Evolent Clinical Guideline 2714.CC for Peer-to-Peer Review Process

Guideline Number: EVH_CG_2714.CC	Applicable Codes	
"Evolent" refers to Evolent Health LLC and Evolent Specialty Services, Inc. 		
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STATEMENT

General Information

- *It is an expectation that all patients receive care/services from a licensed clinician. All appropriate supporting documentation, including recent pertinent office visit notes, laboratory data, and results of any special testing must be provided. If applicable: All prior relevant imaging results and the reason that alternative imaging cannot be performed must be included in the documentation submitted.*
- *Where a specific clinical indication is not directly addressed in this guideline, medical necessity determination will be made based on widely accepted standard of care criteria. These criteria are supported by evidence-based or peer-reviewed sources such as medical literature, societal guidelines, and state/national recommendations.*
- *The guideline criteria in the following sections were developed utilizing evidence-based and peer-reviewed resources from medical publications and societal organization guidelines as well as from widely accepted standard of care, best practice recommendations.*

Purpose

The purpose of this policy is to define the peer-to-peer process including the actions required and the turnaround time to complete.

POLICY

It is the policy of CountyCare Health (CountyCare), to offer and complete the **peer-to-peer review process** after adverse determinations have been completed as required by government requirements, federal and state law, and regulation.

It is the policy of CountyCare not to prohibit providers from requesting peer-to-peer reviews in accordance with requirements set forth in DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES NOTICE OF EMERGENCY AMENDMENT - Section 140.76 Managed Care Utilization Review Standardization and Transparency Practices.

General Note

CountyCare adheres to the requirements for peer-to-peer reviews for health care services that are subject to its service authorization programs. MCOs may request peer-to-peer reviews but shall not automatically require peer-to-peer reviews as part of its service authorization program.

PROCEDURE

- Providers may request a peer-to-peer review within required turnaround times after receipt of the CountyCare (i) notice of intent to make an adverse determination, (ii) request for further documentation, or (iii) notice of adverse benefit determination.

- CountyCare shall make exceptions to this timeframe on a case-by-case basis to accommodate unique, provider-specific circumstances.
- A peer-to-peer review request shall not alter the grievance and appeals rights of enrollees.
- CountyCare may request peer-to-peer reviews but shall not automatically require peer-to-peer reviews as part of its service authorization program.
- If compliance with contractually required timeframes results in a determination being made after a peer-to-peer is scheduled but before the peer-to-peer occurs, CountyCare shall not be out of compliance with required service determinations turnaround times.
- CountyCare shall allow both in-network and out-of-network providers to schedule and request a peer-to-peer review telephonically or in writing by electronic means, facsimile, and web-based secure functionality.
- CountyCare must also allow in-network providers to request and schedule a peer-to-peer review through the provider portal (electronic submission).
- Peer-to-peer reviews shall be held in a manner most efficiently to meet the needs of the enrollee and may be in-person, telephonic, or web based as agreed to by the provider and CountyCare.
- CountyCare must use physicians who are in the same or similar specialty as a physician who typically manages the medical condition or disease.
- CountyCare shall allow providers to submit additional clinical documentation which shall be considered during the peer-to-peer review.
- If requested by the provider, CountyCare shall accept the documentation in lieu of the peer-to-peer review and complete a reconsideration.
    - If based on the clinical information received, CountyCare can modify the original intent to make an adverse determination and is able to approve the service request with the additional information, CountyCare will complete a reconsideration and send an approval determination.
    - If based on the clinical information received, CountyCare cannot modify the original intent to make an adverse determination, and CountyCare shall notify the provider of its decision before the date of the peer-to-peer review to allow the provider the option to cancel or continue with the peer-to-peer review.

PEER-TO-PEER TURNAROUND TIMES (TAT)

- Providers may request a peer-to-peer review within ten (10) calendar days of receipt of the CountyCare (i) notice of intent to make an adverse determination, (ii) request for further documentation, or (iii) notice of adverse benefit determination.
    - CountyCare shall make exceptions to this timeframe on a case-by- case basis to accommodate unique, provider-specific circumstances.
    - A peer-to-peer review request shall not alter the grievance and appeals rights of

enrollees.

