ILLINOIS STATE MEDICAL SOCIETY

Resolution 12.2022-34
(A-23)

Introduced by: John V. Prunskis, MD, ISMS Member

Subject: Peer to Peer Reviewer Must be of Same Specialty as Physician Requesting Procedure

Referred to: Medical Legal Council

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1 Whereas, peer to peer reviews frequently involve physicians that are not of the
2 same specialty designation as the physician requesting that a patient have a certain
3 procedure; and
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5 Whereas, denials of necessary procedures benefiting the patient unfortunately
6 occur during peer to peer route reviews where the physician reviewer is not of the same
7 specialty as the physician recommending a particular procedure; therefore, be it
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9 RESOLVED, that the Illinois State Medical Society (ISMS) adopt policy in
10 support of and cause to be introduced legislation requiring any peer to peer review
11 require a physician from the same specialty as the physician requesting a procedure for
12 a patient, be involved in the peer to peer phone call and decision process; and be it
13 further
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15 RESOLVED, that the Illinois delegation to the AMA submit a resolution
16 directing the AMA to adopt similar policy.

Fiscal Note:

None

Existing ISMS policy related to this issue:

Board of Trustees approved the following PRO Criteria and authorized the chairman to make appropriate use of these criteria: • Be broadly representative, both in terms of clinical practice and geography, of physicians in Illinois. • Be sensitive to the need for review at the earliest reasonable opportunity by a physician with clinical experience in the same area as the physician under review. • Be committed to a cooperative working

relationship with organized medicine, including, where possible, discussion about policy development prior to implementation. • Be committed to a peer review program which emphasizes quality assurance and improvement, attempts to educate the physician, and which utilizes punitive measures as a last resort. • Allow physicians under review adequate due process for appeal. • Provide timely notification of review decisions. • Allow appropriate opportunity for physicians to respond to review decisions. • If possible, be an in-state organization. • Utilize only those physician reviewers who are licensed to practice medicine in all its branches in Illinois. • Conduct appropriate outreach and educational efforts. • Have clear policies avoiding potential conflicts of interest (e.g. no financial relationship to CME or RCME programs by the PRO). • Allow medical society comment upon and provide for release of all review screens. • Provide a process for oversight and education of reviewers. • Be responsive to beneficiary concerns by conducting appropriate outreach activities. • Be committed to continual improvement of the quality and the process of peer review. (BOT 1992-JUN)

House of Delegates adopted Sub. Res. 42 (A-88) as amended which directed that the Society: (1) Work to ensure that PRO standards and criteria are developed and applied equitably; (2) Act to initiate any measures deemed appropriate, including the involvement of HCFA (CMS), the AMA, and the Congressional Delegation, to ensure that these PRO standards, criteria and procedures are implemented in a proper manner; and (3) Support the concept that only qualified, practicing physicians be designated as reviewers of physicians in the same specialty being reviewed. (HOD 1988)

The Board of Trustees approved that ISMS develop and pursue a long-term strategy in developing specific state legislative remedies to reduce or eliminate unnecessary prior authorization requirements. (BOT - JAN 2019)

House of Delegates adopted Substitute Resolution B210 (A-17), Peer-to-Peer, which states: RESOLVED, that ISMS formally adopt and incorporate the AMA Prior Authorization and Utilization Management Reform Principles into its policy manual; and be it further RESOLVED, that ISMS widely share these principles with governmental and private sector third party payers, as appropriate, and specifically in Illinois with the Department of Insurance (DOI) and Department of Healthcare and Family Services (DHFS), urging all third party payers and oversight agencies to adopt guidelines that comply with these principles; and be it further RESOLVED, that ISMS seek or cause to be introduced specific state legislative remedies, as necessary, to cause Illinois third party payers to implement the utilization and prior approval practices addressed in these principles. (HOD 2018; Unfinished Business Report E) *NOTE: Substitute Resolution B210 (A-17) adopted in lieu of Resolutions B210 (A-17) and B212 (A-1

ISMS formally adopts as policy the AMA Prior Authorization and Utilization Management Reform Principles, which can be viewed via: https://www.ama-assn.org/sites/default/files/media-browser/principles-with-signatory-page-for-slsc.pdf (HOD 2018)

Existing AMA policy related to this issue:

