

How to request a peer-to-peer review with a Blue Cross or BCN medical director

For Blue Cross' PPO (commercial), Medicare Plus BlueSM PPO,
BCN HMOSM (commercial) and BCN AdvantageSM requests

Revised February 2020

This document provides instructions on requesting a peer-to-peer review with a Blue Cross or Blue Care Network medical director about services for which an authorization request has been denied by Blue Cross or BCN. The purpose of a peer-to-peer review of a determination on either an inpatient or outpatient authorization request is to exchange information about the clinical nuances of the member's medical condition and the medical necessity of the services.

Note: The processes described below do not apply to authorization requests denied by vendors who manage the authorization process for various services on behalf of Blue Cross or BCN.

Section 1: Non-behavioral health services

A - For inpatient non-behavioral health non-elective admissions (in hospitals, inpatient rehabilitation care, skilled nursing facilities and long-term acute care hospitals) — all plans

Exception: For Medicare Plus Blue and BCN Advantage members in inpatient rehabilitation care, skilled nursing facilities and long-term acute hospitals, peer-to-peer reviews are handled by naviHealth. Refer to the document [Post-acute care services: Frequently asked questions for providers](#). Look for the question "How can I talk to a medical director at naviHealth for a peer-to-peer review?"

and for outpatient preservice non-behavioral health services (in offices, clinics, outpatient hospitals, and ambulatory surgery facilities) — BCN HMO

and for preservice elective inpatient surgical admissions requiring clinical review — BCN HMO and Blue Cross PPO

What to do: Complete the [Physician peer-to-peer request form \(for non-behavioral health cases\)](#) and fax it to 1-866-373-9468 during normal business hours of 8 a.m. to 5 p.m. (except for weekends and holidays). Outreach will not occur until the next business day. The peer-to-peer review will be scheduled on business days, Monday through Friday between 9 a.m. and 4 p.m. (except for holidays). (All times are Eastern time.)

Note: For additional information about BCN HMO requests, refer to the [Care Management chapter](#) of the *BCN Provider Manual*. Look in the sections titled "Guidelines for observations and inpatient hospital admissions" and "Utilization management decisions."

B - For outpatient preservice non-behavioral health services (in offices, clinics, outpatient hospitals, and ambulatory surgery facilities) and for preservice elective inpatient surgical admissions requiring clinical review — BCN Advantage and Medicare Plus Blue

What to do, for BCN Advantage: Complete the [Physician peer-to-peer request form \(for non-behavioral health cases\)](#) and fax it to 1-866-522-7345.

Note: A request for a peer-to-peer review about a BCN Advantage member is initiated as a standard preservice member appeal. During the panel review portion of the appeal process, you'll have an opportunity to talk to a medical director. Refer to the [BCN Advantage chapter](#) of the *BCN Provider Manual* for additional information. Look in the section titled "BCN Advantage member appeals."

What to do, for Medicare Plus Blue: You must initiate an appeal before requesting a peer-to-peer review. To initiate an appeal, follow the instructions in the denial letter you received. In the appeal request, you must indicate you want a peer-to-peer review. During the appeal process, you can ask to talk to a medical director at any time.

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C - For outpatient non-behavioral health services (in offices, clinics, outpatient hospitals, and ambulatory surgery facilities) — Blue Cross' PPO

What to do: Fax the following information to 1-866-752-5756:

- A fax cover sheet with the physician's name and NPI number and the patient's name
- A copy of the nonapproval letter
- A telephone number where we can reach the physician
- A minimum of three dates and times when the physician is available

Send the fax during the normal business hours of 8 a.m. to 5 p.m. (except for weekends and holidays). Outreach will not occur until the next business day. The peer-to-peer review will be scheduled on business days, Monday through Friday, between 6 a.m. and 5:30 p.m. (except for holidays); in some instances, we can accommodate a peer-to-peer review between 6 and 8 p.m. (All times are Eastern time.)

General guidelines for all non-behavioral health requests

Requests for peer-to-peer reviews of non-behavioral health determinations on non-elective inpatient and outpatient services must follow the guidelines listed here.

- Submit requests only for denials that are based on medical necessity.

Note: If an authorization was denied for administrative reasons — for example, if the member was not eligible, the service was not a covered benefit or someone other than the member's assigned primary care physician made the referral — a peer-to-peer review cannot be requested because the medical director wasn't the person who denied the authorization request. Administrative denials must be appealed.

