blue california
Promise Health Plan

Policy Title: Peer to Peer		POLICY #: 10.02.54	
		Line of Business: Medi-Cal	
Department Name: Utilization Management	Original Date: 10/22	Effective Date: 11/22	Revision Date: 9/24
Governing Committee: Medical Services Committee			
Governing Committee Approval: Jennifer Nuovo, MD, Blue Shield Promise Chief Medical Officer		Date: 9/9/24	
Vice President (VP) Approval: Tracy Alvarez, VP, Medical Care Solutions		Date: 9/9/24	

A. PURPOSE

To establish a standardized process to allow the physician or health care provider to easily contact the professional responsible for the denial, delay, or modification, in accordance with Health and Safety Code (HSC) §1367.01(e), (h)(4).

B. DEFINITIONS

1. "Peer-to-peer review" - a physician-level review of medical records used by Blue Shield Promise professionals to determine whether or not to uphold a denial.

C. POLICY

I. Blue Shield Promise will communicate to the members in writing decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively, or concurrent with the provision of health care services. Blue Shield Promise will also communicate these decisions to providers initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and will include a clear and concise explanation of the reasons for Blue Shield Promise's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. Any written communication to a physician or other health care provider of a denial, delay, or modification of a request will include the name and telephone number of the health care professional responsible for the denial,

delay, or modification.

II. The treating physician will have the ability to speak directly with the Blue Shield Promise Health Plan (Blue Shield Promise) physician responsible for the denial, delay, or modification within five (5) calendar days of the initial decision.

D. PROCEDURE

I. The treating physician requesting a peer-to-peer review will call the number provided in the denial letter to discuss the original authorization request with the Blue Shield Promise physician responsible for the decision.

II. The Utilization Management (UM) staff will review additional information, if provided, and present it to the Blue Shield Promise Medical Director or designated peer reviewer.

III. A peer-to-peer review will occur within one business day of receipt of the provider telephone call request.

IV. If the Blue Shield Promise Medical Director or designated peer reviewer reverses the original determination based on additional information provided by the provider, the case will be updated, and new letters sent.

V. If the peer-to-peer review does not resolve a difference of opinion, the provider may then submit an appeal in writing to the Blue Shield Promise Appeals and Grievances Department. See Provider Dispute Resolution P&P 10.18.20.1 Medi-Cal Provider Dispute Resolution Policy and Procedure.

E. MONITORING

N/A

F. REPORTING

N/A

G. ATTACHMENTS

N/A

H. REFERENCES

1. Health and Safety Code §1367.01(e), (h)(4)
2. 10.18.20.1 Medi-Cal Provider Dispute Resolution Policy and Procedure
3. 2024 NCQA UM 7A & 7D

I. REVISION HISTORY:

Date	Modification (Reviewed and/or revised)	E-filing Number

9/24	2024 Annual Review • Reviewed regulatory requirements	
6/24	• Updated timeframe for peer-to-peer review per current UM process • Clarified peer-to-peer review as physician-to-physician discussion • Added references	
10/23	Annual review • Added context to Policy section • Formatting updates	
	Annual review • Split out of Reconsideration 70.2.23 Peer-to-Peer process • Updated Regulatory Requirements DHCS, DMHC	