- CountyCare shall respond to a request for a peer-to-peer review within one (1) business day of receipt of the request confirming the date and time of the peer-to-peer review and instructions for facilitating the review.
- Unless otherwise agreed to by CountyCare and provider, CountyCare shall hold a peer-to-peer review within three (3) business days of receipt of the request.
- When scheduling a peer-to-peer review, CountyCare works with the provider to schedule at their convenience but in cases where they are unable to have a direct conversation with the provider, they will offer at least three (3) dates and times for the review to be completed.
- In cases where CountyCare fails to attend a scheduled peer-to-peer review or otherwise is unable to hold a peer-to-peer review within three (3) business days of receipt of request, CountyCare must treat all post-denial actions, including, but not limited to, appeals when the provider submits the appeal or other post-denial action as urgent.

PROVIDER NOTIFICATION AFTER PEER-TO-PEER

- CountyCare may verbally notify the provider of its decision during or after the peer-to-peer review. However, CountyCare must issue a written decision to the provider submitting the service authorization request within twenty-four (24) hours of the date and time of the peer-to-peer review.
- The written notice shall be issued by electronic means, facsimile, portal, or web-based secure functionality. The written notice shall minimally include the following:
    - Date notice is issued
    - Identification of the health care service
    - The effective date of the decision
    - Plain language instructions on the appeal rights of enrollees, including:
        - the procedures enrollees must follow to exercise their right to an appeal;
        - the circumstances under which an appeal process can be expedited and how to request it;
        - any rights of enrollees to have benefits continue pending resolution of the appeal and how to request that benefits be continued;
        - the right of enrollees to request a fair hearing and the process;
        - the right of the provider to submit a service authorization dispute of the medical necessity denial and the process, and the circumstances under which an external independent review may be requested, consistent with Department policy.
- For service authorization determinations not wholly in favor of the enrollee such as denials, limits, conditions, or restrictions of a health care service, a detailed basis for the determination with any data used to explain the decision, including:

- The principal reason(s) for the determination, including, if applicable, a statement that the determination was based on a failure to submit specified medical records
- Additional documentation necessary for reconsideration or to support an appeal of an adverse benefit determination
- The clinical basis for the determination
- A description of the sources, including citations, that were used in making the determination
- The professional specialty of the individual who made the determination

CODING AND STANDARDS

Codes

N/A

Applicable Lines of Business

☐	CHIP (Children's Health Insurance Program)
☐	Commercial
☐	Exchange/Marketplace
☒	Medicaid
☐	Medicare Advantage

POLICY HISTORY

Date	Summary
November 20, 2025	• This guideline replaces PA.261.CC Peer-to-Peer Review Process • Editorial changes to match the formatting and layout of the new template, no changes to clinical content

LEGAL AND COMPLIANCE

Guideline Approval

Committee

Reviewed / Approved by Evolent Administrative Services Medical Policy Committee

Disclaimer

Evolent Clinical Guidelines do not constitute medical advice. Treating health care professionals are solely responsible for diagnosis, treatment, and medical advice. Evolent uses Clinical Guidelines in accordance with its contractual obligations to provide utilization management. Coverage for services varies for individual members according to the terms of their health care coverage or government program. Individual members' health care coverage may not utilize some Evolent Clinical Guidelines. Evolent clinical guidelines contain guidance that requires prior authorization and service limitations. A list of procedure codes, services or drugs may not be all inclusive and does not imply that a service or drug is a covered or non-covered service or drug. Evolent reserves the right to review and update this Clinical Guideline in its sole discretion. Notice of any changes shall be provided as required by applicable provider agreements and laws or regulations. Members should contact their Plan customer service representative for specific coverage information.

REFERENCES

1. Illinois Department of Healthcare and Family Services. Notice of Emergency Amendment. Section 140.76 Managed Care Utilization Review Standardization and Transparency Practices. **https://team-iha.org/getmedia/5789ff70-d722-4170-94c9-01ca99c737c0/Standardization-Rules.pdf?utm_campaign=Daily%20Briefing&utm_source=hs_email&utm_medium=email&_hsenc=p2ANqtz-_QRPlneUP34o-V0-ovdTztP9lF0Bh65o0oj2p-oPQOJG8vX6uVN5MHYCK9AZjlZbpoOE5K**