- Don't submit for a denial of a member's appeal or grievance. Peer-to-peer reviews are not accepted for a denial related to an appeal or grievance.
- Completion of a peer-to-peer review is not required prior to submitting an appeal request.
- When you request a peer-to-peer review using the *Physician peer-to-peer request form*, you must submit a separate form for each request. We can't accept a form that has information about more than one member. We also can't accept a form used as a face sheet with information about different members attached to it. The reason is that when you fax a form to us, we upload it to the member's case in the e-referral system along with any attachments you've sent with it. If a form uploaded to one member's case has information about other members on it or attached to it, it's a violation of the Health Insurance Portability and Accountability Act.
- Don't submit clinical information after an authorization is denied. Submission of clinical information after an authorization request is denied results in the initiation of an appeal. Once that occurs, it's no longer possible to have a peer-to-peer review, for most members.
- If you miss or refuse to complete a peer-to-peer review with the assigned Blue Cross or BCN medical director, it won't be rescheduled. You'll have to file an appeal.

Note: Peer-to-peer reviews are available only after the initial denial of an authorization request. Also, you must submit the peer-to-peer review request before a provider appeal has been submitted (exception: requests related to Medicare Plus Blue outpatient preservice non-behavioral health services and preservice elective inpatient surgical admissions requiring clinical review). If we denied a first-level provider appeal, you can request a second-level provider appeal. A decision on a second-level provider appeal is binding and final. For more information on appeals, refer to the appropriate provider manual.

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Note: For Medicare Advantage authorizations denied **during or after** a service or admission is provided, you can either request a peer-to-peer review or submit an appeal. For commercial authorizations denied before, during or after a service or admission is provided, you can either request a peer-to-peer review or submit an appeal.

Section 2: Behavioral health services

A - For inpatient behavioral health admissions — BCN HMO and BCN Advantage and for outpatient behavioral health services — BCN HMO

What to do: Call BCN Behavioral Health at 1-877-293-2788 during normal business hours of 8 a.m. to 5 p.m. (except for holidays).

If the call is not answered by a staff member, leave a message with the following information:

- Physician advisor's or physician's name and phone number
- Member's name, date of birth and contract number
- Reason for requesting a peer-to-peer review

After hours, for emergency cases only, call 1-800-482-5982.

Note: Refer to the [Behavioral Health chapter](#) of the *BCN Provider Manual* for additional information. Look in the section titled "Authorization for behavioral health services."

B - For outpatient behavioral health services — BCN Advantage

What to do: Fax the request to the BCN Advantage Appeals and Grievance unit at 1-866-522-7345 along with any pertinent clinical documentation.

Note: A request for a peer-to-peer review about a BCN Advantage member is initiated as a standard preservice member appeal. Refer to the [BCN Advantage chapter](#) of the *BCN Provider Manual* for additional information. Look in the section titled "BCN Advantage member appeals."

C - For inpatient and outpatient (intensive outpatient) behavioral health services — Medicare Plus Blue

What to do: Call Behavioral Health at 1-877-293-2788 during normal business hours of 8 a.m. to 5 p.m. (except for weekends and holidays).

If the call is not answered by a staff member, leave a message with the following information:

- Physician advisor's or physician's name and phone number
- Member's name, date of birth and contract number
- Reason for requesting a peer-to-peer review

After hours, for emergency cases only, call 1-888-803-4960.

Note: Refer to the [Medicare Plus Blue PPO Manual](#) for additional information.

D - For behavioral health services — Blue Cross' PPO requests not managed by New Directions

What to do: Call the number on the back of the member's ID card.

E - For behavioral health services — Blue Cross' PPO requests managed by New Directions

What happens: New Directions utilization management staff notify the provider that the authorization request is placed in physician review status and identifies the date and time by which the review must be completed. New Directions tries to schedule a time for the review; if they are unable to, they make two attempts to reach the attending physician prior to the deadline. If New Directions can't reach the attending physician, they make a determination on the authorization request based on the available information.



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During this process, the provider can call the assigned New Directions utilization management representative directly or call New Directions:

- Federal Employee Program®: 1-800-342-5891
- GM salaried: 1-877-240-0705
- MESSA: 1-800-336-0022
- State of Michigan: 1-866-503-3158
- UAW Retiree Medical Benefits Trust: 1-877-228-3912
- All other groups: 1-800-762-2382