Peer-to-peer reviews policy for medical authorizations

What's a peer-to-peer review?
A peer-to-peer review (P2P) is a discussion between a Priority Health Medical Director or Physician Reviewer and a member's treating physician following a medical authorization denial. The purpose of a P2P is to discuss the clinical information submitted with the initial authorization request.

This process allows providers to have regular, direct access to Priority Health Medical Directors or Physician Reviewers to discuss authorization denials.

Priority Health's Chief Medical Officer, VP of Medical and Clinical Operations, Medical Directors or Physician Reviewers may determine medical necessity for cases that don't meet medical criteria. We require clinical data to support medical necessity before authorizing days / services.

What information is considered at a P2P?
In alignment with industry standards, P2Ps will only consider the information submitted with the initial authorization request.

We'll classify any additional information submitted after the initial denial, whether accompanying the P2P or otherwise, as a level 1 appeal and cancel the P2P.

This will go into effect for inpatient P2Ps on Sept. 4, 2024, and for pre-service P2Ps on Oct. 9, 2024.

When is a P2P available?
Providers may request a P2P for any authorization request denied in accordance with National Committee for Quality Assurance (NCQA) utilization management standards, during the following timelines:

Request type	P2P request timeline
Pre-service requests	Within **15 calendar days** from the date of the denial notification
Inpatient urgent / emergent admission or long-term acute care hospital requests	Within **5 calendar days** from the date of the denial notification
Post-acute skilled nursing facility or acute / sub-acute rehab requests	Within **5 calendar days** from the date of the denial notification

When is a P2P not available?
A P2P isn't available to discuss administrative denial reasons including but not limited to non-covered services, benefit exceptions, ineligible members, readmissions or disputes regarding CMS 4201-F as published in the Federal Register (i.e., Two Midnight Rule).

Additionally, P2P requests aren't permitted:

- If a member or provider appeal has been submitted
- For retrospective authorizations, when the authorization request is submitted after the member was discharged
- For Medicare pre-service denials – Medicare doesn't allow reversal of adverse determinations via peer-to-peer review discussions for pre-service denials. Providers will need to request an appeal

How can providers request a P2P?
Every provider authorization denial notice includes information on how to request a P2P. If a provider requests a P2P, we'll call them to get it scheduled.

If the provider is unavailable at the scheduled call time / misses the P2P call, they may submit a medical necessity appeal. P2P call lines don't have a call-back feature.