Managed Care H-285.998
…(5) Utilization Review The medical protocols and review criteria used in any utilization review or utilization management program must be developed by physicians. Public and private payers should be required to disclose to physicians on request the screening and review criteria, weighting elements, and computer algorithms utilized in the review process, and how they were developed.
A physician of the same specialty must be involved in any decision by a utilization management program to deny or reduce coverage for services based on questions of medical necessity. All health plans conducting utilization management or utilization review should establish an appeals process whereby physicians, other health care providers, and patients may challenge policies restricting access to specific services and decisions to deny coverage for services, and have the right to review of any coverage denial based on medical necessity by a physician independent of the health plan who is of the same specialty and has appropriate expertise and experience in the field.
A physician whose services are being reviewed for medical necessity should be provided the identity of the reviewing physician on request. Any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of services should be licensed to practice medicine and actively practicing in the same jurisdiction as the practitioner who is proposing or providing the reviewed service and should be professionally and individually accountable for his or her decisions….

Approaches to Increase Payer Accountability H-320.968
Our AMA supports the development of legislative initiatives to assure that payers provide their insureds with information enabling them to make informed decisions about choice of plan, and to assure that payers take responsibility when patients are harmed due to the administrative requirements of the plan. Such initiatives should provide for disclosure requirements, the conduct of review, and payer accountability.

…(2) Conduct of Review. Our AMA supports the development of additional draft state and federal legislation to: (a) require private review entities and payers to disclose to physicians on request the screening criteria, weighting elements and computer algorithms utilized in the review process, and how they were developed; (b) **require that any physician who recommends a denial as to the medical necessity of services on behalf of a review entity be of the same specialty as the practitioner who**

provided the services under review; (c) Require every organization that reviews or contracts for review of the medical necessity of services to establish a procedure whereby a physician claimant has an opportunity to appeal a claim denied for lack of medical necessity to a medical consultant or peer review group which is independent of the organization conducting or contracting for the initial review; (d) require that any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of service be licensed to practice medicine in the same jurisdiction as the practitioner who is proposing the service or whose services are being reviewed; (e) require that review entities respond within 48 hours to patient or physician requests for prior authorization, and that they have personnel available by telephone the same business day who are qualified to respond to other concerns or questions regarding medical necessity of services, including determinations about the certification of continued length of stay …

Prior Authorization and Utilization Management Reform H-320.939
… Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician…

Promoting Accountability in Prior Authorization D-285.960
Our AMA will: (1) advocate that peer-to-peer (P2P) prior authorization (PA) determinations must be made and actionable at the end of the P2P discussion notwithstanding mitigating circumstances, which would allow for a determination within 24 hours of the P2P discussion; (2) advocate that the reviewing P2P physician must have the clinical expertise to treat the medical condition or disease under review and have knowledge of the current, evidence-based clinical guidelines and novel treatments; (3) advocate that P2P PA reviewers follow evidence-based guidelines consistent with national medical specialty society guidelines where available and applicable; (4) continue to advocate for a reduction in the overall volume of health plans' PA requirements and urge temporary suspension of all PA requirements and the extension of existing approvals during a declared public health emergency; (5) advocate that health plans must undertake every effort to accommodate the physician's schedule when requiring peer-to-peer prior authorization conversations; and (6) advocate that health plans must not require prior authorization on any medically necessary surgical or other invasive procedure related or incidental to the original procedure if it is furnished during the course of an operation or procedure that was already approved or did not require prior authorization.

Medical Necessity Determinations H-320.995

(1) Our AMA urges: (a) health insurance carriers and government health care financing agencies to rely on appropriate medical peer review programs for adjudication and resolution of all matters concerning quality or utilization of medical services requiring professional judgment, and (b) that peer review programs have as their goal both improved quality of care and more efficient delivery of medical service.

(2) Our AMA urges health insurance carriers, government financing agencies, physicians and medical societies to explore ways of improving communications, such as the following: (a) In furtherance of past Association recommendations that policyholders be thoroughly and clearly informed as to the extent of their coverage, more detailed information explaining the "medical necessity" exclusion should be provided, especially when the exclusion refers more to the site of the service than to the service itself. (b) Insurers should develop formal protocols as to their methodology for determining "medical necessity," including distinctions between those instances where in-house medical expertise is considered sufficient and those where outside consultation is considered necessary; (c) Third party methodologies for determining "medical necessity" should be made available to medical societies and to individual physicians, as well as listings of those specific situations (such as the ordering of either experimental or outdated procedures or questionable hospital admissions) where additional data may be required; (d) In "medical necessity" decisions where the determination may be modified by additional medical evidence, there should be an opportunity for the treating physician to provide such evidence before a final decision not to pay is made.