if approval is not received.

RBMs have published evidence-based guidelines for coverage of most radiation oncology services and generally those specific listed services are approved without delay. It is recognized that not every clinical scenario will fit

[1] https://www.evicore.com/solutions/health-plan/utilization-management/radiation-oncology
[2] https://www.healthhelp.com/wp-content/uploads/2019/04/Radiation_Therapy_2018_04.pdf
[3] https://aimspecialtyhealth.com/solutions/health-plans/clinical-solutions/radiation-oncology/
[4] https://www1.radmd.com/media/240255/avmed-radation-oncology-internal-health-plan-training422015.pdf

into the payer or RBM published guidelines and it is not an infrequent occurrence for a treatment course to be selected that does not fit into pre-defined guidelines. When this occurs the Radiation Oncologist is usually asked to submit additional patient-specific information along with scientific references to support the specific course of treatment. Upon review of the submitted information if the payer still does not provide approval, a peer-to-peer conversation between the Radiation Oncologist and the payer's local or regional Medical Director (or designated specialty physician) is in order. Together they will discuss the details of the case with the goal of reaching an agreement the services are covered and thus will be reimbursed.

There is no specific detailed guidance publicly provided by any payer on peer-to-peer reviews. What is provided is a description of the steps in their appeals process, with typical disclaimers indicating that they may vary from that process as they see fit. This lack of structure does allow for latitude for the radiation oncologist but can also create frustration t especially since there can be variation by payer. The American Medical Association (AMA) has compiled a helpful document that outlines each state's prior authorization state law (if in place) and includes information on the qualification of a reviewer. The document can be found at https://www.ama-assn.org/system/files/2021-04/pa-state-chart.pdf. For example, data from the AMA *Advocacy Resource Center*, "2021 Prior Authorization State Law Chart" indicates in Alabama the qualifications of a reviewer are defined as, *"On appeal, all decisions must be made a physician in the same or a similar general specialty as typically manages the medical condition, procedure, or treatment under discussion as mutually deemed appropriate."* The relatively few states that require the same or similar specialty physician perform reviews provide radiation oncologists with a greater opportunity for the other physician to understand their rationale and justification. That said, there could be states that do not have this requirement and the reviewers respect the specialty knowledge and do not require as much information or defense to gain approval.

Some helpful tips for completing peer-to-peer interactions include:

- Review all available documentation before the interaction and have it available for the discussion.
- Review the payer or RBM guidelines to be clear what you are arguing against.
- Be sure that the medical record documentation supports your argument.
- Avoid patronizing attitude with the "peer" physician.
- Avoid argumentative tone
- Keep in mind that the "peer" physician is almost certainly not the individual who has established the policy and is almost certainly not authorized to change the policy: thus, do not debate the policy in general, but speak only to the issue of why the policy deviation should occur for this particular patient.
- Keep in mind that the "peer" understands deviation from the policy may establish precedent, so will be understandably reluctant to make any deviation.
- Where available, cite, and provide, peer-reviewed publications and/or national specialty society guidelines that challenge the policy.
- Document every payer or RBM interaction, including date, time, and the name and title of the individual with whom you spoke in the medical record.

The Take Home Message

Peer-to-peer reviews are a last resort effort that can be employed by Radiation Oncologists to advocate for their patients and the services they feel are best to treat the patient. The process can be time consuming and challenging but is worth the effort when the result provides education for the medical reviewer, ensures reimbursement for the provider, and lowers the patient's personal financial burden. Radiation Oncologists and their staff should understand how each RBM, and payer handles peer-to-peer reviews to utilize this valuable tool for maximum impact. Although acceptance of negative decisions may save time and effort, failure to fight for

what you believe is in the best interest of your patients provides tacit approval for the policy in question and weakens your ability, and that of equally concerned colleagues, to be successful in future disagreements.